

**COMBINED
School Employees
Benefits Board Meeting
and
Public Employees
Benefits Board Meeting**

September 17, 2018

SPECIAL MEETING

Public Employees Benefits Board School Employees Benefits Board

September 17, 2018
2:45 p.m. – 4:55 p.m.

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

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Public Employees Benefits Board

September 17, 2018
4:55 p.m. – 5:00 p.m.

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| June 7, 2018 Meeting | |
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| July 17, 2018 Meeting | |

TAB 1

Special Meeting
School Employees Benefits Board
September 17, 2018
1:00 p.m. – 2:30 p.m.
Sue Crystal Rooms A & B

Health Care Authority
 Cherry Street Plaza
 626 8th Avenue SE
 Olympia, WA 98501

Call-in Number: 1-888-407-5039

Participant PIN Code: 60995706

| 1:00 p.m.* | Welcome and Introductions | | Lou McDermott, Chair | |
|------------|----------------------------------|-------|---|----------------------------|
| 1:05 p.m. | Meeting Overview | | David Iseminger, Director Employees & Retirees Benefits (ERB) Division | Information |
| 1:10 p.m. | Vision Benefit | TAB 3 | Lauren Johnston, SEBB Procurement and Account Manager, ERB Division | Action |
| 1:20 p.m. | Disability Insurance | TAB 4 | Betsy Cottle, Contract Manager SEB Section, ERB Division Cade Walker, Executive Special Assistant to the ERB Division Director | Information/ Discussion |
| 2:20 p.m. | Public Comment | | | |
| 2:30 p.m. | Adjourn SEBB Meeting | | | |

*All Times Approximate

Special Meeting
COMBINED School Employees Benefits Board
and Public Employees Benefits Board
September 17, 2018
2:45 p.m. – 4:45 p.m.
Sue Crystal Rooms A & B

Health Care Authority
 Cherry Street Plaza
 626 8th Avenue SE
 Olympia, WA 98501

Call-in Number: 1-888-407-5039

Participant PIN Code: 60995706

| 2:45 p.m.* | Welcome and Introductions | | Sue Birch, Chair | |
|------------|---|-------|---|----------------------------|
| 2:50 p.m. | Meeting Overview | | David Iseminger, Director Employees & Retirees Benefits (ERB) Division | Information |
| 2:55 p.m. | Retired and Disabled School Employees Risk Pool Analysis | TAB A | Kayla Hammer, Fiscal Information & Data Analyst, Financial Services Division Kim Wallace, SEBB Finance Manager, Financial Services Division | Information/ Discussion |

| | | | | |
|-----------|---------------------------------|--|--|--|
| 4:25 p.m. | Public Comment | | | |
| 4:45 p.m. | Adjourn Combined Meeting | | | |

*All Times Approximate

Special Meeting

**Public Employees Benefits Board
September 17, 2018
4:50 p.m. – 5:00 p.m.
Sue Crystal Rooms A & B**

Health Care Authority
Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98501

Call-in Number: 1-888-407-5039

Participant PIN Code: 60995706

| | | | | |
|------------|---|-------|------------------|--------|
| 4:50 p.m.* | Welcome and Introductions | | Sue Birch, Chair | |
| 4: 55 p.m. | Approval of Minutes for: March 21, 2018 Meeting April 25, 2018 Meeting May 21, 2018 Meeting June 7, 2018 Meeting June 20, 2018 Meeting July 17, 2018 Meeting | TAB 3 | Sue Birch, Chair | Action |
| 5:00 p.m. | Adjourn PEBB Meeting | | | |

*All Times Approximate

The School Employees Benefits Board will meet Monday, September 17, 2018, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8th AVE SE, Olympia, WA. The SEBB Meeting will start at 1:00 p.m.

The School Employees Benefits Board and Public Employees Benefits Board will meet in combined session on September 17, 2018, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8th AVE SE, Olympia, WA. The Combined SEBB and PEBB Meeting will start at 2:45 p.m.

The Public Employees Benefits Board will meet Monday, September 17, 2018, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8th AVE SE, Olympia, WA. The PEBB Meeting will start at 4:50 p.m.

Final disposition shall not be taken on any matter not listed on the agenda.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

Direct SEBB e-mail to: SEBboard@hca.wa.gov. Materials posted at: <https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program> by close of business on September 14, 2018.

Direct PEBB e-mail to: board@hca.wa.gov. Materials posted at: <http://www.pebb.hca.wa.gov/board/> no later than close of business on September 14, 2018.

TAB A



Retired and Disabled School Employees Risk Pool Analysis

Kayla Hammer
Fiscal Information & Data Analyst
Financial Services
September 17, 2018



Overview

- Background
 - What is the report?
 - Purpose
 - Risk and risk pools
- Anticipated 2020 risk pools
- 2018 PEBB Program enrollment
- PEBB Program Non-Medicare risk pool data & info
- PEBB Program Medicare risk pool data & info
- Retired and disabled school employee risk pool scenarios and implications

What is the Report?

- RCW 41.05.022(4) requires that the Health Care Authority, in consultation with the PEB and SEB Boards, complete and submit an analysis of the most appropriate risk pool for the retired and disabled school employees.
- This analysis is due to the Legislature on December 15, 2018.

Purpose

- HCA is responsible for reporting on the most appropriate risk pool for retired and disabled school employees
- Comments and feedback from Board consultations will be documented
- Appropriate risk pool considerations:
 - Cost impacts
 - Member experience
 - State and federal laws and regulations
 - Implementation and administration complexity

Insurance Risk

The likelihood that an insured event will occur, requiring the insurer to pay a claim.



What is a Risk Pool?

- A group of individuals whose medical risks and costs are combined and evaluated to calculate premiums
- Regardless of personal circumstances if you are part of a risk pool, you pay the same rates for the same plans as everyone in your pool
- Pooling risks allows costs of the less healthy to be offset by the relatively lower costs of the healthy
- The amount of risk impacts the premiums

Risk Pool Dynamics

- Risk pool changes would not result in aggregate cost savings
- Risk pool changes could impact individuals differently
- Combining people with different levels of health risk into a single risk pool increases the level of subsidization from the relatively healthy to the relatively unhealthy; combining people with the same level of health risk has the opposite effect

Anticipated 2020 Medical Risk Pools

PEBB Program Non-Medicare Risk Pool

*State Employees

Non-Medicare
*State Retirees

Non-Medicare
School Retirees

PEBB Program Medicare Risk Pool

Medicare *State
Retirees

Medicare School
Retirees

SEBB Program Risk Pool

School Employees

*State also includes other groups: political subdivision, etc.

Anticipated 2020 Risk Pool Considerations

- PEBB Program Non-Medicare risk pool combines state* employees with state* and school retirees not eligible for Medicare
 - The risk pool is community rated across plans
 - Rates are based on the level of risk within the entire pool
 - State active premium contributions are a portion of the community rate
 - Non-Medicare retirees pay the community rate
- PEBB Program Medicare risk pool combines all state* and K-12 retirees eligible for Medicare
 - Plans are not the same as the Non-Medicare pool
 - Plans are rated separately based on experience
 - State premium contributions are a portion of the plan rate up to a monthly limit

• *State employee includes: political subdivision, K-12, COBRA, etc.

• *State retiree includes: state and political subdivision

2018 PEBB Program Enrollment Data

PEBB Program Member Enrollment

| Group | Associated Risk Pool | Approximate Member Count |
|-----------------------------|---------------------------|--------------------------|
| *State Employees | PEBB Program Non-Medicare | 275,000 |
| *State Retiree Non-Medicare | PEBB Program Non-Medicare | 5,300 |
| *State Retiree Medicare | PEBB Program Medicare | 46,000 |
| School Retiree Non-Medicare | PEBB Program Non-Medicare | 4,000 |
| School Retiree Medicare | PEBB Program Medicare | 48,000 |
| Total | | 380,000 |

- PEBB Program approximate member counts as of August 2018
- *State employee includes: political subdivision, K-12, COBRA, etc.
- *State retiree includes: state and political subdivision

Subscriber Enrollment

| Group | Associated Risk Pool | Approximate Subscriber Count |
|-----------------------------|---------------------------|------------------------------|
| *State Employee | PEBB Program Non-Medicare | 133,000 |
| *State Retiree Non-Medicare | PEBB Program Non-Medicare | 3,000 |
| *State Retiree Medicare | PEBB Program Medicare | 34,000 |
| School Retiree Non-Medicare | PEBB Program Non-Medicare | 2,600 |
| School Retiree Medicare | PEBB Program Medicare | 34,000 |
| Total | | 207,000 |

- PEBB Program approximate subscriber counts as of August 2018
- *State employee includes: political subdivision, K-12, COBRA, etc.
- *State retiree includes: state and political subdivision

2017 PEBB Program Non-Medicare Risk Pool Data

What is a Risk Score?

- A calculated number that is reflective of the risk within a population, or morbidity
- Calculation based on:
 - Demographic information
 - Diagnosis Codes
 - Drug Codes
 - Utilization
- Populations with higher average risk scores are expected to have higher claims costs

Non-Medicare Relative Risk Scores

| Group | Associated Risk Pool | Avg. Risk Score |
|-----------------------------|---------------------------|-----------------|
| State Employee | PEBB Program Non-Medicare | 0.968 |
| State Retiree Non-Medicare | PEBB Program Non-Medicare | 1.853 |
| School Retiree Non-Medicare | PEBB Program Non-Medicare | 1.682 |

- 2017 PEBB Program claims data
- Relative to statewide average of 1.0

Average Monthly Non-Medicare Paid Claims

| Group | Associated Risk Pool | Approximate Paid |
|-----------------------------|---------------------------|------------------|
| State Employee | PEBB Program Non-Medicare | \$520 |
| State Retiree Non-Medicare | PEBB Program Non-Medicare | \$873 |
| School Retiree Non-Medicare | PEBB Program Non-Medicare | \$678 |

- 2017 PEBB Program claims data
- Relative to statewide average of \$535
- Dollar amount is per adult unit per month
- Cost based on utilization and plan selection

Annual Non-Medicare Risk Pool Paid Claims

| Group | % Member Enrollment | Total Paid Claims |
|-----------------------------|---------------------|-------------------|
| State Employee | 62% | \$1,171,262,071 |
| State Retiree Non-Medicare | 13% | \$48,968,744 |
| School Retiree Non-Medicare | 14% | \$35,958,026 |

- 2017 PEBB Program claims data

PEBB Program Medicare Risk Pool

Medicare Risk Pool

- Medicare risk pool information shared separately for numerous reasons:
 - The risk pools are currently separate
 - The insurance plans are different
 - Reimbursement is different
- PEBB Medicare plans are either secondary to Medicare or Medicare Advantage plans

Medicare Risk Scores

- K-12 Medicare retirees are slightly more healthy than the Medicare risk pool as a whole
- K-12 Medicare retirees have significantly higher risk scores than active employees and early retirees
- There are challenges comparing the Medicare Retirees to Non-Medicare

Annual Medicare Risk Pool Medical Benefit Costs

| Group | % Member Enrollment | Medical Benefits Cost |
|-------------------------|---------------------|-----------------------|
| State Retiree Medicare | 46% | \$181,572,064 |
| School Retiree Medicare | 52% | \$186,340,420 |

- Medical benefit cost based on: paid self-insured claims, administrative fees, and fully insured premiums

Scenarios: Implications & Considerations

Create SEBB Program Non-Medicare Risk Pool

PEBB Program Non-Medicare Risk Pool

State Employees

Non-Medicare
State Retirees

PEBB Program Medicare Risk Pool

Medicare State
Retirees

Medicare School
Retirees

SEBB Program Non-Medicare Risk Pool

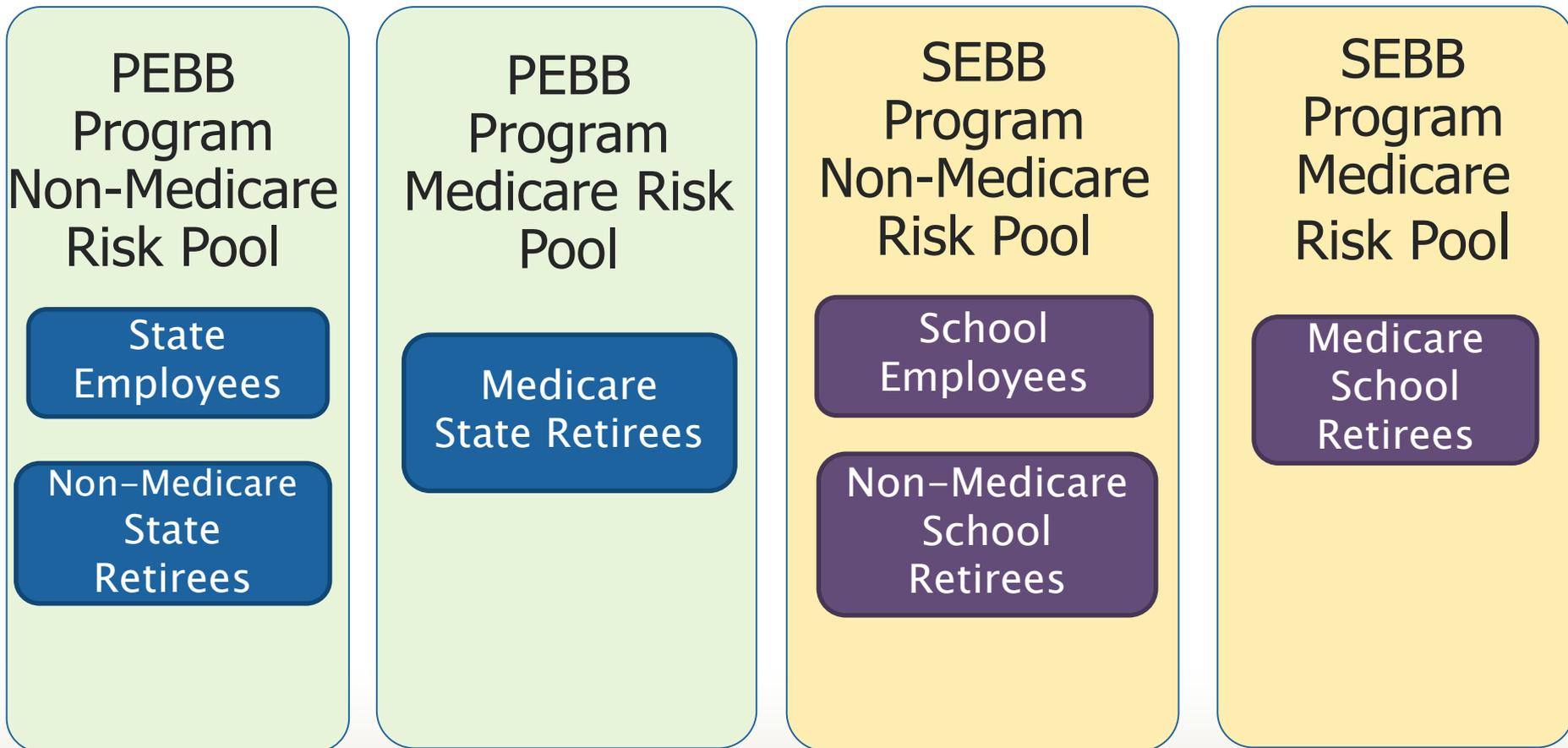
School Employees

Non-Medicare
School Retirees

Considerations

- Requires changes to state legislation
- Non-Medicare school retirees could have the same plan options they used prior to retirement
- Non-Medicare school retirees currently participating in PEBB benefits would likely have to switch insurance plans
- Impacts to the employee populations:
 - Possible decreased premiums for state employees
 - Possible increased premiums for school employees

Create SEBB Program Non-Medicare and Medicare Retirees Risk Pools



Considerations

- Same considerations as previous scenario
- HCA may need to procure a Medicare portfolio for SEBB; requires board review and approval
 - All current PEBB Program Medicare school retirees may have to select new plans (34k subscribers)
- Potential divergences of rates, plan offerings, members costs, and subsidy amounts
- Additional administrative Program costs
- Implications for Medicare retiree rates:
 - Possible decreased premiums for school Medicare retirees
 - Possible increased premiums for state Medicare retirees

Create Two Additional SEBB Program Risk Pools

PEBB Program
Non-Medicare
Risk Pool

State
Employees

Non-Medicare
State Retirees

PEBB
Program
Medicare
Risk Pool

Medicare
State
Retirees

SEBB
Program
Employee
Risk Pool

School
Employees

SEBB Program
Non-Medicare
Retiree Risk
Pool

Non-Medicare
School
Retirees

SEBB Program
Medicare
Retiree Risk
Pool

Medicare
School
Retirees

Considerations

- Similar considerations as previous slides for the Non-Medicare and Medicare risk pools
- There is likely small impact to employees in PEBB and/or SEBB Programs based on the risk pool in which Non-Medicare school retirees are assigned
- A small risk pool for Non-Medicare retirees would be very expensive
 - Estimated premium increase of 58% - 60% assuming no legislated subsidy is in place for Non-Medicare retirees

One SEBB Program Risk Pool

PEBB Program Non-Medicare Risk Pool

State Employees

Non-Medicare
State Retirees

PEBB Program Medicare Risk Pool

Medicare State
Retirees

SEBB Program Risk Pool

School Employees

Non-Medicare
School Retirees

Medicare School
Retirees

Considerations

- Further verification needed on legality
- Could not function as a community-rated risk pool
 - Distinct difference between Medicare and Non-Medicare plans
 - Medicare subscribers in PEBB or SEBB Programs buy Medicare plans
 - Cannot create community-rated pricing
- Would essentially function like slide 25

Questions?

Kayla Hammer

Fiscal Information & Data Analyst

Financial Services

Kayla.hammer@hca.wa.gov

Public Employees Benefits Board Meeting

September 17, 2018

TAB 1

PEB Board Members

| Name | Representing |
|---|-----------------|
| Sue Birch, Director Health Care Authority 626 8 th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-2104 sue.birch@hca.wa.gov | Chair |
| Greg Devereux, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 greg@wfse.org | State Employees |
| Myra Johnson* 6234 South Wapato Lake Drive Tacoma WA 98408 V 253-583-5353 mljohnso@cloverpark.k12.wa.us | K-12 Employees |
| Carol Dotlich 8312 198 th Street E Spanaway WA 98387 V 253-846-6371 wfsecarol@comcast.net | State Retirees |
| Tom MacRobert 4527 Waldrick RD SE Olympia WA 98501 V 360-264-4450 zapmac@hotmail.com | K-12 Retirees |

PEB Board Members

| Name | Representing |
|--|--------------------------------------|
| Tim Barclay 9624 NE 182 nd CT, D Bothell WA 98011 V 206-819-5588 timbarclay51@gmail.com | Benefits Management/Cost Containment |
| Yvonne Tate 1407 169 th PL NE Bellevue WA 98008 V 425-417-4416 ytate@comcast.net | Benefits Management/Cost Containment |
| Vacant* | Benefits Management/Cost Containment |
| Harry Bossi 19619 23 rd DR SE Bothell WA 98012 V 360-689-9275 udubfan93@yahoo.com | Benefits Management/Cost Containment |

Legal Counsel

Katy Hatfield, Assistant Attorney General
7141 Cleanwater Dr SW
PO Box 40124
Olympia WA 98504-0124
V 360-586-6561
KatyK1@atg.wa.gov

*non-voting members

7/2/18



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

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 8th 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



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

2019 Public Employees Benefits Board Meeting Schedule

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

January 31, 2019 (Board Retreat) 9:00 a.m. – 5:00 p.m.

March 20, 2019

April 24, 2019

May 21, 2019

June 5, 2019

June 19, 2019

July 10, 2019

July 17, 2019

July 24, 2019

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

Updated 3/30/18

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

Public Employees Benefits Board
Meeting Minutes

DRAFT

March 21, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:

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

PEB Board Counsel:

Katy Hatfield, Assistant Attorney General

Call to Order

Sue Birch, Chair, called the meeting to order at 1:35 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Agenda Overview

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

Approval of July 2017 PEB Board Meeting Minutes

Greg Devereux: On one of these three sets of minutes, I have a question. I can't find it at the moment, so I'm fine in approving them if I can't find it before we approve them but I'd love to be able to ask the question at some point. I can always call Dave.

Approval of July 12, 2017 PEB Board Meeting Minutes

Yvonne Tate moved and Greg Devereux seconded a motion to approve the July 12, 2017 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

Approval of July 19, 2017 PEB Board Meeting Minutes

Yvonne Tate moved and Greg Devereux seconded a motion to approve the July 19, 2017 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

Approval of July 27, 2017 PEB Board Meeting Minutes

Yvonne Tate moved and Greg Devereux seconded a motion to approve the July 27, 2017 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

Legislative Update

Dave Iseminger, ERB Division Director: I am going to provide an update of what I presented in January. Slide 2 is to remind everyone about the amount of work that executive agencies do when bills are dropped in the Legislature. In the Employees and Retirees Benefits (ERB) Division alone, we had roughly ten bill analysts do this work on top of their everyday workload. Those ten bill analysts collectively did 206 separate analyses. Any time a word changes on the page, the bill had to be reviewed to make sure we understand the potential implications and are able to describe policy and fiscal impacts.

I'm going to focus on the bills that the ERB Division was lead and responsible for coordinating all of the analysis for the agency, and that also had the potential for a high impact. A high impact in this setting means any sort of potential fiscal impact, requires rule making, or a change in a broad-reaching administrative policy.

Slide 3 is the funneling effect that happens for bills as they go through the process. Of those 52 high impact ERB Division bills, these are the various stages a bill can "die along the legislative process." They have different cutoff periods and self-imposed rules in the process for bills. If bills haven't made it past one of those cutoff periods, the bill is generally dead. There are always exceptions. Bills that are necessary to implement the budget are not subject to these cutoffs.

I will focus on the nine bills that went to the Governor as of this date. The Governor has acted on one bill and eight are pending gubernatorial action. Over the entire course of the legislative session, approximately 313 bills passed the Legislature. The Governor has until next Saturday to take action either signing, partially vetoing, vetoing, or letting something go into law without a signature.

Slide 4 highlights three bills that have potential PEBB Program impacts:

Engrossed Substitute House Bill (ESHB) 2408. My presentation in January had this bill on my SEBB Program impact slide because it didn't have a potential PEBB Program impact. By the time it went through the legislative process, the PEBB Program was added. This bill is preserving access to the individual market and health care coverage in our state. In the past couple of years, there was the potential for bare counties on the Health Benefit Exchange, like Klickitat County and Grays Harbor County, where there would be no insurance options for

individual residents of those counties. Ultimately, the Insurance Commissioner's Office was able to work with carriers and have offerings within those counties, but there are counties that are vulnerable to being bare counties in the future because they have only one carrier in them at this point. As the individual market is moving forward, there are concerns about the stability of offerings in those counties.

The Legislature, in this bill, set up a process that beginning in 2020, any plan on the medical fully insured side that is authorized and offered in either the PEBB or SEBB Programs, must offer a qualified health plan on the Health Benefit Exchange in the same counties that they're serving the PEBB or SEBB populations. An example to put this into practical terms, is Kaiser Permanente of Washington in King County. They're in King County for the PEBB population after 2020 so they also must have a qualified health plan on the Exchange in King County. If they were to expand to a different county, they would need to have a plan on the Exchange in that same county. This applies for both the PEBB and SEBB Programs for any plan that's authorized by this Board or your counterpart sister Board beginning in 2020. This bill is pending action by the Governor.

Greg Devereux: The Federation followed this bill very closely and worked closely with Representative Cody. We didn't think it would have significant impact on PEBB, at least, initially. We will be watching it very carefully to see if it does have an impact in the future.

Dave Iseminger: Engrossed Substitute Senate Bill (ESSB) 6214. A variety of bills were introduced that dealt with occupational disease presumptions for law enforcement and firefighters and this is the bill that passed out of the Legislature on this topic. This bill adds as a presumption to occupational disease, Post Traumatic Stress Disorder (PTSD), for both law enforcement officials and firefighters. This bill could impact the PEBB Program by survivors of individuals who pass away as a result of the diseases that are presumptively occupational diseases. Those survivors would have access to eligibility for PEBB Program benefits as survivors. We do not anticipate a significant impact as a result of this bill because the state actuaries have identified that they don't anticipate a significant increase in deaths simply as a result of adding this presumption. This is a theoretical way that a survivor could have new eligibility in the PEBB Program as a result of this bill. Not a huge impact but it is just another way to remind people how occupational disease presumptions in certain situations, especially when it comes to law enforcement and firefighters, could result in survivor eligibility for PEBB benefits.

Engrossed Substitute Senate Bill (ESSB) 6241. I want to highlight this bill which has many impacts for the SEBB Program. There are a variety of references to the PEBB Program in the bill. When the SEBB Program was created by the Legislature in the summer of 2017, it was codified into RCW 41.05, which is where all the PEBB Program statutes are. The original legislation made the statutory structure hard to read. When you read the law now and you see the "Board," it means both Boards unless one of the specific Boards is mentioned by name. You

don't have to read the whole statutory framework with your SEBB hat and then again with your PEBB hat.

Another key piece for distinguishing between the programs is the definitions of employees. Rather than reading with two hats, the law has been modified so "employees" means PEBB and "school employees" means SEBB. There are separate statutory definitions now used throughout the RCW.

ESSB 6241 started as agency request legislation. It has a lot of clarifying language based on what we understood was the intent of the Legislature in enacting the SEBB Program. It had changes along the way that promoted an opportunity for local school districts to offer and pay for benefits for individuals who do not meet their eligibility threshold. In the SEBB Program, the threshold for benefits is anticipated to work 630 hours. School districts would have the ability to pay for benefits for school employees below 630 hours. That's a very different feature than what exists in the PEBB Program.

Another piece that's part of the SEBB Program is benefits that are outside of the SEBB's authority and jurisdiction, outside of medical, dental, life insurance, disability, etc., school districts, again on their own dime, have the ability to offer optional benefits, but they have to report to HCA on an annual basis what those benefits are. Then HCA and the SEBB Board can evaluate whether they fit in the jurisdiction of the SEBB Board or whether the Legislature may be interested in having it be part of a statewide offering. It's another way to bring information to this Board about other benefit ideas you also may want to consider offering.

There were several benefits bills going through the Legislature that impact both programs because they're about coverage of different benefits. They are:

2SSB 5179. This bill requires both the Medicaid and PEBB Programs offer a minimum amount of coverage for hearing aids. We're not anticipating a significant change in benefit because the threshold under this bill is hearing aids every five years. The Uniform Medical Plan and PEBB plans provide hearing instruments every three years. We believe the Program already meets the dollar coverage amount that's required with having an \$800 benefit. It seems we're already meeting the expectations of this bill.

ESSB 5518 is about reimbursing chiropractic services and is another example of how provider codes impact claims experience within the plans. It requires chiropractic services be paid similarly to physical medicine and rehab codes, evaluation and management codes, and spinal manipulation codes. It's a coding issue but it could impact the claims experience of the plan. It isn't anticipated to have a significant impact based on the fiscal note the agency produced.

SB 5912 is about three-dimensional (3D) mammography. This expressly includes the Uniform Medical Plan and the fully insured commercial market. It requires a \$0 cost-share in part because of a Health Technology Clinical Committee (HTCC) decision. The Uniform Medical Plan already covers this for individuals who are

over 40, as long as it's a screening requirement. Because of how the HTCC decision was implemented, it doesn't change anything about the Uniform Medical Plan. On the fully insured side, there was a recent announcement from Kaiser Permanente of Washington that for individuals under 40, they would also provide 3D mammography with a \$0 cost-share. Even though 3D mammography would be covered, not all facilities have access to it.

SSB 6219 is a reproductive health care bill. It has a variety of different features. I will highlight three aspects of this bill. It does require coverage of all contraceptive drugs, devices, and other FDA approved products related in the contraceptive arena. It also includes coverage for voluntary sterilization, consulting services, and exams. It requires no cost-share except in the instance of a high deductible health plan, in which case the cost-share can only be that which is required for the health plan to maintain qualifying status for an individual to access contributions and withdrawals from an HSA or health savings account.

Coincidentally, around the same time this bill passed, the IRS issued long-awaited guidance that clarified that there did, in fact, need to be cost-shares for things like male sterilization in order for a health plan to be a high deductible health plan and meet the HSA contribution withdrawal requirements.

A second piece of the bill relates to not having medical management techniques that limit enrollee choices to different contraceptives.

A third piece is when maternity care is covered within a plan, that plan also must cover voluntary terminations.

We're not anticipating a significant amount of changes within the plans that are offered within the PEBB Program, however we must make sure we're covering all contraceptives. Traditionally we've covered something in each therapeutic class of contraceptives, and now we'll make some adjustments with regards to the full suite of all contraceptives covered by the bill.

Greg Devereux: Dave, can you repeat the second one again slowly?

Dave Iseminger: The second piece that I highlighted was no medical management techniques that limit enrollee choice for services. Before I move to Slide 6, I did want to highlight two bills that I've talked about for the last two years that still have not passed the Legislature.

Bill 2114 is one I've referred to as the surprise billing bill. It was seeking to address situations where people go for emergency services in an in-network facility, but get services from a provider who's out of network. They can be balance billed for the charges. Although the bill went far in the process, it was not enacted by the Legislature this year.

Bill 1421 was a bill about payment credentials and making sure that state agencies are not maintaining things like bank credit card numbers or magnetic strip

information. This bill was another way of ensuring that there's a minimal amount of information in state systems for any data breaches and protecting consumers. That bill could impact the PEBB Program in the sense that as we do electronic debit services, we maintain a copy of the payment credential in our system to ensure that we can prove we have the authority to access individuals' bank accounts. This bill did not pass the Legislature this year.

Slide 6 highlights the 2018 Supplemental Budget. The funding rate for the next fiscal year was set at \$916. For the current fiscal year it's \$913. Originally when the operating budget was passed in 2017, fiscal year two, which is the fiscal year we're talking about moving into, was set at a higher level. The important thing to know about these funding rates is they really do maintain the current level of benefits. The reason the numbers can fluctuate so much is it's all based on real time projections, the best information we have. As you go further into a biennium, there is more accurate information about what's happening in that biennium. The goal for every biennium is to balance the benefits budget. If the claims projections at the beginning of the year project a higher expenditure, you might have a higher number expected in year two; but as more claims experience comes in, it justifies a lower number in year two. That's what happened this year and what has happened traditionally in the past couple of bienniums. There's no reason for alarm when the funding rate drops. It's still based on current projections. It should cover all benefits, and the level of benefits that we have in our plans.

Bullet 2 is the Medicare Explicit Subsidy. The Legislature raised the subsidy for January 2019. It's set up for calendar years to align with the benefit year, raising that subsidy from \$150 per month to \$168 per month. The same rules that you're accustomed to for the subsidies still applies. It's 50%, or \$168, whichever is less and that comes into play depending on the exact cost of the plans. The maximum amount of the subsidy can be up to \$168. We anticipate that we would bring that as the resolution to this Board to ratify the full \$168 subsidy. This was a welcome addition because it will help the dollar-for-dollar impact to our retirees. Last year there was a significant upward pressure of 20%, \$55 per month for UMP Classic for Medicare retirees that did not go unnoticed. We talked with the Legislature and informed them about the implication for the subsidy being maintained at \$150, so it was great to see it raised.

Carol Dotlich: Does the \$18 increase mean UMP now meets the threshold to get the federal dollars?

Dave Iseminger: Carol, you're referring to the retiree drug subsidy that we get on an annual basis which puts roughly \$20 million into the General Fund State. We won't know until we actually run the numbers in September when we do the credible coverage with our actuaries, but \$168 puts us within a zone of confidence that we believe we'll hit and receive the retiree drug subsidy refund from the federal government in 2019.

Bullet 3 - When the SEBB Program was created by the Legislature, there was \$8M of administrative funds put into the PEBB account as SEBB Program start-up

funds. We were tracking those separately even though it was in the PEBB account. That made many people uneasy about ensuring adequate tracking of the funds separately. In this supplemental budget process, the decision was made to back the money out of the PEBB account and make it a loan from the General Fund State to ensure no mixing of PEBB and SEBB funds. As a result of 6241, there is a full suite of comparable mirrored accounts for separate tracking and separate finances for the two programs.

Bullet 4 – Looking at final benefit changes for 2019. The Legislature and the Governor's Office were supportive of expanding the Diabetes Prevention Program to include a virtual module instead of just relying on an in-person module.

There was also a request to modify the Uniform Dental Plan crown replacement waiting period. Now it is seven years for a crown replacement. The industry standard, as well as our fully insured dental plans, have a five-year waiting period. The proposal would be moving it from seven years to five years.

The Legislature and budget authorized both of those changes if the Board wanted to proceed. We will bring more discussion to this Board at a future meeting to determine your interest in moving forward with those two plan changes as we move into the rate setting season.

I did want to make sure that you were aware that the spousal and tobacco surcharges, which were implemented at the PEBB Program a few years ago, the Legislature indicated intent that they would also apply to the SEBB Program. The budget foreshadows that the surcharges should be taken into account during the initial collective bargaining for the SEBB Program. So that means the tobacco and spousal surcharges will be applied in both programs. I wanted to make sure you were apprised of that.

Decision packages that the agency put forward related to the PEBB Program were fully funded in the budget. There were three primary pieces I wanted to highlight. The first is we've had a substantial subscriber growth within the Uniform Medical Plan. We have a lot of local jurisdictions and even school districts that are joining. I believe from the end of 2017, the period where we had many local jurisdictions coming on, we added about 4,000 subscribers in a matter of two months just from local authorities contracting with the agency to join PEBB Program benefits. There had not been in the counting mechanisms a factor for anticipated growth and so that account had started to fall behind. We made a request to supplement that and put in a factor to account for increases in subscriber rates, just so the account is maintained and can cover the cost for the TPA funds on the subscriber basis. The second piece, and this relates to making sure we're meeting our service level expectations for our customers, is we asked for two additional staff that were supported. One in our call center and another within our Outreach and Training unit, which is the unit that works with employers to help them answer eligibility questions. Both of those are going to supplement our customer support center and hired in July.

Carol Dotlich: I wanted to ask that there be some evaluation process put into place for customer service because the phone lines continue to be problematic. I'm happy you're getting new staff but I would like to see some evaluation process put into place so you can monitor if there are improvements, what are they and how rapidly will we see them?

Dave Iseminger: That's a good foreshadowing, Carol, because when Renee comes up, we're going to talk about some of the changes that have been made, the data that we saw, how that influenced the Open Enrollment we just had in November 2017 and some other changes and how we'll be able to monitor impact.

Carol Dotlich: I would like to share with you that we're well beyond the Open Enrollment period and we're still having a customer service problem.

Dave Iseminger: Renee will be joining me soon and we'll keep on top of that. The third piece of this slide is to highlight the Medicare portfolio evaluation. We talked at the retreat about potential ways of structuring retiree benefits and we would have an ongoing conversation with this Board. Lauren Johnston came to the January Retreat and said, "The evaluation might include things like a private Medicare exchange for PEBB." Not putting people on another exchange but having our own exchange that has more variable plan options. A second idea could be one that's been asked by this Board - what would it look like if the Uniform Medical Plan Classic didn't have prescription drug coverage, then whether there would be a separate part D supplemental plan that retirees could enroll in. Those things will be in the Medicare portfolio evaluation. It is not an official legislative report. We were given supplemental funds to support that analysis and we'll continue to have ongoing conversations with the Board. Those are the highlights of the legislative session.

Sue Birch: I do want to call out and make sure that the Board fully understands that Dave and his staff really had an extraordinarily successful legislative session. There were several weekends where I came in and Connie and others were working late into the night doing all this analysis and whatnot. Dave, I want to call out some attention to you and your staff for a remarkable job and a very successful legislative session. Jane Sakson is here from OFM and I want to call out the partnership with OFM, the fast responses, and all the intensity because this was very legendary, this work of 20 years, the SEBB work. I know we're sitting here with PEBB but I do think it's really important that we recognize the very significant arduous task you all completed this session. So, thank you.

Greg Devereux: I appreciate that the explicit subsidy is going up. It's not substantial, it's not huge, but it's great that it's going in that direction versus the other. I hope it continues. Then we need to get to the bottom of the customer support issue. I think it's great that you are adding staff to that as well. I would agree Lou had very big shoes, but Dave, you're doing a great job. I appreciate you and your staff's work. We talk many times during the session and we appreciate that very much.

2018 Open Enrollment Update

Renee Bourbeau, Benefits Accounts Section Manager, ERB Division. Today I will provide an updates on Open Enrollment activities. Slide 2 – Open Enrollment Engagement. During Open Enrollment, staff traveled to 22 benefits fairs across the state where they shared information about the 2018 PEBB Program benefits with about 2,100 people. We conducted eight benefits fairs in eastern Washington and 14 benefits fairs in western Washington. Vendors in health plans were present at the fairs to answer members' questions. We distributed six GovDelivery email messages to employees, personnel, payroll, and benefits offices throughout Open Enrollment for them to forward to their employees. These messages ensured information about the PEBB Program Open Enrollment was consistent across the employee population.

Based on member feedback, the PEBB Program enhanced My Account to allow users to access from a mobile device. My Account is the platform used for subscribers to make online changes at Open Enrollment. I included the screenshot of what My Account looks like from the HCA website on Slide 2. Basically, the website now adapts to the users screen size, making it easier for a user to make changes with a mobile device. This update will help lower the number of paper forms that need to be keyed by hand. For 2017, 79.4% of Open Enrollment changes were made online, and for 2018, 86.4% of Open Enrollment changes were made online.

Dave Iseminger: Renee, I do want to add in today's society with smart phones, we are used to rotating our phones and suddenly the screen images turn and everything is optimized. It takes quite a bit of work to program that. I remember when we started that project; we began discussing it in late 2016. I want to make sure we acknowledge those types of changes. They may seem simple and they really do improve customer experience, but they do take a lot of work. I was glad our IT support was able to get that done for last Open Enrollment.

Harry Bossi: I just wanted to get clarification, Renee, on the number of benefit fairs. In addition to those, are there not also benefit manager trainings that go on?

Renee Bourbeau: We have pre-benefits fairs that the Outreach and Training staff provide to agency personnel and payroll offices. I don't have the number.

Harry Bossi: So some agencies could have their own presentations or mini fairs, correct? It's a train the trainer kind of thing.

Dave Iseminger: Yes. When Renee's talking about the benefits fairs, she's talking about where staff from the Health Care Authority in the ERB Division travel around the state and meet with members.

Harry Bossi: Yes, I understand.

Dave Iseminger: But then there could be things by the local employer that is also done to supplement.

Harry Bossi: I don't want anybody to think those are the only people that attend. There are lots of others who come. Because the agency schedules something. Okay, thanks.

Renee Bourbeau: That's correct. Thank you. Slide 3. The PEBB Program continued to promote the email subscription feature, which lets subscribers receive the "*For You Benefits*" newsletter and other PEBB Program communications by email. You can find the screenshots of the e-subscription from the HCA website on Slides 3 and 4. To give you numbers, in 2015, 22% subscribers signed up for the email subscription. In 2016, 28% subscribers signed up, and in 2017, 29% subscribers signed up.

Slide 5 - Employees and Non-Medicare Retirees. The graph shows the member count for these populations. In general, enrollment remains steady in most plans. The most significant change, shown in the last two bars is the increase in UMP Plus, the state, self-insured, and Accountable Care Program that includes two provider networks. Enrollment increased by 43% from November 2017 to November 2018. The increase was due to outreach efforts, including a personalized letter to UMP Classic subscribers showing how much they could save annually in premiums by switching to UMP Plus and presentations at the benefits fairs, videos, and webinars during Open Enrollment. You can find a numerical representation of enrollment changes on Slide 7.

Slide 6 – Medicare-Enrolled Retirees enrollment (Member Count) remained fairly stable in most plans. UMP Classic continues to have the highest enrollment followed by Kaiser WA Medicare. Again, you can find representations of the enrollment changes on Slide 7.

Slide 8 – Customer Service Relations. I want to address the issue raised at the Board Retreat regarding difficulty getting through the 1-800 retiree line. First, I would like to provide some background on the number of calls we receive. From August through October 2017, we received 25,455 calls. From November through January, we received 45,967 calls.

Dave Iseminger: Renee, our staffing model at that point had ten individuals in our call center. Is that right?

Renee Bourbeau: We had nine.

Dave Iseminger: Nine. So we had nine individuals answering 46,000 calls.

Renee Bourbeau: The call volume nearly doubles from November through January, which is typical around Open Enrollment. The Customer Service unit provides services to approximately 100,000 members through phone calls, face-to-face communication in the lobby, and keying account enrollment. The 1-800 line is intended for retirees, COBRA, and continuation coverage enrollees only. The unit is not staffed to serve the total 374,000 member population. Agencies, personnel, payroll, and benefits offices serve their employees.

Over the years, we continue to implement strategies to address the higher call volume around Open Enrollment. For example, we use a workforce management tool to identify the number of agents needed on the phone based on historical phone data. We offer other ways for customers to contact us with questions such as by secure email. Staff updates subscribers' accounts as much as possible while on the phone so when a call is done, the agent is ready to take the next call immediately. We offer overtime to staff to handle document processing. We use rolling messages and a frequently asked questions menu on the phone system to provide self-service options for issues and questions members call about most.

In May 2017, we implemented a callback feature, which allows callers to hang up and wait for a return call without losing their place in line. From May through September we received 1,360 callback requests. From October through February 2018, we received 4,027 callback requests. We also redesigned a phone menu in May 2017 to triage callers to their appropriate destination. We received calls from employees that we redirected to their employers. We also received many calls that we redirected to our accounting department or to MetLife, our life insurance carrier. This menu redesign has been successful. From November 2017 through February 2018, 7,623 callers selected the accounting menu option without going through a customer service agent.

Dave Iseminger: Renee, I think that's a profound change. One of the things we identified last year was that many people waited on the phone only to get transferred to another part of this building. We worked in the interim on redesigning the phone menu and getting calls out of our queue and getting people directed to the place that can best answer their question. Just the accounting piece alone was directing 7,000 calls to the right place faster. But you have more!

Renee Bourbeau: I have more. 4,285 employees were redirected to contact their employee's agency personnel, payroll, benefits offices, and again, they didn't wait on the phone to talk to customer service to be redirected to the employers because we cannot look at their account.

Dave Iseminger: Additionally, those employees were not sitting in the queue holding up space for retirees, which is the primary function of the 1-800 line.

Renee Bourbeau: 559 callers selected the MetLife menu option to receive contact information for life insurance questions. The three items above are the main topics and they represent 12,467 redirected calls that freed up the phone line to assist retirees. After Open Enrollment, we also researched what other vendors are doing to manage high call volume at peak times.

While we've made progress, some members continue to have trouble reaching a customer service agent. We are taking a very aggressive approach to ensure we have a customer support system capable of handling our greatest volume of calls. We are looking at additional options, some requiring budget approval, legal, and a human resources discussion before we can implement them. Possible options are to hire additional staff, which we already have; offer extended hours during peak

times or maybe extending hours, using retirees; and using additional agency staff with lighter winter workloads to assist with application processing, call screening, or phone triaging. We would also like to offer in-house workshops, an online tutorial video, and include information on the self-service phone menu about how to fill out the retiree form. This is the number one question we get on the phone and it takes approximately 20 minutes for an agent to help the caller.

Dave Iseminger: Twenty minutes may seem like a lot of time, but over the years as the program requirements have gotten more complicated, the retiree form is approximately eight pages. That is the streamlined version of the content necessary to get all of the information for the different benefit election options. We are heavily prioritizing an online tutorial that can help people click through and understand how to fill out that form. We could then include that option as part of our rolling messages. It may help streamline the process for individuals waiting on hold.

We have high turnover in our call center. We've been working on how to incentivize and make sure we have a full staffing model at all points of the year. As an example, there have been times when half of our call center positions were vacant. Five new staff started last Friday. We are revamping and streamlining our training program to get staff on the phone earlier in order to answer questions without having to know everything about the complex eligibility rules. Our goal is getting staff on the phones faster, in higher numbers, and redirecting people with their number one question to an online tutorial as much as possible.

Carol Dotlich: I want to thank you for your efforts to improve the system and I understand you have a huge call volume. I wondered if you might describe what is the work force management tool you're referring to in your slide.

Renee Bourbeau: We use software called Pipkins. It's a scheduling tool we've used for about six or seven years. It looks at the number of calls received and tells you every 15 minutes how many agents you need on the phone in order to answer the number of calls. We know that in April and May, the number of calls decrease. We would need fewer staff on the phones and more staff working account adjustments. We know the number of calls start increasing July through January because our historical data provides the number of calls we receive. During this period, we put more staff on the phone. However, you must have staff to put on the phone.

Dave Iseminger: Pipkins is essentially a predictive modeling tool that looks at historical call volumes to anticipate staffing needs. It's actually the data we used to justify asking for additional staff. We can see in the predictive model that we need seven people on but we traditionally only have five staff available. That suggests we need more staff to be able to fill that time period.

Carol Dotlich: I just want to clarify, so even though you have nine people perhaps assigned to the call center, there are periods of time when you don't have nine

people there because you don't need that many people so they're actually doing other work here, correct?

Renee Bourbeau: Customer Service Unit staff have three different types of functions. They answer phone calls, they are in the lobby assisting walk-in customers, and they process account adjustments. The lobby traffic also peaks at certain times of the year so we know to have two people in the lobby and fewer on the phone.

Depending on when employees retire, the retiree forms increase. I need three staff on the phone and I redirect staff to do other types of work because we have an increase in forms that need processing for members to be enrolled in coverage timely. It's a constant balance of staffing. Where do you assign the staff based on what you need? We have an imaging system that lets us know how many forms we have for processing. We know how many calls we're going to get based on historical data. It's a very aggressive approach of where staff are assigned to work each day.

Carol Dotlich: When we talked before about the fact that people were calling and getting hung up on, basically because the lines were so tied up so the call would say, "Our lines are really busy right now. Call later." Click. That was very upsetting to the retirees. So you've changed since that period of time, right?

Renee Bourbeau: Yes.

Carol Dotlich: I think it was two weeks ago, I called and I got hung up on again. I was very concerned because it's not Open Enrollment season and I really thought you were going to implement that callback feature where you could be in the queue and people would call you back. When I was on the phone call, I didn't get an option to have a callback. So I'm not understanding, does the phone system change from one period of time to another? Or is that call feature available all the time?

Dave Iseminger: Renee, when you're answering, can you also try to describe, there's a maximum number of people who can be in the queue at any given time and in the callback queue. There is a maximum range as well and how we change that maximum over time.

Renee Bourbeau: We have a certain number of agents who can answer the phone. Last year people were sometimes waiting about an hour and a half before they could get to a customer service agent.

Dave Iseminger: At the worst times, not the entire Open Enrollment period.

Renee Bourbeau: Half an hour to an hour and a half at the worst times because we don't have enough staff to answer the demand in Customer Service. We are constantly meeting with WA Tech, our phone experts, and based on their assessment they suggested we decrease the number of callers that could get into

our line so that members didn't have to wait so long. We are not like Medicaid who has 60 staff who can answer phones. In doing that, it ended up cutting the member off.

Dave Iseminger: It ended up cutting off some people and they would get hung up on. Since Open Enrollment, we've expanded the number that can be in the queue at any given time, but there still is a maximum number of people who can be in a queue. So at the highest call volume areas, there may be individuals who get in a situation where they continue to be unable to get in the queue or get a callback feature.

Greg Devereux: I appreciate the changes already made and those being made. I guess though two things strike me. If I have to wait on a phone for half an hour to an hour - I won't wait an hour and a half and I probably wouldn't wait a half an hour. That's unbelievable, for most individuals. Then to have a system that actually can have a maximum and can cut people off, that too to me seems really - and I'm not being critical of the Health Care Authority. I guess my response is that we should seek the funding to change both of those dramatically because you cannot cut people off, especially a retiree.

I'll give you an experience. I was at my mother's retirement community over the weekend in Ohio. She's 96. I tried to change her phone from one place to another. I got changed to seven different places. I was on the phone 35 minutes and I never achieved my goal. I can't imagine what it would take for her to do that. I couldn't navigate it! I'm not saying that this is that at all, but I really do think all of us have a duty to change that length of time and have a system where the maximum is way more than the total calls that could happen. I will do whatever it takes to move that in the Legislature because other parts of state government do this and they do it well. We should as well, I think.

Sue Birch: Carol and Greg, I think I would ask that you grant some time for us to come back and we'll do a deeper dive further into this. Renee has really done an amazing job advancing further. I have an introductory meeting with my counterpart at WA Tech to discuss this issue of the conduits and the supply chain on some of our broadband constraints. I can assure you we'll be bringing the issue back to the Board, but I do want to call out and appreciate the efforts made thus far. We've got further to go without a doubt.

Tom MacRobert: Help me walk through what would happen in the peak times. I'm making a call, I'm someone who has some concerns, and so I want to talk to someone to help me. I call and when I call it goes out in front, right? There are two people, essentially, that are there to answer that or no?

Dave Iseminger: No.

Renee Bourbeau: We have a 1-800 line you would call, and then basically, you would wait in line.

Dave Iseminger: It's not directed to the front staff of the building. We have our staff on the second floor in the back corner and it routes to their phones, whoever is assigned to be on to answer calls during that time. If there's nobody available, first you would get a rolling message that says, "If your question is blank, blank, or blank, press one." If you press one it says, "You're best going to be served by going to this person." Or number two, you're going to be directed to accounting automatically, and it'll route upstairs to the fifth floor where the accounting folks are. Or if it's number three and you go to MetLife, it'll give you the number to call MetLife. It may even actually transfer there directly. I think it just gives you the number at this point. If you make it through those and that's not going to answer your question, then you're put into the queue. At that point you're asked if you'd like a callback, if there's availability in the queue for another person in the callback, and you're told an approximate wait time.

Tom MacRobert: So the people that are working that once you go into the queue, there's nine people. This is at a peak time that are there potentially to help you answer your questions, is that correct?

Renee Bourbeau: That's correct.

Tom MacRobert: Okay, and then what I'm understanding is nine is not adequate at that peak time because the volume of calls is more than they can handle and that's why people are getting cut off. Okay. Thank you.

Dave Iseminger: I think the other piece to add is we had ten FTEs, but in Open Enrollment last year, it was nine, and some were in the training protocol. Where they were in that training process determined what types of questions they could answer. But the highest point at last Open Enrollment was nine people.

We've identified what our turnover is. In many models where you have a 60-person call center, you know there will always be turnover. You might hire 65 people so that you have on average 60 people. We're looking at the same thing. Can we hire an extra person taking into account the turnover that's going to happen so we average the number we actually should have at any given time? We are also changing our training program to get more people hired after July onto the phone faster to be able to answer some questions.

Harry Bossi: When you come back, could you talk about self-service potential? But not necessarily today.

Sue Birch: Absolutely.

Renee Bourbeau: Yes.

Sue Birch: Renee, thank you for your efforts. This will be an issue that we revisit because I can assure fellow Board Members that customer service is a high priority, something we'll always be working at, but I appreciate the efforts to say we'll get more resources. We do thank you, Dave, for the extra resources thus far.

NW Prescription Drug Consortium

Ray Hanley, Director, Prescription Drug Program. I have been an employee of the Health Care Authority since 2005, which includes the Northwest Prescription Drug Consortium. I've been doing health services research and health policy for about 40 years. I was an academic at the University of Washington School of Medicine and then moved to the Brookings Institution in Washington, D.C. economic studies program. I've co-authored a couple books and chapters and articles on various health services issues. I worked in the private sector. I designed health information decision products for payer, providers, and suppliers where I started working with claims data. I worked for a firm that's now called Truven and my job was to be a product developer. I began working with pharmacy data then, in 1995. I designed products that examined cost, use, and brand switching, which was still quite popular, and looking at lab results and outcomes for various clients. For the last twelve years I've been here at the Health Care Authority. I originally started doing prescription drug model savings for the preferred drug list that was passed in 2004 and have since moved into the Northwest Drug Consortium, today's topic.

Today I will describe the Northwest Drug Consortium and how the Uniform Medical Plan fits in the Consortium. I will discuss Moda's role and the length of the contract that Moda and MedImpact have with the Uniform Medical Plans.

Slide 2 is the purpose of the Northwest Drug Consortium. It's to pool and purchase prescription drugs. It is the first piece of legislation introduced by Christine Gregoire in 2005. It had very heavy support from Labor, AARP, and retirees. The participation in the Northwest Drug Consortium is mandatory for state agencies that purchase prescription drugs directly unless they can demonstrate they can achieve greater discounts by using another purchasing mechanism or another vendor. It's open to local government, private businesses, Labor organizations, and individuals. We currently have about a million people across Oregon and Washington. Our services are provided by Moda Health, a health insurer based in Portland, Oregon.

Greg Devereux: Do you know approximately how many private sector businesses and/or Labor organizations are part of the Consortium?

Ray Hanley: It varies. We had about three or four thousand in the Multiple Employer Trust (MET) and Multiple Employer Welfare Arrangements (MEWA) that actually disappeared shortly after Obamacare. It does fluctuate a bit. Currently in the state of Washington, we do not have any private employers or Labor organizations.

Greg Devereux: Thank you.

Ray Hanley: Slide 3 is an outline of the information I'm sharing today. The Consortium is a very large enterprise with many different facets to it. Today I will focus on those aspects of the Northwest Drug Consortium that are germane to the Uniform Medical Plan (UMP) and the PEB Board.

Slide 4 is the history of the Consortium. In 2005, the Washington Prescription Drug Program (WPDP) was established by the Legislature. The WPDP is my counterpart to the Oregon Prescription Drug Program (OPDP). In 2006, the WPDP and the OPDP signed an interstate agreement using the Department of Justice and the Attorney General's office here. We decided to pool the 4.4 million and 6 million or so folks here in the state into one pool, enabled by legislation. In late 2006, after signing the interstate compact, we initiated our first procurement headed up in Oregon. A number of vendors submitted proposals and Moda was selected to administer the contract.

In 2007 and 2008, Moda took over the Uniform Medical Plan (UMP) and moved away from a previous vendor, Express Scripts. The UMP joined the Consortium because it offered better prices. In 2008, the Consortium expanded into different aspects of drug purchasing. The Consortium talked to the Department of Health regarding their vaccination programs and the ADAP Program, the AIDS program that uses Ryan White funds at DOH, etc. It repriced the Veterans Affairs (VA) program because the Legislature insisted on it even though VA pricing is actually the lowest drug pricing in the United States.

In 2010, we initiated another procurement, and again, several Pharmacy Benefit Management (PBMs) vendors responded. Moda Health also responded with a PBM, MedImpact. They were able to secure through the procurement, a second bite of the apple for the Consortium. The Consortium increased the needs to go beyond the commercial employer group, which UMP is, to include Medicaid. The expansion included the Group Purchasing Organization (GPO). The GPO refers to the fact that hospitals or prisons bring in prescriptions by dealing with wholesalers. It's a completely different side of the pharmacy business and that was part of the stipulation that we required.

In addition, some employers, small groups in particular, are interested in a pharmacy benefit and a medical benefit. With this knowledge, in order to grow the Consortium, potential vendors also needed to offer medical insurance.

In 2015, we started our third RFP for the Consortium. We went through the Office of Special Procurements in Oregon. We gave them a list of the 14 things that Moda had built for us, all customized. As a result, we were able to get a five-year extension on the current contract. It will end December 31, 2021.

We are now to 2018. There are currently about a million members and we are purchasing about \$800,000 worth of drugs across the two states.

Sue Birch: Ray, can I clarify? Is it \$800 million worth of drugs or \$800,000? The document says \$800 million.

Ray Hanley: It's \$800 million. It's a million people and \$800 million.

Sue Birch: Thank you for that. I just wanted to clarify.

Ray Hanley: Slide 5: The graph shows a lot of growth and sustainable success. We started in 2005 with 500 people and are at one million now. Washington is blue in this diagram and it's a bit old, but it still gives you the order of magnitude. Our employer groups currently are about 500,000 people; facilities, which include hospitals and the Department of Corrections here in Washington, about 20,000 people, and the rest are in the discount card.

Slide 6 – Program enrollment by state: You are in the upper left-hand corner; the crown jewel of the Consortium, but this slide shows the other members that are in the Consortium. There's roughly 16 or so names listed on Slide 7, the Department of Corrections, Apple Health, Labor and Industries for whom we provide rebates that were previously not being collected. We have PEBB Program in Oregon; etc.; saif, which is a worker's compensation program similar to Washington's Labor and Industries as it exists in Oregon. Those are our clients.

Slides 8 and 9. This is the main focus, the value proposition or group pharmacy benefits management. It's all about The Triple Aim, and for UMP it's about increasing access, decreasing costs, and increasing quality simultaneously.

Slide 10. What is a participating program? It's many of those major clients identified on Slide 7. On Slide 10, you can substitute the Uniform Medical Plan for "Participating Programs." Right below it is my program, the Washington Prescription Drug Program; then our contract administrator, Moda Health. Moda Health is the ultimate accountable source, who provides subcontractors, but per contract, penalties are assessed against Moda Health.

Moda provides client support. They talk to the member about prescriptions, they bill, and account reconciliation. That doesn't mean they actually handle the transaction at the point of service or at the retail counter of the pharmacy, but they do the analytics and aggregation of the data. About twice a year they come to the Health Care Authority to discuss how things are going on the pharmacy side for the Uniform Medical Plan. In order to find out more about the outcomes, Moda designed and tracked a population-based way to look at people who were taking a very expensive specialty drug to find out how it worked.

MedImpact is our Pharmacy Benefits Manager (PBM). They have the eligibility files' process claims, and make sure your prescription goes through at the retail counter. They also do rebate administration, which involves the additional dollars the drug manufacturers offer to place their drug in the market. The manufacturers want to buy a piece of the market and rebate administration is a way to accomplish that. It gives money to the PBMs to push their drug up on the formulary and make it a preferred drug. MedImpact also is who answers the call center phones after hours.

Slide 11 is a bit more detailed. There's Moda Health, MedImpact, and the program management that I run. We bring purchasing power with a million members. It's a moving target and we have aggressive guarantees. We do a market test annually. Our guarantees are the ceiling on the contract, and anything that exceeds that

guarantee is the responsibility of Moda Health and MedImpact, or their subcontractors.

Moda does the data analytics and insight reporting. They provide very high touch member support services. Consistently throughout the years Moda has had very high customer satisfaction ratings. It's reflected in the service they provide. The billing and reconciliation they do for us let's us know how we're doing on trend and provides us with some innovative clinical programs.

MedImpact handles network and claims management. The network is actually the pharmacies and each pharmacy has a contract with MedImpact so they will accept the rates that we negotiate with MedImpact for the Uniform Medical Plan and our other clients on an annual basis.

The PBMs do pharmacy network administration and eligibility verification, which is critical at point of service. If someone has a pharmacy issue, the PBMs settle the dispute. They have been very responsive.

Tom MacRobert: When you have pharmacies that are preferred providers, who decides if you're a preferred provider?

Ray Hanley: One of the hallmarks of the Northwest Consortium is that we pay one rate to pharmacies. There are no preferred pharmacies, but we do have two networks. We have two networks because the Walgreens' chain would not accept the exact same rate that the other 1,152 pharmacies in the state accepted, including the independents. They feel they are worth more. The Consortium goes back each quarter to see if they are willing to honor our rate. They are not and their argument is that they are on every corner and open 24 hours even though they aren't on every corner and approximately one in four stores are open 24 hours.

Carol Dotlich: I'm very interested in the accountability piece of it and maybe you're going to answer this in your presentation. If you are, that's fine, but I'd like to know what's the auditing procedure to ensure that those pharmacy claims are billed and paid correctly. Is that done prior to the payment being made? How do you determine invoice cost accuracy?

Ray Hanley: I will cover that in a few more slides.

Carol Dotlich: Thank you very much.

Ray Hanley: Slide 12 – Autonomy: Now we'll discuss the value proposition. It's important to understand what you're buying. We offer autonomy. When we started the Consortium, it was more monolithic. There were very few people. We couldn't offer everything to everybody. We've been able to build in flexibility. We can design our own pharmacy programs. You can select between a broad and a value pharmacy network.

In the value pharmacy network, the broad pharmacy network that wouldn't include Walgreens, there are certain opportunities that we had to sidestep because Walgreens needed to be included. Rather than miss that business, we contracted with Walgreens' pharmacies, but we currently don't have anyone using that network.

We customize for our clients. We do a fair amount of things for free, but we're trying to follow quality initiatives like the right drug and right time approach. We have clinician consulting services available. Even on the 100% cash paid discount card, you can call a pharmacist if you have a question. They will answer the phone 24/7.

Collaboration is one of the most important things for the Uniform Medical Plan. Part of what you'll find, Carol, when we talk later about the actual auditing is that the relationship between our current vendor, Moda Health, and their relationship with MedImpact gives the Uniform Medical Plan a really great audit result. It's based on collaboration. UMP has weekly calls, if not more often, with Moda Health to work on issues or ways to improve quality.

For reporting, we have biannual meetings and we look at cost utilization and ad hoc reporting. Opioid use is an example of an ad hoc report. I have a cash card and one of the things I'm very concerned about is how many people are actually using opioids and what's the morphine equivalent of that? I don't have the clinical understanding for that, so Ryan Pistorosi and Donna Sullivan, our pharmacists, work with me. The idea is that we will know when to shut off the pharmacy discount card when it turns into a problem. It's one of the things we keep our eyes on and one of the things Moda is focusing on.

Slide 13 – Savings: Savings is critical to any group. The question is why would you choose us? The answer is because we follow the money and try to ensure financial performance. We have very aggressive price guarantees and discount guarantees. We do that by utilizing the services of the Burchfield auditing firm, a very Cadillac auditing firm. They work for Centers for Medicare and Medicaid Services (CMS) and large employers. Once a year they bring in all of our data, look at our claims and benefits, and give us a market assessment. We have about half a million or so lives in a group benefit program, of which UMP is a part. I want compared to employers that have roughly half a million people on the West Coast and I want those bids to be current. The contract stipulates that we do not pay for our market assessment, which is done by an independent third party, but we do have control over it. It's something that Moda had to accept. If our contract is a point and a half off the market assessment, we automatically go into negotiations, and that did happen last year.

We have a fixed administrative fee so we know exactly how much Moda Health and their subcontractors are making. They pay an administrative cost per claim which is currently \$2.95. I'm 20,000 lives away from bringing it down to \$2.58 per claim because we built incentives into the contract. The administrative cost per claim idea is complicated but the pharmacy business is largely opaque, it's not as transparent. We are very transparent, so much so that we get 100% of your

manufacture rebates delivered back to you, verified by auditing. We have nondisclosure agreements but we have the ability to verify that. That's from the manufacturer, on the supply side.

On the demand side, there's also the pharmacies themselves. The pharmacies in our contracts are reimbursed at the amount in the contract. It comes back to your question, Tom, about all pharmacies being paid the same. We use Burchfield to audit many of those claims that ensure they cleared at the contract price. We have 100% in our discounts, our rebates, and on our administrative fees. We have discount guarantees that improve over time. In our contracts, MedImpact, through Moda Health, cannot offer anyone in either Washington or Oregon a better deal than us.

From the outset of this discussion, I said we have to be able to sell a medical benefit associated with a pharmacy benefit through the Consortium. We had Moda deconstruct their benefits and prove to us on a quarterly basis that their rates offered to any of their groups are not better than ours. That's our reporting on a quarterly basis. We have about 22 performance measures that have to do with geo-access, customer satisfaction, and other things. If they fall below 90%, I could penalize them.

Slide 14 – Experience: Moda Health started in 1955. MedImpact since 1989. MedImpact has roughly 50 million covered lives and is available in all 50 states. The Consortium's been around since 2006. We have a value-based pharmacy network. We include all pharmacies except Walgreens, but you can get to them. We have a local mail order called Postal Prescriptions owned by Kroger. We have a specialty pharmacy based on the West Coast called Ardon. It's a relatively small specialty pharmacy that's regional and they're available 24/7. We also have access to many clinical pharmacists. We even have a discount card. Our uninsured and underinsured members have access to various patient care programs.

Slide 16. Now to Carol's question. There was an annual market report done by Burchfield in March 2018. This slide shows their conclusions from last year. Overall, Consortium pricing was competitive. They said the market conditions could yield about a half a percent more savings as exclusive specialty pharmacy guarantees were improved. Then they offer us something called cost plus pharmacy reimbursement, which is basically building up what you're going to reimburse, refrigeration, transportation, etc. It also says we should consider adjusting our guarantees for specialty drugs, which we did January 2018. We are giving less money out for specialty drugs in accord with our contract requirements and Burchfield's recommendation.

The second part of Slide 16 is germane to you and from the Uniform Medical Plan benefit report. The quote on the bottom of the slide is what they wrote. They took in 1.4 million claims in a year and found 73 errors. That is an error rate of about 5/1000ths. One to five percent is generally the rule of thumb for an error rate. I

attribute this to the staff of the HCA Uniform Medical Plan that work with Moda Health, and indirectly with MedImpact, and people like Ryan Pistorosi.

Dave Iseminger: Ray, would you go through the discount card slides a little faster? We made these slides more robust as more retirees are paying attention to the materials we put out for the Board. We have more slides that address how to do something, or what it looks like, where do you find it, etc. I want the Board to know why we have more materials.

Tim Barclay: Ray, before you jump into that, I have one question on the Moda-MedImpact relationship and how Health Care Authority interacts with them. We spent a lot of time talking about a value formulary at our retreat in January. My impression from that conversation was that much of the work in creating that formulary was done here at the Health Care Authority with Health Care Authority staff. I guess that's surprising to me given MedImpact's volume of business that they wouldn't be taking a lead role in advising us how to establish a formulary. It surprises me also that we seem to be in a position where we're behind in terms of our management of specialty drugs. In terms of our approach to the formulary, we're playing catch up. We're talking about grandfathering people. It feels to me like we're taking steps to recognize the fact that we're behind in our management of those drugs. Help clarify for me what is the role of Moda and MedImpact in terms of the formulary management and how that works.

Ray Hanley: MedImpact will offer you a formulary. MedImpact probably has a thousand formularies that they offer. There's no single formulary. One of the things that Moda does is to provide that level of specialty, understanding. I'm going to call it a boutique type of approach to develop those types of formularies. One of the reasons why we have done so well with our auditing is that we work very closely with them. Yes, we could go out and bring an off the shelf formulary in. Building it ourselves gives us the ability to see, because we have transparent rebates, why are we choosing this drug? Is this the best drug to use? Plus, we have staff at the HCA like clinical pharmacists who understand this stuff. So we can actually build a better product ourselves than taking an off the shelf product from either Moda or MedImpact.

To address your question about specialty rates, specialty is a relatively new product. A few years ago, people didn't even know what the term meant. What Burchfield found was that our pricing was off by about a half a point. That's not unusual. In fact we caught up immediately. I'm not sure I can answer your question directly other than saying, by taking apart the way we reimburse our specialty pharmacy gives us the transparency to see where those additional margins are. We don't want to do margin replacement with our cost plus. We just want to see what it is we're paying for and that's what transparency's about to us. Even though you can get an off the shelf formulary, we would prefer to build our own. In fact my counterpart, Donna Sullivan, the Chief Pharmacy Officer, is at our Pharmacy and Therapeutic Committee today. That's the other half of my job. I run the Pharmacy and Therapeutic Committee for the Washington preferred drug list. We have ten clinicians that actually look at drugs and tell us what should be

safe and effective and what shouldn't be on our Washington preferred drug list. We have the infrastructure here that actually creates that preferred drug list and tells us what's safe and effective as opposed to just taking what's off the shelf. Does that give you a little bit more understanding?

Tim Barclay: It does. Thank you.

Dave Iseminger: Tim, I would just add Ryan is the face of the modeling brought up at the retreat. He's the person who's been working on it most significantly at HCA with strong collaboration from Moda. There was a very robust model developed in partnership between the expectations of HCA to be able to assess different model ideas for presenting to the Board. There is a significant role that Moda has played in collaborating on building the tools for creating the different options that will be presenting to the Board.

Ray Hanley: Slide 18 – Pharmacy Discount Card: This slide is a picture of the website. You can find it at: hca.wa.gov/pdp - prescription drug program or rx.wa.gov. It has our preferred drug list, information on how to get a prescription discount card, and how to get drug pricing.

Slide 19 explains how the prescription drug discount works. It's 100% cash payment by members and you can't use it to reduce your co-insurance or co-payment. The purchases are not subsidized by state funds. The cost is based on our negotiations on a half million lives. People who pay cash pay the most. It's about 30% to 40% higher for cash paying customers. In 2005 before Part D, about 31% of the people over 65 had no prescription drug coverage at all. They were paying very high rates. Our discount card is very popular and can be used at all of our pharmacies. The pharmacies choose to contract with us and agree to accept the discount rate.

Slide 20 – Discount Card Eligibility: It's free to all Washingtonians and there is no annual fee. There are no age restrictions. If you have any insurance, it's probably better than what the discount card can offer because this is 100% cash payment. There are no formulary restrictions and all drugs are available for discount. You can also get vaccinations and immunizations with your discount card. Mail order is available and specialty drugs are available through Ardon. A number of UMP users buy over-the-counter drugs with the discount card. In particular, proton pump inhibitors went from a brand medication to sold over the counter. The discount card is a way for the members to get a better rate.

Sue Birch: Ray, I do think it's important to clarify at this point. So people with pharmacy coverage still stand to do fine with some pharmacy coverage. This is really for people that are completely uninsured. We know there's about 5% still that are completely uninsured, or might have bought some sort of plan somewhere that has no pharmacy coverage. This card would help those two groups, correct?

Ray Hanley: Absolutely. I want to mention too that Medicare beneficiaries call me around October, November because they are in the donut hole. We have been

telling them that when you pay cash, the pharmacy may or may not send that claim to the insurer; it may or may not count against your deductible. You have to check with your plan. That's another group that uses it.

Slide 21 lists the four ways to enroll. I've sent postage-paid enrollment forms to churches; they're available in most Employment Security offices; and halfway houses. We have information in multiple languages. You can also enroll online. Slide 22 – Benefits of website: You can enroll online, use the pharmacy locator, look up drug prices, and order enrollment materials. We have posters, etc., that you can get for promotion.

Slide 23 is where we are today, January 31, 2018. We launched the program in February 2007, and in February, March, and April of 2007 we enrolled 40,000 people in the discount card program. Since the launch, Moda has been charged about \$162 million, of which they paid about \$69 million.

Greg Devereux: Of the 235,000 members listed on Slide 23, how many are state workers?

Dave Iseminger: Or people who were in the donut hole or buying OTCs?

Ray Hanley: I don't ask those types of questions. We provide something to the uninsured and underinsured. It's sort of a fall back safety net type program. I could run the number that are in the Uniform Medical Plan if you'd like to know that.

Greg Devereux: No. It just seems to me this is something that might be more appropriately in DSHS than the Health Care Authority.

Dave Iseminger: The prescription drug card program?

Greg Devereux: Yes

Dave Iseminger: It's a component of the Consortium and Washington Prescription Drug Program services. We included this information in today's presentation because we wanted to make sure retirees who may be in the donut hole or buying OTCs, are aware of this option they can access. It's not a silver bullet but another part of the puzzle that individuals may have to help manage some of their drug cost. It's just another feature of the Consortium.

Ray Hanley: I'm very proud of the last few lines on Slide 23. The most important one is that 96% generic fill rate. These people are voting with their feet and their pocketbooks. We've got really good savings.

Slide 25 – Market Expansion and Growth: One of the questions we have is how are you growing the Consortium. I just brought up three examples. First we bid on business. We are currently bidding on the covered lives in Snohomish County, Washington and in Multnomah County, Oregon. We have bid recently on Oregon

Health Sciences University (OHSU) and Nike, which is a private business. I recently did the Washington Department of Health's Aids Drug Assistance Program (ADAP). We've attracted the interest of other states, most recently Alaska, Delaware, and Louisiana. We're working with Oregon and Moda to present a value proposition to other states that we'll use at places like the National Governor's Association meetings. Finally, we've had attention recently from both the Arnold Foundation and an institute called the Lown Foundation. I spent most of the day with them yesterday. They're trying to recreate the Consortium. And there are other states thinking of joining.

Dave Iseminger: Ray, just to highlight a little bit. Part of the challenge with expansion and growth is you can market but people have to choose you. Or another state legislature may have to give their equivalent of the Health Care Authority the authority to join this Consortium.

Ray Hanley: Right.

Dave Iseminger: There may be multiple legislative cycles that need to occur and a great idea may take several years to get all the stakeholders on board. You field questions from other states about how this could be beneficial to them; but ultimately, they may have their own complex authorizing environment in order to engage in the interstate compact.

Ray Hanley: That's right. I do have a fall back that I use with them. They can join as a participating program, but they are not part of the Steering Committee.

Slide 26 – Northwest Prescription Drug Consortium: This is the Drug Consortium in full bloom. You start at the top with Oregon and Washington where we come together in the prescription drug program. The items in the red are the types of features we offer: MedImpact; Magellan Health (PBM) used on the Medicaid side; Premier, a GPO, etc. Below the red box is the number of members of the Consortium. The blue stripes list the different types of features offered.

Carol Dotlich: Thank you, Ray. My question is, I noticed you have Premier listed on your Moda Health Program Administrator. Is Premier the contract?

Ray Hanley: Yes. We have one contract with Moda who is ultimately accountable. We assess penalties and fees against them. It's their job to bring the subcontractors to the table. Premier is one of the subcontractors. They're a group purchasing organization and we're a member of them. We're also in partnership with Catholic Contracting Group, or Peace Health if you're familiar with that name, to bring additional cost of goods and discounts to our facilities like the Department of Corrections.

Carol Dotlich: There's something called the Minnesota Multistate --

Ray Hanley: Right. Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP). I'm glad you brought that up. I took the Department of Corrections

(DOC) away from MMCAP by giving them better pricing. In this world of pharmacy, they do repricing and MMCAP has been down to visit again. We're not monolithic anymore. With the Premier GPO contract and the MMCAP contract, I can get better insulin pricing on MMCAP, but better pricing on other drugs through my Premier contracts. Right now DOC is setting up a way to get the best pricing for both but it's difficult because you must have double menus. Pharma has beat us again. They've made it very difficult for us to get good pricing on insulin products, but we're trying to build a way around that. We're in MMCAP's crosshairs and we compete against them. I've done a reprice on MMCAP pricing at least twice in the last couple years, both for Oregon Department of Corrections and Washington Department of Corrections. They are well aware of us. They've been around since the 1980s and in 17 states. We're approaching their volume in terms of dollars.

Carol Dotlich: When I was asking about auditing, I asked you if the determination of accuracy is done prior to the payment being made or after the fact?

Ray Hanley: The auditors come in after the fact. In this case, they pulled 1,000,000 claims, about six months. Then they look at your certificate of coverage, your benefit coverage. They're saying you paid these claims per your contract agreement. There are brand names, single source brands, and multi-source brands. They're very cognizant of the different distinctions. They only do pharmacy and it's hard to find an auditing firm that's really that specialized. They were pretty amazed with the success of UMP.

Harry Bossi: The claims accuracy is an incredibly good rate for those who don't know. You're not going to get any better -- well, it could always be better but it's unlikely. Most error rates would typically be 1% and 5%. That's 10,000 to 70,000 erroneous claims that would be expected if we were more typical.

Ray Hanley: Right. I was very impressed. Thank you.

Carol Dotlich: If someone is denied coverage for a medication, what is the process for appeal and at what point is their issue resolved?

Ray Hanley: It would vary from program to program. I would have to turn to Ryan to help me with that question about appeals on the Uniform Medical Plan.

Dave Iseminger: Carol, I think maybe the best way to answer that question is we can either take that offline or we can bring back to the Board if the Board's interested in a general presentation about the appeals process. We can go through the Uniform Medical Plan's pharmacy appeals process for you.

Carol Dotlich: My question was not so much about the medical plan as about the specific drug.

Dave Iseminger: We can go through the specifics of what an appeal would look like of a specific drug in the Uniform Medical Plan. I think that's a much longer

question and would benefit from a more robust answering rather than our off the cuff knowledge.

Sue Birch: Ray, again, thank you. The power of your purchasing and what you're doing for our uninsured and those without pharmacy coverage is really remarkable. Thank you.

Report on Benefits Ideas

Marty Thies, PEBB Account Manager, Portfolio Management and Monitoring Section. I understand there were questions at the retreat regarding Silver Sneakers. I'm here to speak to that and a few other related topics.

Slide 2: Silver Sneakers is very much like another program called Silver and Fit. Both are aimed at those 65 years of age and over, and usually associated with free or discounted gym memberships. Those who participate can take advantage of exercise and fitness options at thousands of facilities across the country. The goal is to enhance senior fitness and to provide opportunities for community interactions and support.

Slide 3: In Washington, Silver Sneakers is offered by Aetna, Amerigroup, Humana, and Kaiser. All of these are in their Medicare Advantage and supplemental programs. In Thurston County, seniors can access the Silver Sneakers program through the fitness facilities listed. There are likely others as well.

Slide 4: This slide shows Kaiser Permanente of Washington information and statistics on their Silver Sneakers Program. This is in their Medicare Advantage Program. Their book of business is over 90,000 retirees. Not all of these are PEBB Program retirees. About one third have gone to a partner location and signed up. Of that third, about half of those have participated in the last year. Of those, approximately 16,000 to 18,000, half of those, fewer than 10,000 on average, visit a facility in any given month. Regarding cost to the plans, that was reported to us as proprietary, though Kaiser did say it's a per member per class fee plus an administrative fee. The Silver and Fit program, I understand, many entities are preferring because it's a fully fixed per member per month fee and people like the predictable cost.

Slide 5: Regarding the UMP Classic Medicare plan and Silver Sneakers, it's offered at Aetna, Humana, Amerigroup, and Kaiser. They receive federal funds to defray costs associated with the Silver Sneakers Program. Our classic Medicare plan is a self-insured Preferred Provider Organization (PPO) and does not receive that federal funding. Offering Silver Sneakers or Silver and Fit would therefore result in a per member cost for the entire Classic Medicare population, not just those who use the benefit. Noting again that in any given month at Kaiser, according to the statistics, 85% to 90% of those eligible for the program don't participate. For all those who might want to participate, and this is especially the case in rural areas, they might not have a facility nearby that provides that service.

Slide 6: At Kaiser and with UMP, there are a lot of health related discounts offered. The sites are listed at the bottom of the slide.

Slide 7 – Gyms and Fitness: This is not just with UMP or 65 and older, though it certainly is accessible to those 65 and older. There are many discounts available. The Active&Fit Direct Program gives discounts on gym memberships; Active and Healthy Program has three local fitness facilities just in Thurston County alone. There are discounts on monthly dues, waiving of enrollment fees, and various discounts by facility. The Premera Plan F subscribes to the Active&Fit Direct Program and has discounts on facilities.

Dave Iseminger: Marty, you did this for Thurston County, but using the links that are on Slide 6, anyone in the public who wanted to look for other local areas would be able to see the discounts that are available and use those links to get to that same type of information?

Marty Thies: That's correct.

Slide 8 – Health Discounts: For your information with regard to discounts offered through both Kaiser and UMP, there are other health related discounts. Vision products including Lasik surgery, which UMP does not cover. Discounts on frames and contacts. With regard to alternative medicine, if someone has used all the chiropractic or massage benefits that Regence allows, there is discounted access to those services. For hearing products and services, there is listed discount access to ampliphone, true hearing, and bell tone hearing products. The discounts would include free trials, warranties for repairs, and loss; and I saw one discount of up to \$1,600 for initial purchase.

Slide 9 – Healthy Lifestyle Discounts: This includes health education, tobacco cessation, and health apps for your phone.

Slide 10 is included to demonstrate the breadth of the discounts available. Everything from fertility services to funeral services.

Dave Iseminger: Marty, just to be clear, these are all things resulting from our medical plan contracts and are just extra discount features. Again, we've tried to highlight these more on the website through that link that's on Slide 6, but the funeral services, for example, that's referenced here is separate from anything that's included as enhancement with our life insurance contract. These are discounts solely related to being enrolled in a specific medical plan.

Marty Thies: Yes. For the most part, Regence contracts with these services.

Slide 11 – Other Discounts: There are additional discounts on movie tickets, hotels, etc.

Adding one of the two official Silver programs to our UMP retiree option would likely take premiums where the retiree population would rather not go. But the good news is there are a lot of discounts available and certainly gym discounts for monthly fees and enrollment.

PEBB Dental Plan Comparison

Betsy Cottle, Contract Manager, Portfolio Management and Monitoring Section. Three of the contracts I'm responsible for are dental contracts. I am here to share how they compare to other products that are available to large groups as a response to a question asked at the retreat. The slides I'm sharing aren't new, but I broke the comparisons down by plan maximum, annual deductible, and orthodontia.

For the annual plan maximum, our plan is right in the middle of the average maximum plan value of \$1,750. I found a couple programs that had a higher plan value, but nobody had an egregiously higher value. Our annual deductible is also well within the parameters of an average deductible for any of the plans I looked at. Our orthodontia is average and more generous than many because many plans exclude it.

Slide 3 – Dental Plan Comparison: I compared three classes: diagnostic and preventive, restorative, and major. For Class I, which is for cleaning and exam, our fees are very similar across the board; as well as for Class II, fillings and crowns. Our dental plan is very similar if not identical to almost every other dental plan I reviewed. Some plans have different ways to pay for services, but the coverage services are almost the same.

Greg Devereux: So when you say you looked at other plans, does that mean Boeing, Fred Hutch, and WEA?

Betsy Cottle: In the most recent review, yes. The comparison was three years ago and I compared 10 to 15 plans across the nation. This represents that research.

Greg Devereux: I guess what I really want to see . . . I don't know how many employees Fred Hutch has but I don't think it's that many. We're the largest employer in the state. I would want to see a comparison of Boeing for sure, but Amazon, you know, other big companies.

Betsy Cottle: In the time available to me, I was able to get an actual certificate from Fred Hutch. I was not able to get one from Amazon or . . .

Greg Devereux: I've had to do this before for bargaining and it's no easy task. So I'm not being critical of the time you've had; but to me, I would want to see a much more robust comparison in Washington State. I understand comparing it to other states. We do that all the time too but I would really like to see it . . .

Betsy Cottle: Do you have specific employers you would like me to pursue?

Greg Devereux: I would be happy to supply a list to Sue.

Betsy Cottle: I'd be happy to do the work.

Greg Devereux: Well, she may not want you to. [laughter] Then, I'll talk to you offline about some of the pricing issues.

Yvonne Tate: Having said that, I think what you'll find is there's less variation in dental benefits by far than what you'll see in medical benefits. It's amazing how similar dental plans are. It really is.

Public Comment

Irene Sevette: First, I want to thank the Board for hearing me today. My name is Irene Sevette. I've been an employee at the University of Washington since 1997. I'm also the wife and now widow of a 100% disabled veteran. As such, that means I'm an enrollee of the Civilian Health and Medical Program of the Department of Veterans Affairs. It's better known as ChampVA. Congress established ChampVA in 1973 to provide health care coverage for widows and children of veterans who died of service-connected disease or injury, or those who were 100% disabled. Now, under federal rules, ChampVA beneficiaries are not entitled to either Tricare or to the Federal Employees Health Benefit Program, both of which as they stand right now are included on the current list of deferral reasons for those going into retirement. For that reason, I'm here seeking an expansion of the deferral reasons in WAC 182-12-205 to allow enrollment in ChampVA to be considered a valid reason to defer under the PEBB Program for retiree coverage.

Under the federal rules, the crucial difference between ChampVA and Tricare is that Tricare is funded and administered through the Department of Defense, and ChampVA is administered and funded through the Department of Veteran's Affairs. As we all know, it's a little shakier situation these days and I've been a UMP member my whole time that I've been at the UW. It functions as my primary, ChampVA functions as my secondary. So now I found out July 6 my options are walk away. Call it quits. No state employee has a safety net, or I pay for non-Medicare eligible coverage indefinitely. I don't have Tricare. I don't have the other. My understanding is that I'm the first ChampVA beneficiary to raise this issue. I'm not alone. According to a congressional report done last month, there are 10,323 ChampVA beneficiaries in the state. Of those, 7,700 of them accessed their ChampVA benefits last year. So as it stands right now, you have two classes of veterans' families within the state employee ranks. You have primarily military retirees who get Tricare and can defer and you have the families of the disabled who cannot. So I'm just asking in interest of equity, treat both groups of veterans the same and do the expansion. With that, I'll open it to questions and thank you for your time.

Greg Devereux: I guess my question is not to you as much as to other folks. Dave or Katy, can we do this by a rule change strictly or does it require a statutory change?

Dave Iseminger: Because the deferral rule was set up in a rule making that stemmed from policy decisions by the Board, and the deferral rule and its various iterations over time really has been a product of policy decisions by the Board, this would have to come back as a policy decision for the Board. Now, typically, we do

rule making with an effective date of January 1, but I believe there are circumstances which this Board could make a policy decision with a different effective date, and then rules would catch up to the policy that this Board made. The Board would have to vote on it.

Greg Devereux: That wasn't my question. Can it be done by rule.

Dave Iseminger: The deferral rule really is a product of rule and policy decisions from this Board. It actually is probably one of the better ways for this Board to address this type of situation if it wanted to.

Sue Birch: Greg, let me clarify. Yes, we can resolve this issue by rule.

Barb Scott: That is true.

Dave Iseminger: Everything I just said was true and everything Sue just said was true.

Greg Devereux: So it seems to me you have to evaluate what the actual cost and impact . . .

Dave Iseminger: I think you've just previewed what is one of the next things that we'll talk about at the April meeting.

Greg Devereux: Meanwhile, Ms. Sevette is retiring in June of 2018?

Irene Sevette: July 6.

Greg Devereux: July. So, hopefully we can expedite the examination.

Dave Iseminger: Within the already established Board calendar meetings, the time to address the situation, or if there is a need to call a special meeting to address this type of situation, we can certainly pursue that as well. It is something this Board could decide with sufficient time for all retirees before a July 6 date.

Greg Devereux: I don't know what the overall impact is but it seems like an incredible inequity between the two groups.

Irene Sevette: Thank you. And if it is helpful, with a copy of my testimony, I included a copy of the congressional report that was done by the Library of Congress.

Dave Iseminger: Connie has that and will get it out to Board members.

Tim Barclay: Dave, I have another question for you. If we were to do this it seems to me we could have people that were in a similar situation, made a choice, and opted for CHAMPVA. My understanding is that the deferral process requires some paperwork at the point of time of retirement to declare your deferral.

Dave Iseminger: Correct.

Tim Barclay: Would there be anything we could do to grandfather those people, make an exception that they would have an opportunity to get back into the . . . because it wasn't available to them? Is there a retroactive correction that we could do and is that something we could try to assess in terms of the fiscal impact of making that decision?

Dave Iseminger: I'm not going to answer that question sitting here right now off the cuff, but as we come back in April with different information, that will be an area, since you've asked, we'll make sure we address the flexibility or inflexibility on that topic.

Tim Barclay: Thank you.

Yvonne Tate: I just wanted to go on record as supporting trying to make this correction, if you can.

Myra Johnson: I too want to look into this deeper and be in support. I do believe it's also a huge inequity and I'm wondering why. So thank you for bringing it to our attention.

Irene Sevette: Thank you. You're welcome. Just to add, I think many people who are in ChampVA function also as fulltime caregivers and caregivers are not particularly good at looking out for themselves.

Sue Birch: Thank you, Irene for coming forward and we'll be bringing this back for further discussion to the Board.

Gale McGaffick: I am fortunate enough to be covered under PEBB insurance through my retiree husband. I do always want to say thank you because I consider myself very fortunate. I just had a couple of comments. As someone who's under the Medicare portion, I am concerned like all of you and I'm sure many in the audience about the significant increase in rates, particularly over the last two years. So I find myself very interested in the Medicare portfolio evaluation and I'm going to go back and review the information that was submitted at your retreat.

What I would like to suggest, because I know these will be policy considerations that you all will talk about, is that you find some way to survey or get feedback from the Medicare folks on your PEBB plans. I realize a paper survey would be prohibitively expensive but I was thinking, and you probably have some ideas too, perhaps for the May mailing. At least I'm someone who gets mailed my bill, perhaps you could create something online, a link to some sort of web document where you could put out different things that you're thinking about to get feedback. Because I'm lucky enough to have some time, at least this time of year when the Legislature isn't in session, to sit here and to hear your deliberations and to be able to give some feedback. I think what would be most significant, because I do

remember the comments of seniors last year who are on fixed incomes, and how really hard this was for them, to have some way to get feedback from more people.

Then, my only other comment is thanks to Mr. Devereux for his comment about dental insurance because I think that is something that deserves another look. I think one of the puzzling things about dental insurance to me is that it starts at one amount and it stays at one amount. Most people, I'm just kind of theorizing, when they first get dental insurance, if they have some immediate need, they're going to get it taken care of. When your teeth hurt, your teeth hurt and they demand attention. I am puzzled as to, and I can't begin to understand all the factors that go into this, why dental insurance doesn't inch upward the longer you have it. So I appreciate you raising the issue. I think it deserves another look especially with the types of prices that people pay for complex dental procedures these days. So again, I thank you for the opportunity to be a part of your plan and to be able to speak to you today and thanks for all your hard work.

Yvonne Tate: We sure got a lot of comment last year when the rate increase was proposed and I think it was one of the most difficult things for us as a Board to have to deal with. We realize that the root cause was the prescription drug increases and I think it's still a huge dilemma for how to deal with that. Certainly, the information we got on the Consortium and the increase buying power that reduces cost is very helpful information, but I'm sure it's something we will continue to try to find solutions for.

Gale McGaffick: Oh, I really appreciate it and I see your dedication at every meeting. I know how concerned you are. My suggestion was just as you consider different ideas to find a way for some outreach and perhaps to get some feedback from just a broader range of folks. Anyway, thanks again for your time.

Sue Birch: Thank you. I believe, Ray, there is one lingering question that Greg has for you.

Greg Devereux: I apologize for prolonging the meeting but I was fascinated to go from 5,000 to a million folks. That's amazing. The one thing, though that I wanted to ask publicly is why do you think private sector businesses haven't joined, especially in light of Amazon and Microsoft and all those folks saying that they're going to go off and really wrestle this health care issue to a standstill? I would think that we could bring in Boeing and all those folks and have an incredible Consortium.

Ray Hanley: I would love that and I'm going to give you three indirect reasons because I don't really have a solid answer. First, I think there's a stigma associated with being the state. I've gone to benefit fairs before and presented to a Microsoft audience and a Boeing audience. I'm from the state. Why would I want to be associated with them? So part of it is the stigma.

The second part is that I have no marketing dollars. I rely on the good faith of being able to find out about these requests for proposals when they become available. Then the good faith of getting together with my partner, Moda, to bid on them. One of the difficulties with any proposal is that when Boeing or Microsoft goes out, you have to respond to a request for a proposal. That can take \$50,000 to \$100,000 worth of resources to be able to respond. Sometimes they're just looking for a price check so they can come back to the current vendor and say, "Can you meet this?" And he'll say, "I'll give you a penny less." They say the sales cycle in health care is slow, if you talk to somebody who sells. There's a lot of people just staying where they are and brokers who are willing to take a little bit of a haircut in order to keep the business.

The third one I'll mention, and I should do it in more hushed tones, is that most of the decisions made about bringing on pharmacy benefits are not made by the employer or the HR department. They're made by consultants. So consultants like Mercer and Wells Fargo, they're the ones who actually come in and take the business and say, "We will do the request for proposals and read those proposals." There's two aspects to this. Sometimes, and I'm just going to do this as an allegation, they have a PPM in their back pocket.

However, there's another thing that I can point to that's more clear and that is I have an administrative cost per claim of \$2.95. It should go to \$2.58 very soon, and I'm bidding against people who have no administrative cost per claim because they have no transparency on their rebates that are being returned to the employers. Nor do they have any guarantees that what they're paying the pharmacy is not different than what the contract actually says. This is called a pass through margin and a rebate margin. So the long and short of it, Greg, the third answer to this is that transparency doesn't show well.

Greg Devereux: Thank you very much.

Preview of Next Meeting's Topics

Dave Iseminger: We'll have an update on the year-end results of the Centers of Excellence Program that was launched by the Board with a full year of results from the total hip and joint replacement. There will be an update on SmartHealth and the \$25 gift card. We'll identify another part of the benefits ideas brought up by the Board in January. Then we'll bring back information about the deferral rule so you can continue evaluating that piece which was brought up in public comment.

I realize I said I would do something in this meeting and I haven't done it yet. If you indulge me for two minutes, I want to tell you one important thing that some of you have asked me about, which is what happened at the SEB Board meeting last week because it was a critical SEB Board meeting where that Board was identifying pieces it wants this agency to go out for procurement. As part of those procurements, we're going to bring data and information to you that we're getting in those procurements for your consideration about potential changes to PEBB Program benefits in the long run. Ultimately this agency will be doing three major procurements in the next couple of months, beginning in April for fully insured

medical plans, for a vision benefit that would not be integrated within a medical plan, and for long-term and short-term disability. The short-term disability option is not a benefit that currently exists in the PEBB Program and the coverage line that would be sought for procurement is an employee-paid optional benefit line.

Carol Dotlich: There are two issues I want to address. One of them sounds perfect for the April meeting. I wanted you to take a look, please, at the Kaiser portability, the coverage for people going out of state, because I had a member call and ask about that. Apparently, Kaiser offers that to some groups, apparently it doesn't offer it to us.

Dave Iseminger: I'd love to follow up with you afterwards to get more details but I understand the general topic.

Carol Dotlich: The second thing is kind of a legal question, I guess. Was an RCW the reason for the separation between the active working members and the retirees? If there was an RCW or some piece of legislation that separated the two groups . . .

Dave Iseminger: Carol, are you referring to the risk pools and why we have two separate risk pools?

Carol Dotlich: Yes, I am.

Dave Iseminger: Okay, we can follow up about that, too.

Lou McDermott, meeting adjourned.

Meeting adjourned at 4:15 p.m.

Public Employees Benefits Board
Meeting Minutes

DRAFT

April 25, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:

Sue Birch
Carol Dotlich (arrived late)
Greg Devereux
Harry Bossi
Tim Barclay
Tom MacRobert
Yvonne Tate

Members on the Phone:

Myra Johnson

PEB Board Counsel:

Katy Hatfield

Call to Order

Sue Birch, Chair, called the meeting to order at 1:35 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Agenda Overview

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

Follow-Up Responses to March 21, 2018 Meeting Questions

Dave Iseminger, ERB Director. There was a question from the March 21, 2018 meeting about what the statutory references are for separate risk pools. In the PEBB Program population, we manage two risk pools. There is the non-Medicare risk pool, with non-Medicare retirees and all active employees, and then there is a separate Medicare risk pool. Two different statutes address the risk pools. RCW 41.05.022 requires a single risk pool for employees and non-Medicare retirees. That's called the non-Medicare risk pool.

Greg Devereux: Do we have that written here?

Dave Iseminger: No.

Greg Devereux: Could you slowly give us the citation again?

Dave Iseminger: Absolutely, Greg. The first one is RCW 41.05.022(2), the non-Medicare risk pool. It describes the single risk pool for employees and non-Medicare retirees. The second citation is RCW 41.05.080(3), and that's where the Medicare risk pool is established. It also explicitly references the subsidy that retirees enjoy. The two risk pools were created in 1994 legislation. There were questions as to why separate risk pools. It was a legislative decision back in 1993.

Sue Birch: Dave, I want to clarify Part D was 2000, roughly a decade after those subsections were created, is that correct?

Dave Iseminger: Correct. That was the only question from last meeting that I wanted to make sure we got on the record so that everyone could track down those citations and understand the basis for the two risk pools.

ChampVA Follow-Up

Barb Scott, Policy, Rules, and Compliance Section Manager, ERB Division. Today I am following up on your request to look at ChampVA and the option of adding it to the list of coverages to which retirees could defer their enrollment in PEBB retiree insurance coverage.

I will discuss the timeline for PEB Board resolutions and provide you with information on the current Board deferral policy, which evolved over time, and the effective date for eligibility policy changes that the Board makes.

We usually bring you policy decisions you need to consider. We introduce those to you at one meeting and bring them back to you in the form of a resolution at a following meeting to start the discussion around the policy decision itself that the Board needs to make. We then take your feedback and refine the resolution for you to take action on at a future meeting. You'll see us doing that again this year. The plan currently is to bring policy resolutions to introduce to you in your June 20 meeting for a vote in one of your July meetings.

ChampVA would be one of those resolutions for the June 20 meeting. Today, I want to talk about what it is and get information from you so we can go forward and start putting a resolution together to introduce to you on June 20. Then we'll bring it back final form as a recommendation to you in a July meeting.

Once the Board takes action on a policy resolution, most of the time it is memorialized in Washington Administrative Code - in rule. For the PEBB Program, we typically do an annual rule making. We sometimes get directives from the legislative session that will affect our PEBB Program rules. In addition, it gives us time to work with the Board on any policy development that you need to decide on. We take that information and roll them into amendments or new sections that need added to PEBB Program rules. Typically, we file what's called the CR-102, where we

put formal amendments to the PEBB Program rules out for public comment. We typically try to file the CR-102 in July just after the July meeting where you take action. Staff are doing a lot of work in advance of that in order to stakeholder those rules extensively. We don't release that until after you've had your July meeting and we brief you on what's in that rule making at a very high level. That's the typical sequence of events. Those rules then go out for public comment. We respond to any public comment we receive, hold a public hearing, and the agency formally adopts them under the agency's authority to adopt rules. Rule changes typically take effect the first of the following year, effective with the new plan year.

Dave Iseminger: Barb has described a lot about the rule making process, but there are other operational pieces any time there's a policy change. The Communications team and Benefits Account staff have to go through our enrollment forms and make modifications to the enrollment forms. For example, when we talk about the deferral rule, part of the retiree form describes the deferral rule and what coverage is allowed. We have to go through the modification of forms. We try to limit the modifications during any one year so we can always say to members, "Do you have the 2019 form?" Not, "Do you have the 2019 form with the date on the bottom that says 'revised' in February versus May?" It helps a lot with version control with the members to make sure they're finding the correct form along the process.

In addition to the rule making pieces, there are other parts of operationalizing changes. What impacts employees is also required training of the HR Department and the PERS/Pay and benefits officers throughout the state so they are up to speed on what changes are happening with regards to eligibility. There are other operational pieces after a policy decision is made by the Board. That might help explain some of the on-ramp time between a July decision from the Board and what could be perceived by some as a delay, until January of the next year.

Barb Scott: That is true. Even the Board resolutions, once they're voted on and adopted by the Board, communication must occur. Although we put stuff on the website not all of our members use that forum. We use our *For Your Benefit* newsletters that go out in advance of Open Enrollment and any other communications that will capture Board decisions, effective dates, and try to help members understand how it affects them and how it changes their eligibility, or the benefits available to them as of January 1.

Slide 4 – PEB Board Retiree Deferral Policy. I've been with the program a long time and in my memory the first real time period where there was a provision put in place by the PEB Board that allowed retirees to not enroll in their PEBB retiree coverage was in the mid-1990s when school district retirees were brought into the PEBB Program. There was a change allowing an employee enrolled in PEBB Program coverage or a school district coverage as a dependent on an employee's coverage, they didn't have to enroll in their retiree coverage right away. They could wait until they weren't covered on that PEBB Program or school district coverage, and then could enroll in their retiree coverage. Other than the policy in place that recognized that we had a pool of retirees that included school district retirees and state retirees, there wasn't a deferral policy in place by the Board until 2001. Prior to that policy,

statute allowed employees to continue their PEBB Program coverage upon retirement, or for Plan 3 employees upon separation as long as they enroll in the coverage at that point.

For a PERS 1 or PERS 2 member, they need to enroll under statute at retirement. When I retire I can continue - and it truly does say the word "continue" – I'm moving from my active employee coverage to my retiree coverage. For the Plan 3 folks, when they separate it says they must immediately enroll.

Historically, the Board found people returning to work sometimes had employer coverage fully paid with no cost out of their pocket. But because the statute required them to enroll in their retiree coverage upon retirement, they were having to double cover themselves, or in some cases they would forfeit their PEBB eligibility in order to have less expensive coverage under their employer. A group of people made decisions based on their own situations. In 2001, the Board was petitioned to look at the issue and they made the decision to put in place a policy that would allow employees or retirees to defer their enrollment in PEBB retiree insurance coverage while they were covered under employer-based group medical plan coverage. For example, if someone went to work for Boeing and they had Boeing coverage available to them, they could enroll in that Boeing coverage and then come back to PEBB retiree coverage. Part of the thinking behind that for the Board was that if it was group medical coverage through employment, in most cases, coverage is comprehensive in nature. They weren't worried about skinny plans where employees or retirees would be covered and then come to the PEBB Program pool seeking services when the other coverage wasn't sufficient. The Board adopted that policy effective January 2001. I couldn't tell you today exactly how many folks take advantage of that rule, but I know we have a good number of folks who defer their coverage because they have post-retirement employment.

Another provision the Board was petitioned to research had to do with folks who had coverage through TRICARE or the Federal Employee Benefits Health Plan, as retirees. They wanted to be able to defer their coverage. They petitioned the Board, and the agency looked into allowing those folks who had coverage through those sources to be able to defer their enrollment and retiree coverage, as long as they were covered under that other coverage. For that population, they wanted to be able to retain their PEBB eligibility and not have to forfeit it in case Congress made a decision to either get rid of the coverage, quit offering it, or to substantially change the coverage so it wasn't as helpful to them. For that population, the Board put in place a policy, again effective January 2001, that allowed those retirees to defer their enrollment as a once in a lifetime option. They would have one opportunity to come back in. Currently in the rules around deferral, it allows for folks to defer their coverage if they want to be covered under their TRICARE or their Federal Employees Benefits Health Plan coverage, and they have a one-time opportunity back in. That's unique to that population.

The Board didn't add an additional provision for deferring coverage until Medicare Part D was put in place at the federal level. That's why you see the Medicare/Medicaid Dual Eligible provision in 2006. That provision was really for

when Medicare Part D was first rolled out, decisions were made at the federal level that if somebody was dually eligible for Medicaid and Medicare, they would be auto enrolled in a Part D plan at the federal level.

At the PEBB Program level, the decision was made to take advantage of and collect the retiree drug subsidy. That created a conflict between being able to collect the retiree drug subsidy for the largest portion of our retiree population and use those dollars, and at the same time, have folks at the federal level auto-enrolling a certain segment of the population. In order to resolve that, the Board put in place the policy that allowed for those who are dually eligible for Medicare and Medicaid to defer their coverage. They could come back to the PEBB Program if they lost that eligibility.

The Board didn't look at the deferral policy as far as adding another provision until the health benefit exchanges were brought up. In 2014, we brought a proposal before the Board that would allow retirees to defer in order to get coverage through a health benefit exchange. The main driver behind that was that a portion of our retiree population would end up being eligible for subsidy on those exchanges. We wanted to make sure there wasn't a barrier in place that prevented them from being able to do that and being able to come back to PEBB Program coverage if for some reason those coverages aren't available in the future.

Sue Birch: Who maintains the log of those that are deferring? Do we have current volumes that have deferred?

Barb Scott: I don't believe we have current volumes. Folks do fill out a form and send it to us to let us know they want to defer coverage, but I don't know that we have a flag in our data systems that allows us to capture that. It's not my understanding that we do.

Dave Iseminger: Usually when a deferral form comes in, if the individual isn't already in the system, an account isn't created in PAY1 for them, but it is put in imaging under their account. When they return and actually enroll, an account is created in PAY1. We are able to pull a subset of who has deferred at some point but we don't have in our current system the ability to pull the exact number of people who are in deferral status.

Barb Scott: We also probably have information included in some reporting and Finance may be able to help us size this. If not, the State Actuary's Office would have some insight because it is something they measure.

Sue Birch: For our next meeting, it would be good to have staff bring that information back. Given the number of things being scrutinized at the federal level, it might be something we want to look at as far as budgeting and risk management.

Harry Bossi: Barb, for clarification, let's use employer-based group, can someone defer a second time, a third time, or a fourth time? Or is it one time? If somebody retires, goes to work for Boeing and opts out because they have great coverage

there but that situation changes, so they opt in to the retiree, but then they get a job offer to go back to work, can they defer back out?

Barb Scott: Yes. Under the provision put in place in 2001 for the employer-based group medical coverage, the deferral policy allows for folks to defer for any period of time they're covered under employer-based group medical. They can go in and out, and we do see that. Anecdotally, we saw more of that occur when K-12 retirees were brought into the pool. They tended to retire at a younger age and go back to teaching part time. There was a time when it was difficult to get teachers for certain classes so you saw districts trying to entice them back to teaching when they had already retired. We do see them go in and out. We also see a bit of that in higher education with our faculty. They'll retire from being faculty and come back part time.

Dave Iseminger: Just to be clear for the record, you can come in and out of deferral status in some of the instances listed on Slide 4, but you have fewer opportunities in others. Barb, can you go through where you have multiple opportunities and when you only have one?

Barb Scott: Bullet 1 absolutely allows for in and out. Bullet 2, the federal retiree medical plan, where TRICARE and Federal Employees Health Benefits Plan live, is a one-time back in. For Bullet 3, Medicare/Medicaid Dual Eligible and Bullet 4, Health Benefit Exchange, I would be guessing. I would have to look at the rule.

Dave Iseminger: For the Health Benefit Exchange, we say it's a round trip ticket and you get one round trip ticket to the Exchange. That one I know. We'll follow up on the third one.

Greg Devereux: So that's one time?

Dave Iseminger: Yes. We'll follow up when we bring the proposed resolution about ChampVA about how many times you can defer under the Medicare/Medicaid.

Harry Bossi: Is TRICARE specifically called out or is it just assumed to be part of a federal retiree medical plan? I'm trying to understand why couldn't ChampVA be if it's similar?

Barb Scott: This is where I really do need your feedback as we move forward. I was going to take you into the complexity of this. I decided not to, but I will. The federal retiree medical plan, at this point in rule, is defined to include TRICARE and the Federal Employees Health Benefits Plan. What I'm hoping to understand today is if you want us to include ChampVA on the same footing? If so, we would add it to that definition but with a new date, depending on the effective date. Or do you want to treat it like TRICARE? Do you want to treat it differently? As I started walking through the rules, I thought I would tuck it into that definition.

Dave Iseminger: But then it would be a one-time deferral.

Barb Scott: Yes. I wanted to make that clear and find out what you're thinking.

Greg Devereux: We're only talking about a state rule?

Barb Scott: Yes. We're talking about the WAC.

Sue Birch: Dave and Barb, are there any other associations or anybody that could help us think of the implications for an aging society that is working longer and/or frequenting the need to go through periods of in and out? For example, it really gets quite complex when you think about the paid caregiver role many families are taking on until someone declines or passes away. There are a multitude of different scenarios. I'm wondering if there are industry kinds of associations where you can do a deeper dive to inform the Board about some of the aging trends and what those implications might mean for this deferral policy.

Barb Scott: If it's in and out of work, probably the best data we can get state-wise would be the Office of State Actuary as far as what's going on around retirements. They would have data that would show those who go in and out of drawing retirement. I don't know that they would really help us get to anything that's below their threshold. For example, if I retire, I could go back to work to a certain level without having to stop my pension benefits. If I hit above a certain level, I'm going to have to stop those pension benefits. Their data may be more geared toward that if we're looking at state numbers.

Sue Birch: I'm thinking of Susan Rinehardt with AARP. I'm thinking of some of the aging policy experts that might be grappling with some of the same sorts of scenarios as they look at design and coverage and how things are shifting.

Dave Iseminger: We can certainly look because I think, Sue, what you were describing is this rule is really, the origin of it was people who wanted to maintain eligibility without dual coverage, and 20 years later we have a different demographic, a different population. We're looking at different issues. The Board has been adding bricks to the wall, and you're asking can we look a little more systemically at the wall and how it's structured?

Sue Birch: So well put. Thank you, Dave.

Barb Scott: It is complicated.

Dave Iseminger: At the same time, we want to address the question that was raised to the Board, which does say let's talk about adding another brick to the wall. But I think it's good to take a look at the wall as a whole, even though we're working on having the Board evaluate a current circumstance.

Sue Birch: We'll put that on your to-do list to bring back at our next strategic planning retreat.

Barb Scott: Slide 5 – Effective Date of Eligibility. Typically, we go through the Board policy decision making process, work on putting that into PEBB Program rules, and generally have things effective January 1 of the next plan year. We try to avoid doing

mid-year or retroactive changes. Sometimes those are legislatively required. We haven't done a retroactive change related to retirees in a long time. I think the last one I saw retroactive related to PEBB Program eligibility that came from legislative direction, was probably for survivors of emergency service personnel killed in the line of duty. The Legislature amended that eligibility and it was a retroactive effect to implement mid-year, which was difficult because of how legislation gets passed. Typically, we do it with the beginning of the plan year. We roll it into our communication materials to notify our members about the change so they're aware and can react to it.

Dave Iseminger: Another reason eligibility changes tend to be prospective is because the premiums paid are built on projections with a known eligibility framework. If you change that framework midstream, the claims cost associated with that change aren't accounted for in the premiums currently being collected. If changes are effective on January 1 of the next plan year, that can be taken into account in the rate setting process for rates that apply in that plan year.

Barb Scott: I've talked with Ms. Svette about her specific case, her retirement date, and how this will play out for her. I will continue to work with her on her retirement as we move forward. I know that is one of your concerns as well.

Greg Devereux: Can you remind us what that ask was? I think it was at the last meeting in terms of ChampVA. Was it deferral for ChampVA?

Dave Iseminger: My recollection of it was ChampVA being eligible for a deferral option. A lot of it was drawing analogies to TRICARE and other options. I don't know if at that time there was an understanding that part of the deferral rule is a once in a lifetime opportunity versus a multi-opportunity for deferral. The ask was could ChampVA be another option for deferral so that dual payment didn't have to occur at the same time.

Barb Scott: We have done some of the research you requested. As far as what ChampVA covers, is it comprehensive-type coverage? The answer is yes, we believe it is. There is a provision where they aren't supposed to cover preventive care, but they truly are covering preventive care. It sounds like they are working toward making that change so it is reflected in their regulations.

Tim Barclay: Since we have our petitioner in the front row, can I ask you a question? I think the Board's very much in favor of this and we're trying to find the right way to do it. If we do this effective January 1, does it meet your needs?

Irene Svette, petitioner. If you do it January 1, where I don't have clarity is if I have one shot only to defer. I retire on July 6 and I have to file my paperwork in the middle of summer on what I'm doing with my health care. I don't know whether I need to pay through to January or whether I need to walk away to maintain my eligibility. This is my question and that hasn't been clarified.

Barb Scott: Irene and I have been corresponding. In order for her to retain her eligibility, she will have to enroll in PEBB coverage. She would be able to defer it as

soon as the deferral provision is available to her. This is consistent with what others have had to do in the past. It's not new but it does mean for the months of August through December, she will need to retain her PEBB coverage in order to be able to retain her eligibility. I need to look at her specific case individually to see if whether or not, it would be more advantageous for her to use another policy provision the Board put in place in 2001 that allows employees to not have to come directly to retirement. They can use what we call the COBRA bridge. You can bridge between your retirement and the date you access your retiree coverage with COBRA coverage. We have not walked through whether or not that's a better option for her, but we will have that conversation once we know where we're going. Irene and I chatted about the sequence of events before this meeting knowing the Board typically takes action on policy resolutions in July. Her retirement date is August 1 so I'll be keeping her abreast of what the Board's decision is and the effective date so she can make informed decisions about her own health care.

Tim Barclay: To clarify then, in this particular case, assuming we follow this timeline and the Board makes a change effective January 1 either through enrollment in the PEBB Program or enrollment in COBRA, essentially she is going to have to pay her premium for four months for coverage she doesn't need.

Barb Scott: It may be for coverage she doesn't need. I need to look at the COBRA bridge provision and work closely with her to see just how much she has to enroll in.

Tim Barclay: Understood.

Sue Birch: I think, to answer Barb's question, you are looking for insight regarding the distinction of ChampVA being its own separate category rolled into the federal TRICARE line?

Barb Scott: Yes, do they get a one-time back in consistent with what we've done with TRICARE, so that if ChampVA is substantially changed and she decides that's not what she wants to use, she gets a one-time opportunity back in? Do you want to make it different than TRICARE? Are they on the same footing? I wanted to make sure we were transparent with you around the one-time provision.

Sue Birch: Barb, you've been doing this for a very long time. Do you have a recommendation to the Board on it being separate criteria or being rolled in? If so, could you express that recommendation?

Barb Scott: I haven't looked at this in-depth, but my initial thought was to roll it in and put it on equal footing with TRICARE.

Dave Iseminger: Just for the record, Barb's in-depth and other people's definitions of in-depth are different.

Barb Scott: I like to be technically accurate.

Sue Birch: Thanks for that distinction.

Barb Scott: I would hate to accidentally give a mistruth to this Board, so I do take care in that.

Greg Devereux: Are there more people? I know we have one petitioner, but do we have any idea of how many ChampVA people there are?

Barb Scott: We may have at least one other. I would have to look. I think I received one other case similar to this with ChampVA. The ones I see more often are the school district folks who missed their original window that closed in 1995. There's a bubble of them that made a decision not to come in and they have continued to petition the Legislature to allow for a second open window. That comes with a cost to the state and it has not passed the Legislature. I often hear from state employees or school district employees who don't quite meet the age requirement, don't have the years of service, or who wanted to leave employment earlier than actually retiring.

Greg Devereux: Thank you.

Harry Bossi: I would suggest you consider rolling it into the same provision. To me it is analogous to TRICARE. I happen to be TRICARE and I can see the fit very easily. I would think we want to be similar if not equal provisions. Otherwise, TRICARE folks may come back and say, "What about us?" That's a good model and one you ought to use would be my recommendation.

Sue Birch: Thank you, Barb. Dave, a point of clarification. Do we need to take formal action at this time or will you bring it back?

Dave Iseminger: Not today. This was informational, for discussion only.

SEBB Procurement Update

Lauren Johnston, SEB Procurement Manager. Slide 2 are resolutions The SEB Board approved on March 15, 2018 to procure for a fully insured group medical plan, as well as a group vision plan. In this case, also referred to as a standalone vision plan because it's not embedded in the medical benefits. Then long- and short-term disability procurements, too. All benefits for the SEBB Program will start January 1, 2020.

Slide 3 – Procurement Process. For the fully insured group medical and group vision plans, we will first do a Request for Information (RFI). By doing an RFI, we will be able to inform collective bargaining and be able to create competitive solicitations from the information gathered. We also want to learn about geographic coverage areas, plan designs, and projected costs for those plans. From that point, we will do a Request for Proposal (RFP) for both of those plans. For disability, we are only releasing a Request for Proposal.

Slide 4 – SEBB Procurement Timeline. The fully insured medical RFP release date is early June 2018. These dates are subject to change, but this is the current schedule. The RFP response for the fully insured medical is due back in early August 2018 and there is a provision later to add the PEBB Program to those plans.

For group vision, the RFP release is scheduled for mid-June 2018 and due back July 2018. It includes the same PEBB Program provision. For disability, we intend an early May 2018 RFP release, and due back June 2018. We are possibly looking at a provision to later add the PEBB Program.

Greg Devereux: When you say a provision to later add PEBB, that means if you procure and somebody who is a provider then PEBB could also have access to that?

Lauren Johnston: Yes. Basically, what we wanted to do is if the PEB Board ever decided to take on those plans for the PEBB Program members, at that point in time we could amend the contract to include the PEBB Program.

Dave Iseminger: Greg, we're trying to add and double-dip into the procurements and leverage the procurement work that we're doing by describing both populations at the same time. We're focused at this time on the statutory requirement to launch benefits in the SEBB Program for January 1, 2020; but also wanting to be able to get as much information to bring to this Board and share what the market showed.

We haven't done a fully insured medical for quite a while on the PEBB Program side. We can find out what the carriers think about the PEBB Program population at the same time as the SEBB Program population, and then present that information to this Board. We would be able to have the procurement and contract mechanism already in place to launch the benefits that you as a Board authorize more quickly at that point, rather than having to wait and do a separate procurement later. The other alternative would be to do the procurement right now for fully insured medical, not mention anything about SEBB, try to draw analogies, and then we'd have to go out and do another procurement at a different point. We can be more efficient with the contracting work now by leaving open the opportunity for PEBB, in the same way we left open the opportunity for SEBB with the Uniform Medical Plan TPA procurement that we recently finalized.

Sue Birch: When we will be posting the RFI responses that we've received or letters of intention?

Dave Iseminger: For the RFIs received yesterday and/or this Friday, our Public Records Office is working through them and will be contacting the carriers. We've already had a lot of interest indicating that people will file public records requests after the dates the RFIs come in. We've let everyone know we're planning to put redacted versions out publicly so individuals don't have to file a public record request. We do that at this agency when we know there's high interest in a particular document. Carriers will be given the opportunity to make sure they've designated things appropriately as proprietary/confidential. We'll post it on the website and then everyone will have it available. That process will take a few days, but it will be faster than if you filed a public records request. We will make sure there's a way they're available on our website after we've gone through the necessary steps to ensure confidential, proprietary information is protected from those who are submitting the responses.

Tim Barclay: Lauren, could you talk more about what it means for a provision to later add PEBB Program. I guess in my mind there are two extremes and maybe we're somewhere in the middle. On one end it could be really not, I think from SEBB's perspective, a value add, in that we're saying, "Oh by the way, in addition to bidding the SEBB Program, you have to leave the door open for us to push the PEBB Program on you in the future if we choose to do so." That would be sort of saddling SEBB with an open door for the PEBB Program. On the other hand, we could go to the other extreme, and give them data and optimism to enroll a substantial number of PEBB Program members, in which case it might actually enhance the SEBB Program procurement, as well as setting us up in the future for a very positive fully insured response. Have you thought about where in this spectrum we're really at in terms of what we're asking the plans? Are we giving them data? Are we asking them to propose two bids, one with and without? What are we really saying when there is a provision to add the PEBB Program later?

Lauren Johnston: Piggybacking on what Dave said about leveraging our efforts, from my understanding, when it comes to putting out an RFP, in order to make sure it's within scope, if we were to ever change the contract you have to put enough of it in the RFP to make sure it's within scope in the first place. We can't add the PEBB Program to a contract later that was never even mentioned in the original RFP. So, for right now, we are not providing PEBB Program data. We're just saying that at some point in the future, if the PEB Board were to decide to add a PEBB Program to these plans, that that might come along as well.

Dave Iseminger: Tim, we are still in the process of developing the RFP. The way I summarize your question is those extremes are obligation versus opportunity. The way we're going to try and craft the RFP is more the opportunity for both programs. Really, the grand question is we're going to have 500,000 -600,000 covered lives between the two programs. Even though they're separate risk pools, at least as it's statutorily set up right now, what is the purchasing power of the two programs together?

Tim Barclay: I would just encourage you to use the leverage that the two populations together can generate.

PEBB Procurement Update

Beth Heston, PEBB Procurement Manager. Slide 2 – 2019 PEBB Procurement Cycle. This slide may look familiar. You have seen various iterations, most recently from Marcia Peterson. She showed you the PEBB Program procurement cycle in totality, the 18-month cycle. Sometimes we say 24 months, because it runs through two Julys. For instance, in July 2018, you will be voting on 2019 benefits. Starting in July 2018, we'll also begin thinking about 2020 benefits. We're always ahead. My job comes in the middle. Around January of each year, the Benefits Design and Strategy work moves from being ideas and exploratory to a more solidified role. While nothing is written in concrete until we get to Board vote, we have ideas we bring to you of what we think would be good benefit changes or necessary benefit changes for the coming year.

At the January 2018 Retreat, I brought to you the Virtual Diabetes Prevention Program for UMP and the change for Dental Class 3 - restorations, crowns, etc., and the limit to be lowered from seven years to five years. Those are still the biggest benefit changes that are going forward, but the process during January and February is when I write the request for renewals and people often have questions. We've called it different things like request for refresh or request for renewal. We are not going out for a new procurement. We go back to our carriers and we're introducing some new benefit changes or new pricing because the legislative budget changes.

The Request for Renewal this year went out on March 23 to our current carriers, Kaiser Washington, Kaiser Northwest, and UMP. At the same time, our renewals went out to our dental contractors. We didn't have one for our life contractor because we are under a rate guarantee, but we did have one sent for Standard Insurance for long-term disability. We no longer have a long-term care carrier and we're not able to find one even though I did my due diligence and researched this year. We still cannot find anyone to sell us a group long-term care product.

We are now waiting for carrier responses. During their response, they give us any changes they might have or want to make for your consideration. They also give us new rate bids. Those are due back Friday. Once we receive them, we'll review them and the negotiation period begins based on the plans and the rates.

I will come to you in June and inform you of what has come of the negotiations and get your feedback, and then bring back final decision to you in July for a vote. After the vote, we go into contract finalization and prepare for the November Open Enrollment.

Dave Iseminger: I want to highlight more about that May to July area that's coming up. When we talk about beginning the negotiation process with carriers on the plans and rates, the types of things we're working on, our actuaries are telling us what the challenges are with some of the assumptions that are built into the rates from the carrier side. The carrier side is challenging our assumptions and we're talking about different pressures that are built into what carriers have put forward as rates. When we get into the June process, I will talk with Katy Hatfield about what we can talk about in Executive Session with the Board, where we are in the middle of the rate-setting process, what it looks like, and the potential premium impacts for the plan changes the carriers are proposing. We'll get more feedback from you about what direction you want us to go as we finalize the negotiation process.

The Board can't come together and sit in every negotiation session for all carriers, but we want to make sure we talk to you appropriately under the Executive Session rules and the Open Public Meetings Act. We'll discuss where there are benefit design changes and how they could impact premium, get your insight and direction as to how you want us to finalize rates. Then we would bring those finalized rates back to you in July for the final rate setting. I wanted to provide more context to that part of the circle.

Tom MacRobert: So you have two things going on simultaneously, if I'm understanding it. On the one hand, you're in the process of going through renewals, for example, since we got the seven year changed to five year. So starting in next January you're going to have to request a renewal for that?

Beth Heston: Actually, it will have to be in place this fall. We sign all of our contracts before the year starts. Delta Dental will be implementing that change to our Uniform Dental Plan and we will have it certified in the contract for next year, which we'll hope to sign no later than October 31 this year. It will go into effect for 2019.

Tom MacRobert: The other piece is, at the same time you're doing that, you're also getting information for possible new benefits that you could negotiate going forward in April and May or March and April?

Beth Heston: In March and April we send out our request. This year we didn't request any changes to our fully insured plans. We did request a change with our self-insured plan, that Regence would find someone to offer the Virtual Diabetes Prevention Program (VDPP). They are in the process of locating their subcontractor, take our input, and make the best choice for them. That's done. That will be part of an amendment to their contract this fall and signed for next year.

Centers of Excellence Program Update

Marty Thies, Account Manager, Centers of Excellence (COE) Program. Last year the Centers of Excellence Program was just getting underway. We now have a year of experience and I'm here to give you an update.

The state has committed to health care quality. In 2011, the Legislature established the Bree Collaborative. The intention was to gather stakeholders to address issues in the health care marketplace. The deliverable was to establish evidence-based recommendations for improving health care outcomes. In 2014, the Legislature directed HCA to increase value-based purchasing and payment, and to increase access to high quality, high-value care instead of "fee-for-service." "Fee for service" is every time a service is provided a payment is made. Essentially providers could potentially be rewarded for quantity of service rather than quality of service.

This is a procurement program where we identify and contract with health care facilities that follow Bree clinical criteria, best practices, and have evidence of the excellent outcomes achieved for their patients. Quality is the goal of this program, especially for serious procedures like surgeries. With regard to the benefit design, we started with a procurement for Centers of Excellence for total joint replacements, knees and hips. This is the starting place for bundled payments across the country, usually because there is high utilization as well as high variability, both in cost and outcomes. The idea is to bundle together all the various services that contribute to a standard episode of care, in this case total joint replacement, and pay a prospective, contractual price for that bundle.

The second step is to incentivize members to use the Centers of Excellence Program. It's a choice for members. They can go elsewhere for their joint

replacement with the usual arrangements and copays. This COE benefit is available to UMP Classic and CDHP members who are 18 years or older, exhibiting osteoarthritis or other condition that makes a joint replacement appropriate, and for those not enrolled in Medicare as their primary coverage. The bundle includes the surgery and the inpatient stay, the implant, any durable medical equipment (DME), necessary post-op, case management, transportation, and accommodations. There is no out of pocket for those getting a joint replacement at the Center of Excellence. However, CDHP members do need to meet their high deductible first.

Sue Birch: Marty, could you clarify in the surgical component. Does it cover the pre-op?

Marty Thies: Yes. As soon as members contact Premera and begin their inquiry, it's all covered. Slide 5 depicts that journey. A member will recognize they have an issue and contact Premera to learn more. If they are eligible, Premera will refer them to Virginia Mason. The member has their surgery, their post-op, and physical therapy after discharge takes place in their home community.

The Centers of Excellence team is Virginia Mason Medical Center for this bundle. When the RFP was released, we anticipated multiple Centers of Excellence, but Virginia Mason stood out because of their low complication rate, patient-focused approach, and their adoption of the Bree criteria best practices. Premera is the third-party administrator for all bundles, not just the total joint replacement. They handle beginning to end concierge case management. This is a serious surgery and a lot to navigate. Premera has been the entity that walks members through the process from start to finish. We signed contracts in fall 2016 and went live January 1, 2017.

The first year we built business processes, established communications, and learned to troubleshoot together as issues arose.

Slide 8 shows the results of the first year. In 2017, there were 122 referrals from Premera to Virginia Mason and 95 completed surgeries. The remaining referrals were still in the program but hadn't had their surgery by December 31. There were a little under a dozen people not referred for surgery. We don't know why they didn't have their surgery, but perhaps they had a family event and they had to cancel their surgery, nicotine use, or a BMI issue, all which are components of optimum preparation for a joint replacement.

The average number of joint replacements in the UMP Classic and CDHP populations over the period 2014 to 2016 was 649 surgeries. In 2017 both Center of Excellence and non-Center of Excellence, we had 648 surgeries. In the three-year period prior to 2017, Virginia Mason averaged 24 of those joint replacements. Essentially that number quadrupled for UMP members who selected the Center of Excellence. The COE Program is about quality.

Slide 9 – Clinical Outcomes. The coral column at the far right of this table indicates 90-day complications after surgery, as well as 182-day surgical revisions. We have no record of any complications or revisions. The yellow column directly to the left of

that enumerates the complications and surgical revisions for procedures NOT performed at the COE.

Slide 10 – Member Surveys. Thirty days post-op, Premera sends a survey to everyone who has undergone a surgery. It contains 16 questions rated one through ten. This slide has the average scores. I selected three that indicated the work Premera did, and three that indicated the work Virginia Mason has done. These are very positive assessments of the work done by both of our partners, with an overall satisfaction rate of 9.5 out of a possible 10.

Carol Dotlich: This program is used by both the non-Medicare and Medicare pools?

Marty Thies: It is not available to those where Medicare is the primary payer.

Slide 11 shows some of the comments we received.

Greg Devereux: Back on Slide 9. It shows the non-Center of Excellence total joint replacement had three complications. One a seven-day, two a 30-day? Is this in the PEBB non-Center of Excellence portion? It's just us – PEBB.

Marty Thies: Correct. This was an inquiry we made to Regence regarding claims data.

Dave Iseminger: This is all PEBB data. When we say non-COE, when Marty said there were 648 surgeries in 2017, we had 95 that were in the coral column, and 648 minus 95 in the yellow column. This is just what's appeared in the data so far. There are claims run out on both sides that needs to occur.

Greg Devereux: Correct. Going back to the very beginning - the whole point, when you talked about joint replacement and you mentioned the second bullet was high variability in cost and outcomes, I assume that means we're trying to get folks in to the Center of Excellence to reduce cost and reduce variability. That's the whole point of this.

Marty Thies: Correct and we did contract for a prospective price.

Sue Birch: I might add, because yesterday the Washington Health Alliance Board was discussing this construct, and I think it's really important to note that there's quite a correlation between high quality and low cost. It is the common denominator, which one might think that higher cost is going to get me higher quality. We're fighting that in health care, as you know. I think the representation, too, that Marty's trying to show us is the high, high quality and the cost is coming down, I believe.

Marty Thies: Yes. In the table on Slide 9, you'll note the additional cost for post-op which we did not experience in the COE population.

Dave Iseminger: More importantly, the members did not experience the pain of that complication, or the challenges related to those complications.

Marty Thies: Correct. My favorite member comment is, "One of the most positive medical experiences I've ever had." These superlatives are common in the narrative comments of the surveys.

Slide 12 shows demographics: female to male was 60 to 40, which was typical as women show a higher incidence of osteoarthritis and cartilage loss. Regarding age, three-fourths are 45-64 years of age, the older half of the PEBB Program population. Those 65 and older indicated here are still active employees.

Slide 13 – Predictably. Most participants are UMP Classic enrollees. More knee surgeries performed than hips at the COE, proportions again that are in tune with national trends.

Slide 14 indicates where participants live. There was some concern that a Seattle-based Center of Excellence would dissuade members from around the state, but the east/west split is in approximate proportion to the population distribution. To the far right, the I-5 corridor (Whatcom to Thurston counties) with King County accounting for about 32%.

Slide 15 indicates our outreach efforts. The blue line is welcome packets requested. When a member calls Premera, if they want more information Premera sends them a packet. That has been between 10 and 20 per month. Calls received are those to the Premera customer service line set up explicitly for this purpose, and website visits is all the traffic on the Premera site. You can see to the far left the lines all coming down from the initial Open Enrollment in 2016 where this benefit was first announced and publicized. On the far right you can see the website hits that directly correlate to the November 2017 Open Enrollment.

Sue Birch: Marty, what's in the welcome packet? For example, are there decision-making aids, or what is in a welcome packet?

Marcia Peterson: Information about the program itself. Most importantly, forms that people must fill out in order to allow Premera to gather their information together. It's one of the primary things that Premera does. It's the concierge aspect of this, gathering the medical records from different providers throughout this journey they've been on. Pull it together and then they send it all to Virginia Mason. They need approval to do that.

Sue Birch: So this isn't where we have any certified decision support tools?

Marcia Peterson: Decision support tools are done verbally. They are on Premera's website and through Virginia Mason as well. That's actually a piece of the design. That was very important to get the two of them to work together to use the same decision support tools so we could have consistency with our members. We continue to work on that with them.

Carol Dotlich: I don't know the history of this, but did the original resolution not include the Medicare population?

Marcia Peterson: No, it did not. We are unable to include Medicare because they have their program that they're doing with bundled payments and they handle their payments around that. We could talk more about that later, if you would like to.

Dave Iseminger: Also remember, for the Medicare population UMP pays secondary for medical services and Medicare pays primary, which is flipped for pharmacy. We keep saying that in the pharmacy pieces to remind everyone that UMP pays primary on pharmacy. But that's another reason, because Medicare has its own bundled payment program and it is the primary payer. We've left the focus of this payment program on the non-Medicare and active employee population.

Marcia Peterson: If I can just add, on a policy side, and Sue may know this from discussions she's had, Medicare is interested in this program. They are talking to us about it. They are scratching their heads in terms of how they could do something like this. Their program is different. They have bundled payments, but it's a very different approach. They look at ours and say, "Wow, it's got some really great design to it." They continue to look and we continue to talk with them.

Marty Thies: Slide 16 – Cost Overview. This is a generous benefit and a clear concern would be that travel benefit and concierge service would balloon costs, but that hasn't been the case. Upper left you can see that 97% of the costs for the program are medical. Lower right is a breakdown of the travel costs. Lodging accounts for the lion's share, parking is second. We noticed this was quite high at the outset. They were using full-day parking passes. We have addressed that issue and the proportion of the travel expenses that go to parking should continue to drop and stabilize over time.

Slide 17 – 2017 Member Savings. In the period 2014-2016, our data shows that the average out of pocket was about \$855. For 2017, it indicates it went up to \$988. It really depends on the facility you go to. For this program, for most participants, there is zero out of pocket. I think it's fair to say we have saved members approximately \$94,000 in the first year of this program.

Slide 18 – Cost Comparison with Non-COE TJRs. As far as plan claim savings compared to those who in 2017 got their surgery someplace other than the Center of Excellence, UMP saved more than 15% per Center of Excellence joint replacement.

Tim Barclay: Marty, can you provide just the total spend on total joint replacements both in and out, and compare the years prior to 2017 and see what happened? Just to our total spend?

Marty Thies: Total spend for all joint replacements?

Tim Barclay: We already said our utilization essentially didn't change by one. What happened to our total spend?

Dave Iseminger: We will follow up with that after this meeting. I don't want Marty to guess off the top of his head.

Centers of Excellence Program – Spinal Fusion

Marcia Peterson, Section Manager, Benefits, Strategy, and Design. I am here to talk about expanding the Centers of Excellence Program to include spinal fusion. Marty talked about the Bree Collaborative, and just to remind you, it was established by the Legislature in 2011. Its purpose is to develop evidence-based guidelines for procedures or therapies where there is found to be wide variation in either cost or quality. We use the Bree criteria as much as possible in our contracts. We use it in our UMP Plus contract and in the Centers of Excellence Program.

Slide 20. The Bree Collaborative identified four different bundled episodes of care to date. We have looked at all four; and through looking at our UMP members, and looking at things like volume, cost and quality, we identified spinal fusion as the area for our next bundled episode of care.

Some background on spinal fusion. You may be all too familiar with it, either personally or with friends. It's one of the most costly procedures, particularly if there are complications, which there often are. These complications can be devastating to the patient. While it can be highly appropriate for some people to undergo spinal fusion, there is evidence that many people are undergoing unnecessary surgery - surgery that doesn't address their problem.

Slide 21 – Overkill. I've highlighted this article from a 2015 issue of the New Yorker which maybe some of you have seen by the surgeon Atul Gawande, who talks about spinal fusion, the amount of money spent on that, and it is an example of unnecessary care. Slide 22 is an example of this surgery not going well that was in the news about a year ago. The head coach of the Golden State Warriors was very vocal about his negative experience around back surgery, and there have been a number of other public figures who have spoken out around spinal fusion.

Slide 23 – Variation in Care. An area that drew our attention to spinal fusion is the fact that where you live tends to determine whether you'll get spinal fusion. In 2015, the Washington Health Alliance did a report looking geographically at rates of care, what kinds of care people were getting in different areas, and found that if you are a woman between the age of 45-54 living in Olympia, you were 192% more likely to have this procedure than your counterparts in Seattle. This made us think it's an area we should look at so we looked at cost and quality. Among our own members shown on this slide, you see that over three years the total of UMP members receiving spinal fusion came to about 633, with an allowed cost amount of more than \$30 million. The average cost was \$49,000 and it ranged from about \$30,000 to as high as \$80,000, and that's taking out those costs that are over \$100,000, those outlier costs. Take those out, and the range is still high.

Slide 25. This slide is difficult to read but I wanted to show this was from the actual report that we got from Milliman around the range in cost, allowed cost by facility. Along the left-hand axis, you have the allowed costs ranging from zero to \$300,000. Along the horizontal axis you can see numbers one, two, three, those are hospitals. I've taken off the names of the hospitals, but the number underneath it shows how many surgery episodes they had over that three-year period. Hospital number one on the far left says 134 surgical episodes, either single or multiple spinal fusion.

They range from as high as \$250,000 down to fairly low, about a \$59,000 average cost, which is where the little red dot is. You can see it ranges all the way along with quite a bit of variation in terms of how many surgeries are done at different hospitals. Evidence shows that volume does matter in something as complicated as this, so you see a wider variation in some of these areas where they haven't done that many.

Slide 26 shows our timeline in going forward. We are in the midst of a procurement for spinal fusion Centers of Excellence. I say that plural because we will accept up to three in the procurement. We released the RFP on February 1, 2018. The responses were due last Friday and we're evaluating those with hopefully a benefit launch to members in January 2019. This will be very similar to the Total Joint Centers of Excellence Program Marty just walked through in terms of member experience. It's a voluntary program. Members would have little to no out-of-pocket cost. We try to remove as many barriers as possible for members. Travel is covered. People need to meet the Bree criteria, including having a care companion and meeting appropriateness and fitness for surgery.

Yvonne Tate: Are you doing anything to determine whether or not this is a good option to offer, based on what the outcomes have been?

Marcia Peterson: Yes, we looked at variation in outcomes as well.

Yvonne Tate: So there weren't a lot of positive versus negative outcomes?

Marcia Peterson: We can really only look at the negative ones.

Sue Birch: I think she is asking about the appropriateness and fitness. There is criteria to become a recipient of a spinal fusion under a COE-type program. Is that what you're looking at?

Yvonne Tate: Yes, that and whether or not it's an effective tool, overall, to use.

Marcia Peterson: Thank you for bringing that up, because that's exactly what this program is designed to do. We found in some of these programs nationwide, as much as 50% of those people referred to these Centers of Excellence programs end up not having this surgery. They've found it's not appropriate for their symptoms. That caught our attention. It's interesting, because with the Total Joint Centers of Excellence, we're not seeing that. In general, we're seeing people who go through the surgery program at Virginia Mason through the Centers of Excellence Program, meet the criteria. It's not an inappropriate surgery for them, based on their symptoms; but in other programs, it is a concern. It is something you see a lot. We're hoping with this program to avoid inappropriate surgeries. We don't want people to go through all the possible complications, changes to their lives, not actually needing surgery, and not have it address their problem.

Carol Dotlich: I would like to know the average out-of-pocket cost for joint replacement surgery for the Medicare population.

Dave Iseminger: We'll follow up with that after this meeting.

Sue Birch: If I could just add a little bit. The Bree Collaborative really does an amazing job doing this work independently. We're so fortunate to have had the Legislature stand up the Bree process because they really do the heavy lift, creating the construct. They look at a number of different issues every year. They look at what the issue is, and then level set the medical criteria and the clinical appropriateness. They look at everything; they look at the cost variation and do a thorough analysis. Then they tease it up to look at what's the action, what's the solution we can take. These Centers of Excellence really have been remarkable. My question to you is how many other states have copied our Centers of Excellence model? How many other places in the country have this sort of COE program built into their benefit design?

Marcia Peterson: None of them yet. Although we have been asked to do presentations all over the country to states, other large employers, and purchasing groups. There's a lot of interest behind it, and because of being a public entity, we have a "How To" manual, an RFP, things that we can share with them in order to go forward. There's a lot of interest and we're very encouraging.

Sue Birch: It's really remarkable. Colorado looked at how we could implement this and we couldn't get everything to align. We couldn't get the momentum behind it, but to get the kind of standardization, cost, and quality, deliver on just the value option, and then to see the client stories, it's really remarkable what you all and the state have done. So thank you for your work on bringing up Centers of Excellence. Good job.

SmartHealth

Justin Hahn, Washington Wellness Program Manager. I'm here to bring you an update on SmartHealth. I will focus on a SmartHealth overview, 2018 SmartHealth Program, and then SmartHealth participation from 2016 - 2018.

Slide 4 is a quote from Governor Inslee that underlines the support and leverage we receive from the Governor and what SmartHealth can do for employee engagement and organizational results. SmartHealth started in 2015. We're partnered with our vendor, Limeade and this is our fourth year.

Slide 5. SmartHealth takes a whole-person approach. It uses a health assessment plus more. It's not just your physical body, but the full range of what's going on in your life. It's a health and wellness portal designed to measurably increase well-being. As an example, an employee has four key life areas, physical, emotional, work, and financial. Underneath those four life areas are 34 different life dimensions, things like managing stress and anxiety, sleep and energy level, job satisfaction, back health, etc. There are 215 questions she answers every year to inform how she's doing along those 34 dimensions in those four primary areas. This platform becomes personal when someone takes this well-being assessment. It tells you your top three strengths and three areas you need to work on. On an aggregate level, the

organization, agency, or higher education can see those results and make actionable steps.

Slide 6 – SmartHealth is secure, private, and confidential. We take this very seriously. We follow stringent HIPAA privacy standards. Personally identifiable health data is never shared with the employer or Washington Wellness staff. Data from groups with less than 20 people is not revealed. When looking at the SmartHealth dashboard, we can see how many people: are participating in what activities, have completed the well-being assessment, have earned a \$125 wellness incentive. Those numbers are not connected to an individual.

Slide 7 is the value proposition circuit. SmartHealth is good for employees and organizations. The idea is if we invest in well-being using SmartHealth, we increase employee engagement. By increasing employee engagement, we increase organizational results, which means we have better and greater organizations. Well-being defined is it's an optimal state of health, happiness, and purpose. That purpose is important. It's the emotional connection you have to yourself, to your work, to your life.

Slide 8 – SmartHealth increases well-being. This slide is the cohort analysis we've done since 2015. When you answer one of those 215 questions on the well-being assessment (WBA), you answer them on a Likert scale of 1 to 5. Looking at those participants that have lower well-being answered 3.5 or lower. The same people took the WBA in 2015, again in 2016, and 2017. There are 12,000 employees that started with low well-being scores of 3.5 or lower. What we saw in 2016 and seeing for 2017 is that every one of those 34 dimensions improved. Some a lot, some not as much. It says something about how SmartHealth increases well-being for our population. There's a lot of research that talks about this, but we see it bearing out for our population, especially those that need it the most.

Slide 9 is about higher engagement equaling better organizational results. This slide is from Gallup. It's a meta-analysis that looked at close to 50,000 work units that included nearly 1.4 million employees and it's not just the public sector, but private sector as well. You'll see things like sales and profitability, but the interesting thing is that it compares the upper top quartile to the bottom quartile, with regards to engagement. There are linkages I have not gone into between higher well-being and being more engaged. What does it mean to be more engaged? Some of the highlights are absenteeism down by 41%, safety incidents down by 70%, productivity up by 17%, and profitability up by 21%. The bad things are going down, the good things are going up. This is good news.

Slide 11 - 2018 SmartHealth Strategy. We're in our fourth year and our 2018 SmartHealth strategy is really starting with an intrinsic motivator. There's intrinsic and extrinsic motivators. Intrinsic is really the motivator that comes from inside of you. What motivates you? We started there because that's the most lasting. We've had this going for two years now. It asks you to take some time. Identify your purpose. Those revolving activities on SmartHealth bring this to a different challenge or a different activity every quarter, to engage people in their purpose. If we can

engage them with that and link that to SmartHealth as a tool to support their purpose it will stick that much more.

We also have extrinsic incentives, those that come from outside in. An example of that is a \$25 Amazon gift card for completing your well-being assessment. This is new for 2018. Another incentive is the traditional \$125 incentive upon getting to level two.

We have a strategic communications plan that is frequent, varied and branded. We have SmartHealth portal enhancement. We're increasing our training, our resources, technical assistance, especially to larger organizations.

Slide 12 talks about the three different levels. Level 1 is completing your well-being assessment worth 800 points. That's when you earn your \$25 Amazon gift card, which must be earned and claimed by the end of the calendar year. Level 2 is the \$125 incentive applied to the next year's medical deductible or CDHP/HSA. The cutoff for the \$125 incentive is September 30, except for new employees it could be as late as the end of the year. Level 3 is focused on getting people to continue to engage on the platform. The intrinsic motivator is receiving a Wellness Champion certificate.

Slide 13 lists 2018 Ready-to-use Resources. We chiefly work with wellness coordinators many of whom are volunteers so we're also approaching leaders, supervisors, and individual employees directly. We have flyers, videos, team activities, all these things listed here. We also have a SmartHealth presentation we put together for wellness coordinators or anybody from an organization that can present and talk about the benefits of this program.

Slide 14 is a list of 2018 SmartHealth Events.

Slide 16 – SmartHealth Registrations, looks at data and comparisons for 2018. I think the \$25 Amazon gift card created interest in SmartHealth. Looking at 2017 new registrations, they totaled 6,746. As of April 18, 2017, we had 2,500 new registrations. Looking at 2018, new registrations as of April 15 total 6,554. We're almost at end of the year numbers compared to 2017 which is quite encouraging. We're getting more people to join and growing our pipeline of employees that can benefit from this program. As we focus on our events and our messaging, we want to pull those folks toward greater participation on the platform.

Slide 17 is well-being assessment completions. The blue bar is 2016, green bar is 2017, and the purple bar is 2018. Horizontal axis is the week and the numbers are on the vertical axis. We are at approximately 30,144 well-being assessments complete. For 2017 there were 32,000 completed for the whole year. Things are going quite well in that department.

Slide 18 shows the incentive qualifications. When we talk about incentives, it's the historical, traditional incentive of the \$125. Again, same colors for the same bars.

We're lagging a bit behind on the \$125 right now, compared to previous years, but we did get a bump in the last couple of weeks.

Greg Devereux: Justin, there is still time in the bargaining process this summer to increase that incentive and raise that number significantly.

Justin Hahn: That's good to know. Thank you, Greg.

Sue Birch: This is great to have this element. I participated in an awards ceremony not too long ago. There is quite a bit of competition between the departments and the wellness coordinators to increase response and involvement. It's great that there is a very active theme about wellness and building a culture of health.

UMP Value Formulary Options

Donna Sullivan, Chief Pharmacy Officer. I'm here to continue the conversation about the value-based formulary. This has been a several-year conversation of reviewing options about reducing drug trend, going over background on formularies in general, looking at some of the formulary options, and then proposing a recommendation, and then how to move forward.

Slide 3 – Our Journey. This journey started in 2012. We were looking at making changes for cost savings and noticed a lot of our members were getting their Tier 3 medications, their high-cost medications, at the mail order pharmacy where they only paid \$100 for a three-month supply. In order to transition utilization and encourage people to get Tier 2 medications, or generic medications, we aligned our pharmacy benefit between the retail pharmacies and the mail order pharmacies to have the same out-of-pocket costs. They have the three different tiers based on a percentage coinsurance where Tier 1 and Tier 2 have a cap of \$25 or \$75 per month. Then Tier 3 was 50% with no cap. We implemented that in 2012. Then in 2013 we started getting more communications from members that were on Tier 3 medications that couldn't afford their medications. They tried all the other preferred products, or the generic products. It was medically necessary for them to take this drug.

We considered several options on how to move forward for 2014. We looked at implementing a closed formulary, which has similarities to the value formulary we're talking about today. Placing a per claim maximum on Tier 3 or allowing patients on a Tier 3 drug to get an exception. That exception would be if their doctor could justify the medication was medically necessary, they would get an override or an exception and allowed to pay the Tier 2 cost-share amount for that particular drug. That's what was implemented in 2015. It did provide some relief for some patients, but it created inequity in our benefits. We had two patients taking the exact same drug. One is paying \$75 per month and another patient could be paying \$500-\$600 per month, whatever the 50% of that cost was. We have this inequity and patients that knew their benefit well and knew that they could request an exception did. Some patients might have needed that medication just as much and didn't know there was an option for an exception. This inequitable situation is why we felt we should move towards the value-based formulary in future years.

We started the discussion last year to address this issue. The value-based concept is not necessarily for cost savings, but for a more equitable benefit for our members. When the Medicare cost increases in premiums happened, we look to this as possibly a savings opportunity as well.

Slide 4 - Overview of Options to Reduce Pharmacy Trend. The Uniform Medical Plan participates in the Northwest Prescription Drug Consortium. That means we have access to a fully transparent contract for our pharmacy benefit. Our Pharmacy Benefit Manager (PBM) pays the pharmacies exactly what they charge to us. We have tight performance guarantees on our costs. We require the pass through pricing, and then each year we have an independent third party come in and look at our pharmacy rates, what we pay the pharmacies, and compare that to what other large commercial payers pay. In the last year the Consortium pharmacy network outperformed their performance guarantee on the cost of the drugs by 3.1%, meaning we were paid 3.1% less than the guarantee we were given. This brings a lot of value to Uniform Medical Plan.

Sue Birch: Donna, what does that 3.1% translate to in real dollars?

Donna Sullivan: I don't have the dollar figure off the top of my head. It was for the entire Consortium, so we're talking about for a medical plan plus all of the Oregon programs, so it's a considerable figure.

Sue Birch: Several millions?

Donna Sullivan: Yes, it would be in the millions. Then in 2016, we had the prescription drug price and purchasing summits where we talked about long-term strategy. The list of options on Slide 5 are not necessarily something that the agency can do without assistance from either the state, requiring legislation, or the federal government. We've already increased price transparency in our PBM contract. We can try to increase price transparency from the manufacturers, as well as pharmacy benefit managers. There's discussion about a utility model, bulk purchasing. Federal options would be doing something with Medicaid reimbursement so commercial payers could get more aggressive discounts. Reimporting from Canada, which is not likely a solution. Then other strategies, such as value-based purchasing contracts directly with manufacturers. We can keep these in the back of our mind for down the road, but they are going to take a couple of years to try to get to one of these particular strategies.

Slide 6 – Short-term Options to Reduce Drug Trend. For our actual program we can do nothing. We can make no changes. However, the drug trend is anticipated to keep increasing at a rate of 10.4% for our non-Medicare population, and 12.5% for our Medicare population. We can change the members' cost-share. We could reduce the pressure on the premiums, change their deductible, increase their coinsurance, increase the maximum out of pocket, but that is something you as a Board have told us you're not interested in doing. You're trying to reduce member out-of-pocket share. We don't feel that is an option on the table for us, but we can always have those conversations.

The next thing is to try to guide member utilization to those high-value drugs that we want them to take, that give them better outcomes that might have a lower cost for the drug itself; but overall would lower the cost of their care, in particular and drive them to those high-value alternatives.

Tom MacRobert: On the increase of 10.4% for non-Medicare and 12.5% for Medicare, is that for both Uniform and Kaiser?

Donna Sullivan: No, that is for the Uniform Medical Plan only.

Slide 7 – Formulary Models. This slide provides background on formulary models. There are open formularies where non-formulary drugs are still available on higher member cost-share, which is what we currently have. For closed formularies, non-formulary drugs are not covered unless medically necessary and reviewed on a case-by-case basis.

There is a hybrid, where you might close some classes but not all classes. If certain drugs are excluded and we say we are not going to cover these drugs, there's not an option to even request it. Maybe through an appeal or a benefit exception, but the doctor can't ask for a non-formulary drug.

The value-based formulary emphasizes the clinical effectiveness of the drug rather than its costs. You might put a higher-cost drug in a lower cost-share or a low-cost drug in a higher cost-share based on how effective and the value that those drugs provide.

Dave Iseminger: As Chair Birch mentioned earlier, many times it's counterintuitive, but lower cost can come with higher quality. There are many instances where the more effective drug would be less costly.

Donna Sullivan: Possibly, yes. Slide 8 - Other Terms. We talk about "grandfathering" where a member will remain on a drug if its status changes. A multi-source brand is a brand that has a generic equivalent, meaning they have the same ingredient, the same dosage form. Then we have copay coupons offered by the manufacturers for patient assistance programs for their drugs.

Slide 9 – National Background on Formulary Use. Closed formularies were very common in the late 1980s and early 1990s. There was a shift in the marketplace to patient access and you started seeing open formularies where members could get the non-formulary drugs if they were willing to pay more for it. That's where we are now. What we're seeing is a trend to these hybrid formularies, where plans are excluding those high cost drugs that they don't think provide value, which might give them a bigger discount on a competitor drug. They're also trending towards value-based formularies.

Slide 10 – Challenges to Formulary Management. With an open formulary, manufacturers have copays coupons, which are post adjudication coupons for the patient. The patient takes their prescription to the pharmacy if they have a

prescription and the pharmacy will fill the prescription, bill the medical plan, and tell the patient they owe \$200 on the drug. The pharmacy can submit that coupon to the manufacturer through their point-of-sale system, like any prescription claim, and the coupon will take care of some of that member copay, sometimes the entire amount. For specialty drugs, I've seen copay coupons with a maximum amount of \$5,000. Manufacturer coupons were geared towards the plans that have high cost-share tiers for specialty drugs in 2006 after the Medicare Part D plans came out. That's where copay coupons originated.

Manufacturers will also have patient assistance programs. If your drug is not covered by your plan, they'll pick up the full amount of the drug. Most of these programs, the copay coupons and the patient assistance programs, have annual limits, or it's a one-time one-year thing; but some can actually be renewed.

In 2007, 23 out of 85 multi-source brand name drugs accounted for \$700 million in drug expenditure. It just keeps increasing and the copay coupons allow the members to continue to take those high cost drugs, even if they're on the highest cost-share tier.

Slide 11 – Trend for Managed Formularies. This slide is a little dated, but the concept still holds that the tighter you manage the formulary, the better trend you will have. With more limits, clinical policies around drugs, quantity limits, a smaller set of preferred drugs, then you're more likely to have a better trend and guide those patients to the drugs that provide the most value.

Slide 12 – Information on Value Formulary Model. For this model, we will go through a few scenarios: the model looked at covering certain drugs only when medically necessary, what would happen if members were grandfathered on their current non-preferred drug, and what happens to the savings and cost estimates when you look at different percentages of patients that would request an exception to not being grandfathered. Then go on to approve those requests, as well as the number of exceptions you expect to approve. The value model uses claims data from 2015 through the end of 2017. If you're trying to track the dollars back to the previous presentation given in January, there is additional data in this version of the model, so the numbers don't exactly track.

Slide 13. We originally started this to address the Medicare projections and their premiums. We looked at the trend for Medicare and looking for 2019, if you were to reduce the trend by 1% we would need to save \$2 million in claims. 1% reduction in trend equals about a \$2 premium.

Dave Iseminger: Our preliminary estimate is that 1% in trend is about \$2 million in claims costs for the plan and approximately \$2 in premium. There was a question about what is the relationship between trend, premium, and claims cost. If you're trying to influence the premium by \$10, that means you have to find \$10 million in claims, which is 5% of trend. I wanted to give people some kind of proxies and estimates of what a 1% reduction in trend means.

Donna Sullivan: Then for the non-Medicare rate, you would have to save more to reduce the trend for that population.

Dave Iseminger: I want to make sure everyone realizes that second piece on Slide 13 where it says reduced projected Medicare trend for 2020, 2021, and 2022 by 1%, we see that \$2.4 million is more than the \$2 million right now. That really just underscores this only gets harder the longer we wait.

Sue Birch: This is fascinating to me. Is it the type of drugs that non-Medicare users use that's creating that variation? Are there more hypertensives or more -

Donna Sullivan: It's really interesting. Our best explanation is that the older population, with their chronic diseases, started on older medications. Let's take an example of diabetics. A lot of the older Medicare population are still on sulfonylureas and some of those older generic drugs to treat their medications. If they're doing just fine, there's no reason to put them on a new drug. We have the younger non-Medicare population, and now the guidelines have changed the course of therapy. There are more expensive brand name drugs in the diabetes toolkit and more of the non-Medicare members are on those newer, more expensive diabetes medications. We could probably extrapolate that to several other chronic disease states. That's our best explanation at this time.

Slide 15 – Option 1a is moving multi-source brands to being non-covered, unless medically necessary. Looking at Medicare only, if we put all multi-source brands as non-covered unless medically necessary, we would not grandfather current users. Members who demonstrate the non-covered drug is medically necessary would pay a Tier 2 cost-share if they are granted an exception. 7,500 Medicare members would be impacted, about 13% of the entire Medicare population. We project the cost avoidance is about \$770,000 in 2019 and an additional \$2.19 million per year in 2020 through 2022, on average.

Dave Iseminger: When you look at the options and numbering system and try to correlate it with the options in the prior presentation, they don't match up one for one. So, very quickly: Option 1a is the equivalent of what was titled Option 1 in January's retreat presentation. As we go along, I'll try to clarify what's what. Remember, if you're trying to hit a 1% trend, Option 1a here doesn't even hit 1% in claims cost avoidance, or even \$2 in premium costs.

Greg Devereux: Dave, in some places in these slides it says Medicare some places, some places it says non-Medicare, and some places it is silent. So I'm not sure in the end, it appears that this all, including the recommendation, addresses Medicare.

Donna Sullivan: I will point out what slides apply to Medicare and what slides apply to non-Medicare. For the recommendation slide, the intent was to have dialogue among the Board Members, because it's really your decision if you want to -

Dave Iseminger: Split the formulary differently for non-Medicare and Medicare or if you have a single formulary and apply it to the entire UMP population. We've tried in

the options to describe Medicare only, which would imply splitting the formulary and having a different formulary for the non-Medicare risk pool versus applying to the entire UMP population, meaning both non-Medicare and Medicare, as well as actives.

Donna Sullivan: An example, Greg, would be moving on to the next slide, Option 1a+. This is all UMP. So this would be applying the same benefit design to the non-Medicare and Medicare populations. I believe that this was Option 4 in the January 2018 presentation. Slide 18 shows only the additional savings you would get from the non-Medicare population. These are separate because the premiums are set differently for the Medicare population and the non-Medicare population. They are in different risk pools. So adding the UMP non-Medicare members to this value formulary doesn't help the Medicare members because those costs are segregated when it comes down to setting the premium. For the UMP non-Medicare population, it would be about 5% of the total UMP population and the projected cost avoidance would be \$1.41 million for the non-Medicare members. Then for 2020-2022, it would be about \$4 million.

Slide 20 - Option 2a is focusing on the diabetes drug class itself, specifically for the Medicare population. In this scenario, all non-preferred drugs are covered only when medically necessary. We would grandfather current users if they were on a single-source brand and would not grandfather users if they were on a multi-source brand. If there was a generic available, they would have to switch to the generic.

Harry Bossi: We use a medically necessary quite a bit. To get that, does it require a medical doctor to do the justification? Does it require a medical director at the other end to disapprove the request?

Donna Sullivan: Yes. What we're talking about is a prior authorization. The doctor, the prescriber, would have to submit documentation that the patient has tried the preferred products and they didn't work, the patient had a significant adverse event, or they might have other contraindications where there's drug interactions, allergies where they couldn't take the preferred drugs for those. It's not clinically appropriate for them to try the preferred products. Those would be approved. If it's not approved, then yes, it would be denied by the medical director. Current patients who are grandfathered, or who got the exception, would pay the Tier 2 cost-share.

Slide 21 - 850 Medicare members would be impacted. We assumed 25% of the patients would request an exception, and 20% of those would get approved. 700 members would see a reduced cost-share. This is the one where we grandfathered. This would cause a claim increase, because instead of paying 50% of the cost of the drug, they're now paying \$75. We are estimating there would be a claims increase of about \$315,000 in 2019. However, there would be cost savings, or cost avoidance, in 2020 or 2022.

Tom MacRobert: When we had the original presentation in January, Option 2a was including all multiple-source brands of drugs and now this 2a is only referencing diabetes drugs. Is that correct?

Donna Sullivan: That is correct.

Dave Iseminger: So real quick. 2a, 2b, and 2c do align with 2a, 2b, and 2c from January. In this instance, for slides 20-28 we've honed in on specific drug classes. If you took the principles described in January and only did it for one drug class, showing exactly what would happen for that drug class, the charts that follow on slides 31, 32, 33, show what the effect is of doing those principles drug class by drug class. You could see the impact of picking and choosing different drugs within that model. 2a, 2b, and 2c are the same principles as they were in January, but it was rolling up and showing the impact of all of these drugs. We decided to present you now the information on a drug class by drug class basis to see how the principles apply to each class.

Tom MacRobert: So basically, in this particular case, you're giving us a show of what one drug would look like. Then you're saying, "But this could still be applied to all those different classes."

Dave Iseminger: Yes. We wanted to do a deeper dive and it takes 6, 7, 8 slides to do the deeper dive of what the impact is for just one drug class; we gave you the summary table so you could apply the same principles in the deeper dive, and then ask, "What does this column mean? If I go back to 2b for diabetes, I can see what the principal was and how it impacted there and have a better understanding of how it hits drug class by drug class," rather than just giving you the total roll up.

Donna Sullivan: These options are not all distinct. It doesn't mean we could do any one of these options for any drug class and still implement a value formulary. If we decided Option 2a for diabetes and we thought we needed to grandfather people on their medications because it's not appropriate to make them switch, then we can look to see what the impact would be. We may say levothyroxine is one that people on these brands could go to the generic levothyroxine. It's the same medication. Maybe people should have to switch. So these are the different levers we pull as we develop the recommendation of which drug classes we feel there would be value in implementing this type of benefit and then trying to roll up what the total cost would be. We would do this on a drug class by drug class basis.

Slide 22 – Option 2b is for Medicare only. Current users would be grandfathered if they are on a single-source brand and not be grandfathered if they are on a multi-source brand. Patients grandfathered would pay a Tier 3 copay instead of the Tier 2 copay, but they could request an exception to pay the Tier 2 cost-share. This is not my favorite scenario because it still has the inequitable benefit where you have members taking the same drug and paying different amounts. You can see the results on Slide 23. The projected cost avoidance now is \$49,000 for 2019. Same number of members are impacted and there's slightly more cost avoidance projected in the following years.

Dave Iseminger: For today's meeting, we need to stop at 4:00 p.m. We will spend more time on pharmacy at a future meeting, but I want to make sure the Board is aware of the structure of the remaining slides as you reflect on these between now

and the next meeting. I was glad Tom asked the question that he did, "Is 2a really just about diabetes?" Our intent was to apply the principles of the Option 2 series from January to one drug class and show you drug by drug in the summary chart that follows.

I would like to end today looking at 35. We typically bring you a proposed resolution at one meeting and ask you to take action at the next meeting. We know this is a much longer journey, so we wanted to put forward some principles we were seeing and start to pressure test ideas that could be in a final resolution. This is not a resolution that we're going to ask you to take action on at the next meeting. We want to tee up principles that could be in a final resolution. If you have any initial thoughts, please share them now; but also seriously take and reflect upon the words that are on this page and be prepared to have a more thorough discussion at the next Board meeting.

Greg Devereux: The recommendation on page 34, both of the bullets say it affects Medicare members. The draft policy resolution on the next page I don't think differentiates between Medicare and non-Medicare?

Dave Iseminger: Correct, Greg. This was not a comprehensive resolution. There would need to be clarity in a final resolution as to the exact population impacted. The words "UMP Medicare only" don't appear on Slide 35. In fact, if the Board wants to take forward the recommendation on Slide 34 in a final resolution, we would clarify the population. You are recognizing a difference between the recommendation and the subcomponents. Slide 35 is not a comprehensive list of a final resolution.

Donna Sullivan: Greg, originally we were recommending Medicare only; but after further discussion, we felt it was the Board's decision. We wanted you to have further discussion around should this apply to both Medicare and non-Medicare. We just didn't take the Medicare out of here. It's unintentional, it's not supposed to be directing just to Medicare.

Greg Devereux: I understand that and I don't mean to be critical, but this is really important to our members. Really, really important. To have Medicare on one page be the recommendation, and then a draft policy on the next page not be clear, words really, really matter. I know it's examples, but it gets people pretty excited about what might happen.

Sue Birch: Greg, thank you for that. I think that's why staff are bringing this forward as preliminary. As Dave indicated, we're going to have more conversations about this. We're not taking any action today, but I hear you saying it already, there's some sensitivity about that and we'll work next time to make certain it's either more specific or consistent. We're not asking for action today.

Dave Iseminger: Or at the next meeting. Any final resolution will be as clear as clear can be; because in reality, although the recommendation is about Medicare, if the Board really doesn't want to split the formulary, then the words on Slide 35 can't split the formulary. It's making sure to set up the discussion that we have.

Sue Birch: To Greg's point, I think the request back to staff is let's either start getting much more explicit and clear, or if there is direction from the Board today, which I don't think there can be, because I think we are just getting educated. Being a nurse in this field for a long time, I really appreciate this deep dive, but we're going to need to hear this again and keep working the data and the information before we can come to a more informed decision.

Tim Barclay: My take is that the valued formulary represents a more appropriate and effective use of resources. If that's true, and I think it is, I really question why we wouldn't do it on the non-Medicare population as well. Why it would be good for one and not the other? As I read through this packet and this documentation, that was the head scratcher for me, why all of a sudden we pulled back and said let's only do this to Medicare.

Second question, I don't understand the intent and purpose of grandfathering. It sets us up, again, for people who are doing the same thing of paying different amounts. If the value formulary makes sense and is the right thing to do, I don't know why we would grandfather people to avoid it. I'd like to have that conversation.

Then the third thing is, I'm a little worried about our continued kick the can down the road on this conversation, because earlier we talked about plans that have to submit rates next week. We're going to be voting on rates in July and we're setting policies that impact rates, and we're dragging it out. I'm worried what this conversation does to our rate setting if we don't ramp up the acceleration on having the tough conversation and making some decisions.

Dave Iseminger: Tim, just to clarify, the rates that are coming in are on the fully insured plans. This formulary discussion is about the self-insured plans. Although there is an impact, there is a distinction in the pieces. A little bit.

Tim Barclay: I think in the negotiation process, in wrapping up rates though, the calculation of the index rate, what it does to member contributions, and how it all comes together is definitely impacted by this. It will cause us delays.

Dave Iseminger: Which is also why we'll need the Board to take action one way or the other in June so we can finalize the rate setting process in July to bring votes to the Board for rates at the end of July.

Tom MacRobert: When I went through these yesterday, the conversation I've had, there is one option that I couldn't quite figure out and that is option 2b+. There was the 2a, 2b, and 2c, which kind of matched the original 2a, 2b, and 2c, but it was just using the diabetes drug, right? Is it my understanding that 2b+ is like the original Option 4? One of the 1s was also kind of like Option 4. It's unclear exactly where this is.

Dave Iseminger: Tom, we will publish a crosswalk from January to June for Board Members and the public to help with the confusion created with the plus/minus/a/b/2/1 situation.

Donna Sullivan: For clarification, 2b+ includes the non-Medicare population and the Medicare population. The slides with the pluses, those are including the non-Medicare population.

Tom MacRobert: Okay. I did have one comment and that was to reinforce what Tim said. I believe, Tim, you said - in reading the notes from the July meetings last summer, you made the same comment about kick the can down the road but not addressing the underlying problem. I think we're kind of looking at that so I would hope when we get to these conversations in June and July, we begin to look at what can we do to make sure we don't have to keep coming back and making more and more restrictions as we go forward.

Carol Dotlich: I just want to express, again, as I have at the last meeting, my concern that the impacts of some of these decisions have greater weight on people who can least afford to deal with them. I would like this Board to keep in mind the situation that our Medicare population currently is dealing with and I don't want them singled out for special burdens.

Public Comment

Fred Yancey: I represent school retirees and school employees on health and pension issues. I have about six basic points that I made throughout the meeting. Going back to the start of the meeting, you talked about the deferral period. I don't know that this is the purview of this committee, but we have a number of members, and there was a bill this last session to do that, to reopen the period for those people that had second thoughts and missed the opportunity to enroll in PEBB. Why you only get that very narrow "I'm going to retire, I better apply tomorrow to belong to PEBB," I'm not sure the number of members who have said, "I wish we had a second chance to re-enroll."

The issue of risk pools. I brought this up before and thank you for the RCW citations. Why there continue to persist two separate risk pools. It adversely affects the rates for retirees and has, as was rightly pointed out, these are fixed income, lower income people.

The SEBB procurement thing. You asked this question. I thought you asked this, but it seems like they're asking for bids, these preliminary bids for risk pools solely for SEBB, and a risk pool solely for PEBB. I don't know if you're asking for a rate, if it's combined. I don't know if you can do that. I'm just unsure on that.

SmartHealth program. I'm not sure, I don't think Medicare supplement people can apply for that program, and yet we need to be SmartHealth oriented as well. So I'm not sure why we're excluded from getting an Amazon gift card. That's a joke. Excluded from the SmartHealth aspect.

The copay coupons, I believe, and correct me, but this point wasn't made, are income based. You can only use a copay coupon and prescription based on your income, is my understanding, the ones that I've looked at because I see these, when

I go to get a prescription filled, you know you get a card from this and you look at it and it goes, I think they're income based but I wouldn't -

Sue Birch: We can ask for clarification. It's my understanding they're not, but we can get clarification.

Fred Yancey: Then the last part, which is concerning prescription drugs. You talk about cost. What you're really talking about is the cost of paying a claim. I'm concerned about the cost of paying for the insurance. Where is the concern for the person that is buying the insurance themselves? If you can save \$2 in premiums, what is that worth when your rate, or out-of-pocket expense for prescription drugs goes up 50-60%? Retirees are concerned about the huge increase for them in Uniform this year, primarily driven by prescription costs. Yet, if you move to a more restrictive formulary, their out-of-pocket expenses, I believe, would far exceed the premium increase. I'm just not sure how you balance that. And along those lines, when you talk about, you know, one example you said the effect of the recommendation was there are 1,083 Medicare members, how many Medicare members are in Uniform? There is no baseline there. I don't know if that is 1% of the members or if that's 50% of the members, or whatever. It just had no baseline. You save a small amount of premium. You save \$2 in premium but you've placed a huge financial outlay on the backs of the users. So on the one hand you're concerned about premium and you're concerned about paying out claims, but I don't hear any concern about what people have to pay out of pocket. Thank you for your time.

Sue Birch: Fred, thank you for your comments. I see Dave taking copious notes and I'm sure the Board will work this onto their deliberations as we move forward through the process.

Irene Svette: Irene Svette, CHAMPVA recipient. First of all, I just want to thank the Board for your willingness to go forward treating CHAMPVA and TRICARE as equivalent programs, and I hope that they will remain linked in this way going forward under your approach. I want to thank Barbara for her willingness to work with me on the COBRA issue and the retirement. But in answer to what Tim said, the difference between January and a July effective date for me is about \$3,200 out of pocket, and that's because CHAMPVA has restrictions on what insurance plans I can take. If I take an HSA plan, they will no longer cover my out of pocket.

Sue Birch: The next meeting May 21, 2018, 1:30 p.m. to 4:00 p.m.

Myra Johnson: I wanted to say something before we close. Today was very informative. It's not as productive as being in person, as it is to be on the phone. I do have some other questions that I will definitely hold off until the next meeting, but again thank you again for this opportunity and I will be present at the next meeting, hopefully.

Sue Birch: Great. And Myra, if there's anything that Dave or his team can answer for you before that next meeting, please don't be bashful about getting those questions or making a call to either myself or Dave.

Preview of May 21, 2018 PEB Board Meeting

Dave Iseminger: I would extend that to anybody on the Board. In May we will continue talking about drugs in a couple of different contexts. We'll have more discussion from Donna and Ryan about the formulary options, with less confusing crosswalks between our options and more consistency in how we're describing the populations. It will be leading up towards proposed resolution for your consideration and ultimate action before the end of June.

We will also provide real time insight on drugs that are in the pipeline. There's a lot of advancements happening and there are cost implications for the plan. We'll make sure you're aware of those new or innovative drugs that are hitting the market soon and the impacts on the formulary.

Sue Birch: Meeting adjourned at 4:15 p.m.

Public Employees Benefits Board
Meeting Minutes

DRAFT

May 21, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:

Sue Birch
Harry Bossi
Greg Devereux
Tim Barclay
Carol Dotlich
Yvonne Tate
Tom MacRobert

Members via Phone:

Myra Johnson

PEB Board Counsel:

Katy Hatfield

Call to Order

Sue Birch, Chair, called the meeting to order at 1:33 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Meeting Overview

Lou McDermott, Deputy Director of the Health Care Authority, provided an overview of the agenda on Dave Iseminger's behalf. Dave is on vacation.

Sue Birch: At recent meetings, Dave has tried to follow up on questions from prior meetings. The pharmacy-related questions will be covered during today's presentation. Dave will bring back insights on the non-pharmacy questions at our next meeting. Today is all about pharmacy and drugs. We want to make sure there's time for Board Members to ask questions.

Medicare Retiree Premium Preview

Tanya Deuel, PEBB Finance Manager, Financial Services Division. Today's presentation is a preview on the preliminary development of the Medicare retiree rates for plan year 2019. One of the key reasons we're able to accelerate the

timeline slightly is that the Legislature established the Medicare explicit subsidy earlier than it has in previous years.

Last year's legislative session was a short session, which adjourned on time and gave us the value of the Medicare explicit subsidy. Next year is a long session and we don't anticipate that we can accelerate the timeline as quickly next year.

For the upcoming plan year 2019, we are anticipating relatively flat retiree premium contributions. One of the key reasons is that the Legislature increased the Medicare explicit subsidy from \$150 to \$168. There are also slightly improved pharmacy trends for plan year 2019. The Legislature has not changed the value of the Medicare explicit subsidy since 2012.

Slide 3 is a quick refresher of the relationship between the Medicare explicit subsidy and its impact on the Medicare retiree contributions. This is a visualization of the UMP Classic Medicare retiree premiums from plan year 2016 to plan year 2018. The bar on the far left is Plan Year 2016, next is Plan Year 2017, followed by Plan Year 2018, and the far right bar is titled Plan Year 2018 Scenario. This is titled "Scenario" because it's the exact total rate of the UMP Classic Medicare retiree rate for 2018, but modeled with both the \$150 Medicare explicit subsidy and the \$168 Medicare explicit subsidy.

The top blue part of the bar is the Medicare explicit subsidy. That is the state's contribution towards the Medicare retiree rates. As the total bar increases, the amount of blue has remained the same, meaning the amount on the orange part has increased. That portion is paid by the Medicare retiree. In the two bars on the right, if we look at the orange portion, as the blue section increased from \$150 to \$168, the amount in orange actually decreased.

Megan Atkinson: I want to emphasize the point of this presentation, and the reason we're coming to you with very preliminary numbers is because we are not yet finished with procurement. We're in the midst of going back and forth with conversations around rate development, but to Tanya's point, the rates are looking relatively flat. When you were having these conversations last year, they were not looking flat as you can see on this chart. The difference between 2017 and 2018 was a significant increase. We are not expecting that same trend to continue into the second year. The reason we are illustrating this bar chart with you using 2018 rates is not that we literally believe 2019 will numerically be exactly equal to 2018. We're trying to illustrate for you the difference, the significant impact of the legislative decision to go from \$150 to \$168 and how that impact, dollar for dollar, is playing out on the member premium.

The Legislature made the decision to go from \$150 to \$168. Those are year-by-year decisions by the Legislature. There is no guarantee the Legislature will stay at \$168 in 2020, 2021, etc., but that's what we have right now.

Sue Birch: I'd be remiss in not formally thanking the Legislature and staff. Thank you for bringing this information to us. We hope you can keep holding things flat or

moving in a different direction since we're all about making things as efficient as possible.

UMP Value Formulary Options

Ryan Pistorresi, Assistant Chief Pharmacy Officer, Health Care Authority. Today we'll be presenting on the UMP Value formulary. Previously, when presenting the value formulary, we've presented different scenarios and options. Today we're going to focus on the core values, principles of the value formulary, and how it can address two current issues facing UMP. We have a recommendation at the end prior to a draft policy resolution, but we will not be reviewing the scenarios in depth like we have at previous meetings.

Slide 3 – Formulary Models: First, we'll start with terms we'll be using throughout today's presentation. We'll go over different types of formularies. The first one is the open formulary in which all drugs are covered under a plan formulary. The non-preferred drugs are available at a higher member cost-share.

There is a closed formulary which has no coverage for the non-formulary drugs. This is a much stricter formulary. These drugs are often blocked for rebate purposes. If a Pharmacy Benefits Manager (PBM) has a preferred drug and they're getting a very good rebate on it, they will try to drive as much of their utilization to that drug in order to save them money. By blocking the competitor drugs, they're able to maximize the amount of utilization they have for those drugs.

A hybrid formulary is seen more in the commercial marketplace. This formulary has a select mix of drugs and classes identified as warranting an exclusion, either for clinical or financial reasons.

The value-based formulary, which we will be talking about today, emphasizes the clinical effectiveness of the drug, rather than just the cost. Non-preferred drugs are covered only when they are medically necessary and clinically appropriate after reviewing the individual clinical circumstances by looking at the members and determining how these drugs can be used for them.

Tom MacRobert: I have some questions just to make sure everybody understands clearly the terminology. When you refer to the formulary, you're talking about a list of preferred drugs. Is that correct?

Ryan Pistorresi: Yes. When I'm talking about a formulary, it's a list of preferred and non-preferred drugs.

Tom MacRobert: You also used the term non-formulary. I'm assuming when you do that you mean those are drugs not on the preferred drug list.

Ryan Pistorresi: Yes. When a drug is non-formulary, it is not covered by the plan. When talking about a formulary in general, we're talking about all the types of drugs that could be covered. Then when a drug is non-formulary, it is not covered by the

plan. When we're talking about a formulary, the terms could be preferred, non-preferred, and non-formulary.

Tom MacRobert: Okay. You also have Tier 1, Tier 2, and Tier 3 drugs. Those are all typically on the preferred drug list but at a different cost basis?

Ryan Pistoresi: Yes, that is correct. The Tier 1, Tier 2, and Tier 3 drugs are all on the preferred drug list.

Tom MacRobert: Okay, thank you.

Ryan Pistoresi: Slide 4 – Other Terms: Grandfathering means a member would continue to receive the same benefit for a drug even after the new policies are effective. I want to emphasize that as we talk about some of the options later today, we do want to make it clear that we can grandfather members who join UMP after the January 1, 2019 date if they meet the qualifications. If they joined UMP at the start of the plan year and met the criteria, they could be grandfathered. That is a possibility.

Multi-source Brand (MSB) means the originator drug that originally held the patent, but the patent expired, and now there are generic equivalents. This is opposite of a single-source brand drug, which is an originator drug that still holds the patent and does not have any generic competition.

Copay coupons is a remuneration to patients for specific brand name drugs applied after the drug has been built in the health plan and used in place of the member cost-share. What these programs do is take away the member's incentive to choose an equally effective lower cost alternative by offering copay coupons and patient assistant programs. To follow up to Tim's question from the last presentation about grandfathering, what grandfathering can do is allow patients who are stable on their medications to continue on it without going through an administrative process. This helps reduce the amount of administrative costs while not interrupting patient care. Did that adequately address your question?

Carol Dotlich: My question is about grandfathering. If I'm new to the plan in 2019, how do I know I am grandfathered or not? In other words, since I haven't been in the program before, you wouldn't necessarily know what drugs I've been on over time, right? What is the process for becoming a grandfathered person in 2019 if you haven't been in the plan before?

Ryan Pistoresi: We'll go into some of the scenarios of grandfathering later on, but what I can tell you is there is a process for your provider to submit a request and provide documentation that you have been using a drug and you've been stable on it. If those meet the criteria for grandfathering a patient on their specific drug, then that would qualify for them. Just like if you were a UMP patient and we had that information previously.

Carol Dotlich: How would I find out that I could have that drug? Would I go to the pharmacy and be told, "No, you can't have that drug. You have to get a statement

from your doctor and send it to your insurance." Or is there some advanced way of providing documentation or whatever before the plan takes effect? I'm looking for a process.

Ryan Pistorosi: We haven't necessarily looked at a communication process yet, but I do think that would be a good idea to be proactive and to let members know that if we are going to be changing to the value formulary to provide them with the information so we don't interrupt their care. That way they can continue on the medications even with this transition in 2019.

Donna Sullivan: This is Donna Sullivan, Chief Pharmacy Officer with the Health Care Authority. We do notify members at least 30 days in advance if their medication is going to change tiers. Any member affected by the value formulary would be notified well in advance at the end of 2018. We would also make sure to include in the open enrollment materials that we pass out at the benefit fairs information about the formulary and the value formulary, what we're doing and why we're doing it. We would make sure that all members are well aware of what the changes are and what they need to do to if they are impacted by the value formulary.

Harry Bossi: Ryan, regarding grandfathering. Carol was suggesting or referring to, wouldn't it be the same process as showing medical necessity? Why would we need to use the term grandfathering? It would just be medical necessity like it would be someone who had been in the plan for years who was prescribed a new drug that wasn't part of the plan.

Ryan Pistorosi: Yes, the grandfathering is similar to determining medical necessity for that drug, but throughout the presentation we'll be using this grandfathering term for those types of situations.

Greg Devereux: I actually see a distinction between those two. I thought what Carol was trying to get at is if given the 30-day notification, I'm told that my drug may change, I then go to my physician and say, "Can you write me a note?" I don't know whether the Health Care Authority has a form or whatever. Then, you bring that to the pharmacy and they're allowed to honor it. I think that's different. Medical necessity to me means you might have to try several different things and then prove that the specific drug is the one you need. That's different than just simply saying, "I need to continue on this specific drug." To me it's a distinction.

Ryan Pistorosi: Let me see if I can clarify your point. The medical necessity is determining whether the drug is appropriate to use, whereas the grandfathering is to continue a patient on that drug. So, yes, grandfathering is more about someone who is established on a drug or a drug regimen, can demonstrate they are on it for a medically necessary reason, and that it is clinically appropriate. Whereas the medical necessity is you have a specific diagnosis for that drug and can you take that drug for that reason. Is that your point?

Donna Sullivan: I think you have it almost right but not quite. Greg, yes, to your point, grandfathering means that the person who's already established on that drug

gets to continue on that drug and they don't have to justify medical necessity. We verify that you've been on it and you can continue. Where medical necessity comes in would be if you're on the drug, it's not being grandfathered, and you're being asked to quit. If you're unable to switch, you would have to demonstrate medical necessity to remain on the drug.

Greg Devereux: That was the distinction I was trying to draw.

Tim Barclay: If we were to not grandfather, getting back to Greg's point, would we require the person to actually use alternative drugs and prove they don't work in order to get back to where they were? Or would a simple conversation and a form submitted by their physician to say, "No, we absolutely don't want this person to try any alternatives. We need to stick with this." Is that sufficient? If we don't grandfather, are we going to make people try alternatives or is there a way around that?

Ryan Pistorresi: If we do not grandfather members on their drugs, they will either need to switch to alternative drugs, or if they have tried those alternative drugs in the past, or there are contraindications, say, drug-drug interactions, or other issues with those drugs, the provider would need to send a form requesting that they do not need to go through that process.

Tim Barclay: Just to clarify then, so let's suppose I'm a person who is taking a drug since its inception. There were no alternatives. I've been on this drug for many years. It's working. I don't know if the alternatives work or not. We pass a policy that does not include grandfathering. Just to be real clear, do I or don't I have to try the alternatives or can my physician allow me to stay on the current drug without having to go experiment with the alternatives first?

Ryan Pistorresi: In that situation your provider could submit a request and say, "My patient has not taken the alternatives but for these reasons needs to continue on this drug." Then, after a review of the clinical circumstances, they may either approve it and allow you to then continue, or not approve it and require you to take the alternatives.

Lou McDermott: Tim, basically, if there's no other medical reason, you just haven't tried anything else, and you've always been on it, then you would have to switch drugs. You would have to try the other drugs.

Tim Barclay: I'll just lay my point out now. I don't necessarily want to debate it now. I want you to be able to go through your presentation, but I guess that's my concern with grandfathering is my assumption is we have many, many people who started taking a drug when it was the only option. Now we have generic equivalents, which in theory could work just fine for a given patient, but they just don't ever change. It kind of defeats the purpose a little bit in my mind if we just blanket grandfather everyone and say, "Keep doing what you're doing." It seems like we haven't done a whole lot. That's my concern with it. Given that there's a way around it without a person who truly needs to be on that drug to have to switch and suffer the

consequences of an alternative if their physician can come in and say, "Yeah, this is what they have to have." For me, I'm not, at this point, not convinced that grandfathering is the right thing to do. I just wanted to throw that out there.

Ryan Pistorosi: Tim, when we get into our draft policy resolution we do have a slight nuance between the multi-source brand drugs that do have generic equivalents versus the single-source brand drugs that do not have generic equivalents. When we get to that, I'll see if that addresses your concern. If not, then we can discuss further.

Tim Barclay: Thank you.

Ryan Pistorosi: We have a follow up question about the copay coupons. The question is, "Are the copay coupons income-based?" After doing some research, I found that, no, the copay coupons are available to anyone with commercial insurance. They are not based on income. Patients who have federal insurance or who do not have any insurance do not qualify for the copay coupon cards. Patients with federal assistance are not allowed to use these because they count as kickbacks under the Federal Anti-Kickback Statute.

Slide 5 – Our Journey. We'll begin with why we're discussing the value formulary today. In 2012, we changed our mail order pharmacy cost-sharing from a flat copay to a percentage co-insurance. This was done to align the mail order pharmacy with the retail benefit. Soon after, we identified a member equity issue. We were getting reports from members who were unable to afford their medications and unable to change to preferred or generic drugs. These members were using non-preferred drugs through the mail order pharmacy and had a medically necessary reason to use these drugs because the preferred drugs or the generic drugs were not appropriate for them. We began studying different ways to address this member equity issue. In 2015, we allowed a tier exception process in which members using Tier 3 drugs could submit a request to change their cost-share to a Tier 2 cost-share. What this process did is provide relief to some members who were granted the exception, but then this led to another issue in which different members were paying different amounts for the same drug. This process required the members to know about this policy in order to get this specific UMP benefit.

So let's take a look at a case to help explain this in more detail. We have two UMP members, Lou and Dave, who are both using Victoza to manage their diabetes. Both members have tried all the preferred medications in this class and they are either ineffective or non-clinically appropriate. Both are currently paying 50% for this medication, which is about \$370 per month. Lou, knows about the Tier 3 exception process and his provider submits a request. Because Lou meets the criteria and is approved, Lou will now pay the Tier 2 cost-share for his Tier 3 medication, which is \$75 per month.

Dave, however, also meets the criteria for this Tier 3 exception process but does not know about it and is not able to request it. Now we have two UMP members using the same drug and who both meet the criteria for this policy, but one is paying \$75

per month and the other is paying \$370 per month. This is the equity issue explained.

Harry Bossi: Is there not a maximum out-of-pocket for the plan year for the member on the drugs?

Ryan Pistoresi: Yes, so there is a maximum out-of-pocket cost for the members. For the Classic population it's \$2,000 per year. But the main takeaway from this slide is that there is a difference between the UMP members and what they're paying for that same medication.

Slide 7 – Other Ways to Address Equity Issues. This slide shows other options we considered back in 2013 and 2014 to address this issue. One option was to implement a closed formulary, which would make all the currently non-preferred drugs become non-formulary drugs and cover them only when medically necessary. This would require all members currently using Tier 3 drugs to request an exception similar to the Tier 3 exception process I just mentioned. When reviewing this option, we did see that it would address the equity issue but it would increase the administrative costs of the plan as well as plan costs and could potentially increase member premiums.

Another option we looked at is to place a claim maximum on Tier 3 drugs similar to how we have a maximum on Tier 3 specialty drugs. This was done because many specialty drugs cost thousands of dollars per month, even tens of thousands of dollars per month. If we had a 50% cost-share for the members, they would be spending \$2,000 out of pocket at the first month every year.

The last option considered was to implement a value formulary, where we would identify drug classes that demonstrate value, and non-preferred drugs would only be covered when medically necessary and clinically appropriate. This directs members to the most cost effective drugs in these classes. It still allows the members with individual circumstances that need to use non-preferred drugs to do that. In addition to the equity issue we discussed, we're also looking at addressing member premiums, especially for our Medicare population.

Slide 8 – Implemented Strategies. The value formulary may help with member premiums. In the January meeting when we presented on the value formulary, one of the Board Members requested information about other strategies that we were looking at besides changing the formulary that could help address our drug trend. In 2016, the Health Care Authority convened the Washington Prescription Drug Price and Purchasing Summit Series, in which we gathered several key stakeholders from around the region to talk about different strategies to address drug price and drug utilization. We identified several long-term strategies. Some of the strategies currently implemented by the Northwest Prescription Drug Consortium are on this slide, including demanding more transparency from pharmacy benefit managers (PBMs), including a 100% return of rebates. That way, if a drug manufacturer has rebates on a drug, that entire rebate amount is passed on to the plan. Another strategy is tighter performance guarantees, insuring that the PBM is at a market

competitive rate for purchasing of medications. Requiring pass-through pricing prevents the PBM from keeping the spread from what we pay the PBM to what the PBM pays the pharmacy and allowing us to see that what we are paying the PBM is going directly to the pharmacy and that they're not keeping any of the margin in between. Also, we require third party market checks of the local retail pharmacy market rates, which would allow us to see where we are in comparison to other plans.

Carol Dotlich: I have a question back on the first slide, Slide 7. When you talked about the per claim maximum on Tier 3 drugs, I need more information about that.

Ryan Pistoresi: A per claim maximum on Tier 3 drugs would be similar to what we have for Tier 1 and Tier 2 drugs where we have a percentage coinsurance up to a dollar threshold. For Tier 1 drugs, members will pay a 10% cost-share but no more than \$25 per drug. If a drug costs \$300 per month, that 10% cost-share would be \$30 but because we have a maximum on it of \$25, the member would pay \$25. However, if it's below that threshold, if the drug costs \$1 a month, the member would pay ten cents.

Carol Dotlich: Can you apply that to the Tier 3 drugs?

Ryan Pistoresi: Yes, we could. That is an option we considered in 2013 and 2014 to address this.

Carol Dotlich: What were the dollar figures looking like?

Ryan Pistoresi: Unfortunately, I was not at HCA at this time and I don't have that.

Donna Sullivan: We were looking at \$150 and \$225 per month for the maximum out-of-pocket towards that month, for that prescription.

Carol Dotlich: Thank you.

Sue Birch: Ryan, on the independent third party market checks of local retail pharmacy market rates, what did the audits show? What did they tell?

Ryan Pistoresi: Burchfield did perform an audit within the last year, assessing our rates, but I don't have the exact numbers for you today.

Donna Sullivan: I can answer that question. What Burchfield does is they compare what we're reimbursing pharmacies to what other large employers are reimbursing pharmacies in the same region. I think it's a market difference of a half a percentage point between what we're paying and what the average market is bearing. Our reimbursement rates will automatically adjust to those center rates. This time we did have a rate adjustment. It's automatic and happens behind the scenes for the plan.

Sue Birch: Was it a nominal savings to us, Donna?

Donna Sullivan: Yes, it was. I don't have that number. It was a million or more dollars.

Ryan Pistoresi: Slide 9 – Current Board Options for 2019. These are options available to the Board that could address pharmacy spends for 2019. The first option is making no changes. It would be unchanged from the current projections. What Tanya and Megan had presented, it would continue to be what we're developing. This would also not address the member equity issue.

Another option would change the member cost-share. It would be changing the deductible, the coinsurance, or the maximum out-of-pocket, which would reduce the amount the plan spends. This would likely shift the cost over to the UMP members. This option does not address the equity issue but may be an option to address the rising specialty drug trend.

The last option, one of the core values of the value formulary, is to guide member utilization. It would direct members to higher value, lower costs, therapeutic alternatives in drug classes, but allow the use of non-preferred drugs when medically necessary and clinically appropriate. Guiding member utilization has been an effective strategy for reducing drug trend. For example, Express Scripts, a national PBM, shows different formulary management strategies can have a different result on drug trend.

Slide 10 shows the drug trend for three different management styles for different plans. Plan design and management can have a good impact on a drug trend. The value formulary would direct members to the highest value drugs and could help reduce the drug trends for UMP.

Slide 11 – Information on Value Formulary Model. Now that we've discussed some of the current issues regarding the equity issue for members and the drug trend, we can move into the value formulary which will help show how it can address these issues. The value formulary was developed from our pharmacy third party administrator, Moda Health. They took our drug claims data and allowed us to create different scenarios where we could examine what happens when non-covered drugs are covered only when the preferred drugs are not medically necessary or clinically appropriate. What happens when we grandfather members or don't grandfather members? What happens when we change or adjust the amount of appeals requested or the approval rate for those appeals? This is using our own UMP claims data from 2016 to 2017. It projects what we would see for the member impact cost avoidance and the administrative costs from the plan years of 2019 to 2022. As some of the Board Members noticed in our April presentation, there were some differences between the January model and the April model.

Slide 12 shows what changed between January and April. The main difference is that we updated claims data. In the January presentation, we were using claims data from June 2016 to May 2017. When we had Moda work on the model, they were able to update it to calendar year 2017. This changes the shift of the utilization for the drugs. Members previously on a preferred Tier 2 drug in the old claims data may

have shifted to a new generic in the new claims data, which would reduce the amount they're spending on a drug because they shifted from a brand to a generic. This is the one factor that influenced the updated model.

We also had Moda update a few other areas, including the drug trend for the Medicare and non-Medicare populations. We increased a number of exception requests and appeals we may receive. We also updated our drug substitution assumptions to better reflect clinically appropriate alternatives and what we currently see as the market share for these drugs.

To Tom's question from the last meeting, there is a crosswalk from the January to the April presentation on Slide 19, and in the Appendix. The different scenarios are also included in the Appendix.

Slide 13 is more updated information about what the value formulary may do in terms of member premiums. For the Medicare population, in order to reduce the trend by 1%, the plan would need to save about \$1.7 million in claims. This would reduce the projected member premium by about \$2.50 per month. If you had a target to reduce the premium by \$5 with this value formulary, we would need to aim for about \$3.4 million of claims savings for Medicare. For non-Medicare, it's slightly different. To reduce the trend by 1%, the plan would need to save about \$2.0 million in claims. This would reduce the premium by about \$1 per month for the Classic population. Also included on the slide is information for 2020 targets. We don't have a way to identify what that would do for member premiums, only on what we would see for drug trend. In addition to addressing the drug trend, the value formulary also addresses the member equity issue that we've discussed.

Slide 14 goes back to the example we had earlier with Lou and Dave, but this time it applies to the equity issue. If the diabetes drug class is part of the UMP value formulary, members on Victoza could be grandfathered in. Members don't need to know about this Tier 3 exception process because it would be applied to all members using this medication who had been stable on it. Now, both Lou and Dave are paying the same amount for the same medication, which would be \$75 per month.

Slide 15 are some of the principles we are looking to focus on with the value formulary. First, focus on the drug classes that can achieve cost savings without reducing the quality of care to our members. We want to make a difference to the premiums without sacrificing care. We want to be able to grandfather members who have used these medications for a long time or who are in refill protected classes.

Sue Birch: Could you explain what a refill protected drug class is? We didn't study that terminology.

Ryan Pistoiresi: Yes, I apologize for bringing up a new term without previously defining it. A refill-protected class is a class of medications with narrow therapeutic indexes, which means they have a narrow window in order to treat a patient without becoming either subtherapeutic or too toxic for the member. These drug classes are

things like HIV, antipsychotics, immunotherapies, Hepatitis C treatments, antidepressants, and a few other classes.

Slide 16 lists things to consider with the value formulary. It shows different options, impact to members, the number of members who may be impacted, impact to costs, and the overall impact through the value formulary to the plan.

The top row looks at the multi-source brand drugs, which would have more of a minimal impact to members because there are generic alternatives available, but it would affect the lower number of members and have a low impact to cost. So a low disruption, also the lowest savings.

The bottom row is all drug classes, which would have the highest impact to members and impact the most amount of UMP members. Upon our review, we determined this would have a medium impact to cost. Not the highest impact to costs but this would have the highest member disruption.

The middle row is the menu of options that the Board Members talked about at the January meeting. Being able to customize the value formulary, pick and choose which drug classes, and to tailor the value formulary to have the highest amount of savings with the lowest member impact. This could have a medium amount of impact to members. Being able to tailor the value formulary and choose the individual drug classes could be a low to medium impact for the members and a low to medium impact for the cost. Allowing this would then increase the value that the value formulary has for the plan.

Slide 17 explains the options a little more. One of the options for a value formulary could be with the different drug classes. Drug classes could be diabetes, cholesterol, beta blockers, androgens, etc. Being able to pick and choose the different drug classes would allow us to help resolve the equity issue in those drug classes, but also acknowledge that for the other drug classes not part of the value formulary, the issue would remain. Grandfathering could allow members in these classes to continue on their current medications. Members new to UMP in 2019 or beyond could be directed to preferred drugs. Or if they had been stable on these non-preferred drugs and could demonstrate that they are medically necessary, they would be eligible to be grandfathered.

Carol Dotlich: It sounded like either/or when you were talking about grandfathering. You sounded like it had to be medically necessary. It wasn't just like you were stable for a long time.

Ryan Pistoresi: One of the things we'll talk about with the policy resolution later is that grandfathering can be applied for the members who are stable and have been on these drugs for a number of years, or could be for the members who have to demonstrate they're medically necessary and the alternatives don't work for them. We could look at that when we get to the policy resolution.

Value formulary for just the multi-source brand drugs would apply to drugs in all the multi-source brand drugs in all the drug classes. In this situation, they would only be covered when medically necessary and clinically appropriate. This would resolve the equity issue around the multi-source brand drugs but still remain for members using single-source drugs.

Slide 18 are grandfathering examples. Scott is a long time UMP member using an antipsychotic Abilify for bipolar disorder. Since the antipsychotics are a refill protected class, Scott would be grandfathered and pay the \$75 per month for the prescription. We have another member, Lou, who joined UMP in July 2019. Under this grandfathering scenario, Lou was diagnosed with bipolar years ago and was been stable on Abilify for five years. In this situation, Lou's provider could request Abilify and Lou would then pay the \$75 per month on the prescription, allowing him to be grandfathered in, even though he joined in July 2019. The last example is Dave, new to UMP in July 2019 and recently diagnosed with bipolar disorder. Dave will be directed to the preferred antipsychotics first. If these medications are not effective, Dave could be allowed to try the non-preferred antipsychotics. This is an example of what it would look like under some of the different grandfathering scenarios, not necessarily that antipsychotics would be a part of the value formulary.

Slide 19 is our recommendation and crosswalk help. The recommendation to the Board is to look at Option 2a which was presented at the January 2018 PEB Board Retreat with one modification. That would be to apply the value formulary to all UMP members instead of only the Medicare UMP members. At the April 2018 meeting, Option 2a provided an example of what it would look like for an individual drug class while applying the principles described for Option 2a in the January 2018 meeting. This was to help the Board understand the granular aspects of this option, what it would look like at an individual drug class level. In April, Option 2a did not address the multi-source brand drugs like we did in the January meeting, but those were addressed in our Options 1a and 1a+, which were presented in April. Some of those options from the April meeting are included in the Appendix.

Slide 20 – Draft Policy Resolution PEBB 2018-xx. Proposal for Value Formulary. Beginning January 1, 2019, all UMP plans require the use of a value based formulary with:

- a select mix of drugs within a drug class that are covered only when medically necessary and all preferred products have been ineffective or are not clinically appropriate, and
- multi-source brand drugs being covered only when medically necessary and clinically appropriate, and
- members how have been taking a non-preferred drug at the same dose for at least one year being grandfathered with the same cost-share tier as other similar preferred drugs in that class, and
- the grandfather period for brand name drugs ends when a generic or equivalent or interchangeable biologic becomes available, unless the grandfathered multi-source brand name drug is medically necessary and clinically appropriate.

The first bullet is a core concept of the value formulary and addresses the member equity issue.

The second bullet means that members who have been using the multi-source brand drugs that have generic equivalents will have the same ingredient at the same strength and same dosage form available to them.

The third bullet would apply to members taking the non-preferred single-source brand drugs. If a member was using a non-preferred multi-source brand drug, the second clause would apply to them.

The last bullet means the members were grandfathered on a specific ingredient, not a specific brand name drug. The member will always have that ingredient available to them at that same strength and same dosage form, but they may have to switch from the brand manufacturer to the generic manufacturer, similar to the current UMP pharmacy benefit when a single-source brand becomes a multi-source brand.

Tom MacRobert: When we met in January, your last slide specifically said that we would like to examine 2a, 2b, and 2c in more depth. Between that meeting and now, basically 2b and 2c were eliminated and only 2a is the focus. I'm curious as to how that decision came to be, to only focus on 2a.

Ryan Pistoresi: We're focusing more on 2a rather than 2b and 2c due to the member equity issue, allowing members to be grandfathered on these drugs when they are stable, and to reduce the amount we may see in terms of administrative costs. Examining 2b in detail, we realized that some of the assumptions in the value formulary may not have been accurate. If you look in your Appendix, Slide 37, this scenario shows the overall plan cost depending on the number of requests members could submit. Option 2b would be a scenario in which the members would be grandfathered at Tier 3, so the members would not see a change in their cost-share but could still go through the tier exception process. Again, this one does not address the equity issue. Depending on the number of requests members submit, and depending on the amount of approvals, the plan could potentially see \$133,000 in terms of savings if no one submitted a request to actually increasing the plan cost to \$139,000 if every one of those members submitted a request. Depending on how many members submitted a request in the B scenarios, it would increase the plan costs. That's one of the things we learned between the January and April meetings.

Harry Bossi: Can you give us a sense for what percent of overrides or medical necessities have been approved in the last few years. Do you have that information? Not necessarily how many but on average. 50%? 70%? 90%? Just a sense for how likely, in the past, overrides have been granted, if "override" is the correct term.

Ryan Pistoresi: I don't have an exact number available to you today, but from my review of our Tier 3 exception process, it looks like about a third of them are approved for the members who request them. I don't see any differences between different drug classes. The diabetes drug class is about 33% and other classes are similar.

Tim Barclay: If we can look at Slide 42 of the Appendix, I want to make sure I'm reading this correctly. I believe what you're recommending is the first scenario under each of the drug classes, the grandfather with the Tier 2.

Ryan Pistorresi: Yes. If Option 2a was pursued, it would be the top row of each of the different therapeutic classes.

Tim Barclay: So we headed down this path before with the primary goal of savings. We wanted to do it in a responsible way that wouldn't negatively impact people and their care. Yet, I look at this page and three of the four drug classes actually increase costs with the recommended solution. I'm reading this correctly, right?

Ryan Pistorresi: Yes. For the April meeting we prepared 12 different drug classes; but as you'll note from one of the earlier slides, I did not mention some of the classes, so the ophthalmologic drugs, the dermatologic drugs, those ones may not necessarily be recommended for the value formulary because they do increase the plan cost. One of the principles we're looking at with the value formulary is selecting drug classes that can demonstrate drug savings.

Tim Barclay: I think, furthermore, what this exhibit shows is the cost of the grandfathering clause. If you take the first drug class there, it's a difference in 2019 of costing \$225,000 versus saving \$410,000 by throwing on the broad grandfather clause. If I understand correctly, the purpose of grandfathering, if I'm hearing the presentation correctly, is the equity issue. That's what's driving this grandfather decision, which, again, is curious to me because we created the inequity by trying to do the right thing by allowing people a process by which they could avoid the higher cost-share in a situation where they have no choice but to take the more expensive drug. Now, because we've done a less than adequate job of communicating that to our population to use that exception, we're going to lower the cost for everybody to make it fair. That seems like a curious route that we got to a place where we're now allowing the cost-share on all Tier 3 drugs down to a Tier 2 level.

I guess my question would be, are there better ways to address the equity issue other than cutting cost-share? For example, it seems like we have the ability to analyze data because one of the requirements is that people have tried all these other drugs first. Is there a way to use data to look and see if people are eligible for the exception and notifying them? Can we do a better job of communicating somehow to address the equity issue rather than increasing plan costs in a fairly dramatic way? For me, I'm struggling because we're getting a convergence here of multiple ideas; the value based formulary, the equity issue. These things are all coming together and I feel like we're twisting things up and not necessarily getting to the best place.

Donna Sullivan: I want to address Slide 42. You can look at it by saying Tier 2 would be worst-case scenario. Tier 1 is grandfathering, Tier 2 is the worst-case scenario. No grandfathering at Tier 2 is potentially the best-case scenario. We have to be very cautious when you look at these slides in the model because this model is very sensitive to the number of patients that request an exception. I believe the

savings in the third column, there's a huge potential that this could be overstating the savings, dependent on how accurate we were in requests for estimating the number of patients that would request an exception and it be granted. I understand your plight but it's something that is very difficult to estimate and it differs from drug class to drug class. We have seen certain drug classes where patients will switch their medications and others won't. This model is not set up to go in and individually account for that inelasticity.

The other thing is there are often times where there's a clinical reason to grandfather the patient. I don't want to lose sight of that by saying we're not going to grandfather anybody because if there is someone on an anticonvulsant or antidepressant and they have been on it and doing well, there's a clinical reason why we don't want to ask them to switch their medication and essentially stop their care. There are many different aspects and nuances to grandfathering, when it's a good time to do it and when it's not a good. There are also times when drugs are not preferred but they have a similar cost to the preferred drug. Grandfathering those patients actually increases costs because we are now paying a bigger portion of that drug. There are other times where not grandfathering the number of patients that would request an exception would outweigh the savings we would get by not grandfathering. It's a difficult thing to establish.

Tim Barclay: I appreciate that, Donna. Let me ask you another question because you said something that concerns me. I thought we chose these classes and we're talking about a process of a value based formulary and categorizing drugs in such a way that we really believed that equivalent therapeutic sources were available. You just made the comment that you rattled off several different classes where you'd be very concerned about asking people to switch categories because it could disrupt their care. I would have assumed that those categories you just named weren't even part of this conversation as being part of the value based formulary where we try to push people into an alternative source. I thought that's where we started in this value based formulary conversation - specifically choosing drugs and drug classes where reasonable therapeutic alternatives were readily available.

Donna Sullivan: That is an option. I think what we didn't make clear is that grandfathering can be drug class specific. We don't have to say everybody's grandfathered or nobody's grandfathered. We can make a decision based on each drug class and do that in order to tailor our savings. I wouldn't say let's not put the antipsychotic on the value formulary because we're concerned about people having to switch medications. We will grandfather them, but we have an array of medications, many of them generic. If the provider doesn't know which drug is going to work first, why not start with the least expensive drug and work towards the other medications. Start with the generic drug. If that's not working then switch to the next preferred drug and so on, instead of just going right to the non-preferred drug, which may not work anyway. It's how we're guiding the prescribing utilization.

Sue Birch: Donna, is it fair to say that antidepressants, the psychotherapeutics, and the Parkinson drugs are the three most sensitive? Those three classes?

Donna Sullivan: I would say that antipsychotics and antidepressants. There is not a wide range of drugs for Parkinson's Disease. Most have brands that are also generic. I think almost all have generic. There wouldn't be much switching in that particular class.

Tom MacRobert: It seems a lot of this is being driven by this equity issue. Do we have any idea how many people are affected by this?

Ryan Pistorresi: I don't think we have a good idea of the actual number of members who could be eligible for this Tier 3 exception process. We can look and see how many of our members are using Tier 3 drugs who have used the preferred products before compared to the number of members who have not stepped through the preferred products and have stepped to Tier 3 drugs.

Carol Dotlich: My question is about page 42. Are these actual numbers of people affected by these particular conditions or drugs or just an example?

Ryan Pistorresi: These numbers are based on what we have in our model and the number of members are the UMP Medicare only at this point. I did not have the non-Medicare numbers ready for this table. The costs are also Medicare only. The number of members listed are currently utilizing the non-preferred drugs that would be part of the value formulary.

Carol Dotlich: So these numbers are all for non-preferred? And these are all real people?

Ryan Pistorresi: Yes.

Tim Barclay: Just one more minor issue, I think on the draft proposal. On your first bullet point, just a wording thing. You say they'd be covered when medically necessary and all preferred products have been ineffective. Do we really want to put the word "all" in there? I mean it could be of a drug class where there are many, many preferred products and do they really have to try them all before they can move on? You don't have to answer it now. Just a concern about the wording there that, is that what we really mean?

Donna Sullivan: Sorry to interrupt, Ryan, but going back to my point, if you don't have a good reason of why that non-preferred drug is going to work, why wouldn't you try all of the preferred products first? I think it depends on if there a clinical reason where the doctor, instead of having to try all the preferred products, submits a request and says, "Based on these clinical parameters of my patient and this drug, I think this drug's going to work and these others are not." If they don't have that clinical reasoning, I don't see a reason not to try all of the preferred products. Sometimes it's just one or two anyway.

Yvonne Tate: I can give you an example of that. In my particular situation, my nemesis are these doggone statin drugs for cholesterol. I've probably been through four of them and they all give me the same problem: muscle cramps and things like

that. I'm finally on my fifth one that isn't giving me that problem, but I had to go through a bunch of them before I could find one that works. I don't think that's an unusual thing to ask.

Tom MacRobert: On the second page of the policy draft, at the bottom it says "medically necessary and clinically appropriate." It seems to me in a lot of the discussions we've had in different scenarios, at a certain point, there's this appeal process that comes into effect. I'm curious to know who gets to make the decision. The patient and the doctor work together to make a determination as to which drug is most effective and then they write an appeal. Who does that appeal go to and who makes the decision? Is it a doctor? Is it a group of doctors? How is that decision made?

Ryan Pistorresi: Appeals are submitted to Moda Health, our pharmacy third party administrator. They have clinicians review. It is often sent to a pharmacist who then does the review of the patient charts and submitted documentation. They do a review of the medical literature to see what evidence there is to back up this decision, makes a decision, and informs the member.

Tom MacRobert: Was that the one third get approved that you were referring to? Is that about the percentage? So two thirds are not approved and one third are approved?

Ryan Pistorresi: Yes. For the tier exception process, it goes to a pharmacist. From my recollection, about one third of the Tier 3 exceptions are approved about two thirds are not.

Harry Bossi: I asked a similar question last meeting or the one before. My recall was I was told it was a physician that made the determination not a pharmacist. Could we get a clarification on that?

Donna Sullivan: I probably made that answer. I might have misspoken. I'll clarify. I believe it's either a physician or his delegate, which might be a pharmacist. We'll clarify that and bring it back to you.

Carol Dotlich: I just want to be very clear. It's my understanding that under this draft proposal, people who have been taking a drug for a year are grandfathered in on that drug and don't have a higher cost-share.

Ryan Pistorresi: Yes. As the draft proposal is currently written, the members who had been using the drugs under clause three, would be grandfathered at the same cost-share tier as other similar preferred drugs in that class. To that point, if a member is currently using a multi-source brand drug, they would not be grandfathered unless they had tried the generic equivalent and it was ineffective for them, which is to the second clause for the multi-source brand. Or you could look at the fourth clause, which says the grandfather period for brand name drugs ends when a generic equivalent or interchangeable biologic becomes available.

Carol Dotlich: My concern with the older population is change is hard for them and compliance is an issue. If you have someone who's stable on a drug for a long period of time, I would prefer to see them grandfathered no matter what the drug is because if they're out of compliance with their treatment plan, it's a serious issue very quickly for them.

Ryan Pistoresi: Under our proposal, we would always allow that same ingredient to be available to the patient. If the patient was taking a brand name drug, the generic, the same copy of that medication, the only difference being the manufacturer, that same ingredient will always be available to that patient.

Donna Sullivan: I just wanted to let you know, currently our benefit design is when drugs, those off patent and a generic becomes available, it gets moved to Tier 3. We also have mandatory generic substitution rules in our state. Pharmacists are automatically starting to switch to each of these generics once they come out onto the market. That's been going on for decades. The multi-source brand issue is not something new. It's our current policy and we're just saying now that we're not going to cover them as opposed to allowing them to be covered under Tier 3 if the patient chooses to pay the 50%.

Carol Dotlich: I guess I would say to you that for some people, additives, what is mixed in the pill is an issue. It's not just the basic drug but there are other considerations. I'm wondering why if the patient doesn't object to the change, if the patient is given a choice, I think most of the time the patient would choose the less expensive option. I think people should have a choice. In other words, if somebody's been on Abilify, for example, for a long time for a serious condition, I don't think they should be made to change based on somebody's idea that something else will work the same. I think that patient should have a choice in that, a voice in that. I guess what I'm saying to you is, I prefer that people that have been on a drug for a long time be grandfathered. If they're offered options to use a generic and they choose to do that, I think that's great. I think a lot of people would do that. I think there are people, however, who will not do that and will be out of compliance with their treatment as a result of a change like that.

Lou McDermott: Donna, can I throw in two cents? I haven't been a part of all these discussions. Obviously, you've been working with Dave and Sue and going through this process. But one of the things, when I was PEB Director that we were taking into consideration was, to your point about choice and members having that ability. The more choice you have is usually associated with cost. What some of our members are experiencing is because of that choice, because of that open formulary, their costs are going up in terms of premium. The older generation who usually are the retired population, they're the ones who are feeling the pharmaceutical impacts more acutely because it's a larger portion of their premium.

In the younger population, the active population, pharmacy is only one component of the whole mix of expenses. Even if we have an increase trend in pharmacy, it has a more of a minimal impact on the member, but for the retirees, it's more acutely felt. So, yes, it's true that going through some of these processes and changing the

benefit is going to limit some of the choices, but it'll also take some of the pressure off the premium, which we've heard many members say was affecting their ability to take the drugs anyway. They were going every other month. They were skipping medications.

I totally hear you and I do wish that it wasn't so acutely felt in that population, but because the subsidy's been locked in for a long time and we're maximizing the subsidy right now at \$168, that's one of the only reasons why we're not going to have another increase. The Legislature, the last time they changed it was 2012, so counting on them to continually increase the subsidy is probably not going to happen. I think folks are trying to pick the sweet spot that allows change to occur with compassion, with understanding that if you really do need to take it, you have tried other things, there's an avenue for you. But at the same time, moving that population over to the most cost effective drug as easily as possible, with good communication and with good science. That's just my two cents, my perspective on why we're trying to recommend this change.

Carol Dotlich: It's interesting to me that since Medicare picks up a lot of the cost for the elder population that our insurance premiums are so high.

Lou McDermott: They don't pick up drugs.

Carol Dotlich: I understand that. I'm talking about, it's interesting to me that our premiums are so high anyway when Medicare picks up a lot of things.

Lou McDermott: Because these premiums are paying for the bulk of the pharmaceuticals. The pharmaceuticals, when you look at cost trends throughout the country, the different sectors, when you look at in-patient, out-patient, all these different areas within medical, you see one trend. When you look at pharmacy, you see another trend. I think, and now I'm reaching a little because I'm trying to remember back, but I believe one of our increases in the specialty pharmacy was in the high 20%. You're having a 20% increase in costs in specialty pharmacy, which was driving the overall pharmacy costs. Less than 1% of all the pills being doled out was specialty. We're seeing massive increases in pharmacy expenditures throughout the country.

Greg Devereux: Ryan, did I take away from the conversation when we were discussing 42 through 44, I think, that some of these therapeutic classes would not be considered? Like the antidepressants and --

Sue Birch: Antipsychotics.

Greg Devereux: Yes, they might come off?

Ryan Pistori: Yes, we just wanted to present to you a different mix of drug classes to show you that there is a lot of variation between the number of members impacted and the amount of cost avoidance we would see over the years, depending on these different scenarios.

In our January meeting, we shared a set of ten drug classes. The Board Members were curious about what individual drug classes look like? We created this table to show you what some of the differences could be for these different drug classes. For example, the ophthalmologic drug class, you can see it has a very high, in fact, of these drug classes, it has the highest amount of members impacted. The cost avoidance may not necessarily be the highest. We would not necessarily pursue this one for the value formulary for 2019. This shows there is diversity within the different drug classes.

Sue Birch: That was my question. Of the classes we're looking at, which one is there the most sensitivity to?

Greg Devereux: No, I remember that, but I guess what makes me nervous is are we voting at the next meeting on a recommendation?

Lou McDermott: No. I think the next meeting a proposal will come before the Board, but I believe the vote for the pharmacy benefit is scheduled for June 20.

Greg Devereux: Okay because I would really want to know what therapeutic classes we're talking about. I believe, Ryan, you said these charts covered Medicare only currently.

Ryan Pistoresi: That is correct.

Greg Devereux: And if there's any way to get non-Medicare by the next meeting, that would be great. I'd love to see the impact.

Sue Birch: Again, the point was to have these ongoing tutorial sessions because it's a lot for us to take in and to be able to ask questions so staff could go back and refine the information. We're coming along, but great questions.

Greg Devereux: I appreciate that tremendously.

Tim Barclay: One other request for information, if you could. We talked earlier about copay coupons. I would be interested to know what drug classes are where that's a prevalent issue; and in particular, which drugs are doing that and how you are thinking of classifying those drugs. That may play a role in how we respond and what we do in terms of how that behavior is taking place.

Ryan Pistoresi: Unfortunately, we aren't able to quantify the copay coupon issue within our population because what we see in our pharmacy claims data is the first amount that we bill. We don't see whether the members are paying out of pocket for these drugs or using copay coupons. We are unable to capture that information. If we are able to quantify that issue for UMP, we'd probably be looking at what we see nationally in terms of copay coupon use.

Lou McDermott: I think what Tim's getting at is understanding which drugs have the copay opportunity, not necessarily who's taking it or not because we don't have access to that.

Donna Sullivan: Lou, I think you can assume that any brand name drug has a copay coupon. It's pretty much our experience from Arden that they've told us almost all of the brand name drugs have copay coupons, even a multi-source brand.

Public Comment

Fred Yancey: I represent Washington State School of Retirees Association. First of all, let me tell you, this is all new to me and not easily understood. If I say something that is incorrect then it's out of ignorance not fake news.

The rate sheet you were presented with at the very first, showing the subsidy, I didn't understand because the figures don't add up to what the rates retirees pay for insurance for Medicare. I'm not sure what the point of that is. As an example, if you're a subscriber and a spouse, and you have one Medicare eligible person and you're in UMP Classic, you pay \$986 a month for insurance. Now, you can subtract \$168 from that and you're still out of pocket a lot. I'm not sure that chart kind of implies you're only paying \$300-something. I'm just not sure what the chart was trying to show.

Sue Birch: It's for a single subscriber, so one person only.

Fred Yancey: Well, see, that rate would be \$333, which is in a \$400 figure on the far right. So I'm still -- you understand my confusion? I just don't understand the connection.

Yvonne Tate: I was going to say, now, you know, Medicare is an actual variable rate. How much Medicare charges you depends on your income. So different people pay different amounts for Medicare.

Fred Yancey: Right. No question. I was just looking at the amount you pay for the UMP Classic through the PEBB Program.

Tanya Deuel: The \$333 for UMP Classic is before the subsidy. So this amount plus \$150 is the 2018 total rate. So \$483. Yes.

Fred Yancey: Gotcha. Yet this would be \$428. This would be \$278, \$378, \$420. So, you understand what I'm saying? If you add these two, they should --

Tanya Deuel: This is only 2018. So this, \$328 plus \$150 --

Fred Yancey: Right. Is \$478.

Tanya Deuel: Correct and that's the total amount.

Fred Yancey: But do you understand my confusion? I understand that this chart says \$478, this one says \$333.

Tanya Deuel: Because this is the portion published on this chart.

Fred Yancey: So this should be \$333.

Tanya Deuel: There's approximately a \$5 admin fee.

Fred Yancey: Okay, that's the difference. So the difference in that cost would be admin. Thank you.

I'm not sure what "medical necessity and clinically appropriate" means. When I go to my doctor, my doctor gives me a prescription. I'm not sure he knows what's medically -- what those terms would mean. He knows I could be cynical, he knows what salesman has been in to see him. He knows what is the general prescription, sort of, that is given for various diseases. But everything depends on a determination on what medical necessity is and clinical appropriate. If I understood it correctly, it's unclear that determination, should you appeal it, is either by a doctor, a pharmacist, or a delegate. I think it was by a nurse in my case, you know, that made a determination once, and I appealed and I requested a physician examine it. What I found is when you appeal, squeaky wheel gets the grease, basically, is what I've found. A physician did review it and approved it because what I keep going in my mind is, you know, these people need these medications because they're ill. While you're ill, we want you to try a variety of medications or we want you to do the paperwork and the appeal process and the note gathering, if you will, to get the medication you need. I don't have an answer for it but I just keep the picture in my mind that I'm not seeing. We're talking rates and savings and so forth but I'm not seeing the sick person here.

When you save a premium, you save a \$2.00 premium a month by shifting my out-of-pocket cost in excess of that \$2.50, that may be a savings to PEBB but it's not a savings to the consumer or the retiree.

A third, I would really like to see more research done as to why people are turned down. If I was told that I only stood a 33% chance of winning a court case, I'd never go to court. So why is that and why are 66%, roughly, turned down? That's really all I have. I'm here only as a number of you are to speak for retirees, who had a 50-some odd dollar increase in their Uniform rates that barely got -- didn't even cover the inflation since it was frozen in 2011 at \$150. Thank you for your time.

Yvonne Tate: I just wanted to say on this issue of what's medically necessary. I think we can all agree we don't want administrators making that decision because they're not providers. What they've done is contracted with this pharmacy benefit company that uses providers to make that decision. But I think the very difficult decision to make, and I think you rightly pointed out, maybe the physician is making that representation based on being influenced by something else. It's kind of an interplay between the member's physician and the medical staff that we've contracted

with to try to make that decision. To me, it's always going to be a difficult decision to make, unfortunately.

Tom MacRobert: Yes, that brings up a question that I would like to see answered. We've determined that approximately 67% of these appeals are rejected. I'd like to know, if we get information as to why these appeals are rejected, what is the basis of the rejections? Do we have any knowledge of that or does only the individual consumer who makes the appeal find out? Do we have a way of knowing that? I'd like to know.

Sue Birch: So we will task staff to come back with that information at our future meetings. I'm certain there'll be some information available.

Carol Dotlich: I would like to comment that I hear what our person who testified said. I just wanted to add that I have a real concern for all the members that I represent that would not begin to appeal anything because they simply can't. I don't know how you address those people because I know people who are in my group who are very caring people who cannot see. They don't file appeals. They ask the neighbor to read stuff to them. They don't write anything and there are a number of people like that, people who are in a nursing home. They're not able. To change their meds, to require them to appeal things to stay on meds they've already been on, at their age, I think is cruel. I'm just very concerned about the impact on those real people who are living at the end of their lives. I have real heart for that and I hope our Board will too.

Sue Birch: Carol, thank you for your comments. I do just want to comment as a nurse that oftentimes, the team of health providers that are involved will work with the client to get through an appeal process, especially like, Yvonne, if we can use your example, when they are really trying to get the best response from the drugs, they work with the clients. It's not just a go figure this out on your own. I do just want to represent that there's a lot of caring health professionals that assist with the appeal processes, but thank you for your comments and I think we all take that to heart.

The next meeting is June 7, from 1:30 p.m. to 4 p.m. We will meet in Executive Session at noon.

Preview of June 7, 2018 SEB Board Meeting

Lou McDermott: We will answer non-pharmacy related questions asked by the Board. We'll continue to refine the resolution on the value based pharmacy formulary and present other benefit changes for Board review that are being proposed by our fully insured products.

Sue Birch: Meeting adjourned 3:15 p.m.

Public Employees Benefits Board
Meeting Minutes

DRAFT

June 7, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:45 p.m.

Members Present:

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

PEB Board Counsel:

Katy Hatfield

Call to Order

Sue Birch, Chair, called the meeting to order at 1:36 p.m.

Pursuant to RCW 42.30.110, the Board met this afternoon in Executive Session to consider proprietary or confidential non-published information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026 when public knowledge regarding the discussion is likely to result in an adverse legal or financial consequence to the agency. The executive session began at 12:00 p.m. and concluded at 1:26 p.m. No action, as defined in RCW 42.30.020(3), was taken during Executive Session.

Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Meeting Overview

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

Follow-up Questions from Prior Meetings

Dave Iseminger: I have information from five questions that were asked at the April 25 meeting. The first two are related to the deferral rule for retiree coverage.

At the April meeting, Barb Scott presented information about ChampVA because of requests and information in public comment that was provided to the Board earlier this year. In presenting that information, the Board had a question about how many members have deferred coverage and historically accessed that coverage rule. I can't provide you with numbers today. The Pay1 System we use does not have an indicator to track when an individual defers. When an individual defers coverages, they submit their form indicating they intend to defer. We do not create an account for them in Pay1 until they come back and enroll in coverage. There is not an indicator in our system to tell us they came back from deferral status. The only way we could provide numbers at this point is if we did a manual review of all accounts and the paperwork within the system. Automatically tracking this is something we're thinking about as we replace our system going forward. When the deferral rule was created in 2001, the system wasn't set up to be able to track it that way. Our administration over the last 17 years doesn't afford us a way to give you that type of information.

The second piece related to Slide 4 in Barb Scott's April 25 presentation that went through the different ways an individual can go through the deferral process. There was a Board question about which options are one-time opportunities and which ones can happen more than one time.

The first one is an individual able to defer because they have employer-based group medical coverage as an employee or a dependent of another employee. If I'm a retiree enrolling on my spouse's employer-sponsored plan, that's a multiple trip ticket. You can do that many times. You can come in and out under the deferral rule through PEBB retiree coverage with other employer-sponsored insurance or group medical insurance.

The second deferral policy relates to federal retiree medical plans such as Tricare. This is a one-time ability to return from deferral status and enroll in PEBB medical plans.

The third opportunity is if you're enrolled in Medicare and Medicaid and come back into PEBB retiree coverage. That is as many times as the circumstances present themselves. That can happen multiple times allowing someone into and out of deferral status.

The fourth one is a reminder that individuals who are enrolling in Health Benefit Exchange coverage have a one-time opportunity to come back into PEBB retiree coverage after having gone to the Exchange.

At our next Board meeting, Barb will bring back resolutions related to ChampVA. Any questions about the two I presented on first? Because those are deferral related and I'm going to shift topics.

The next two questions related to a presentation on the Centers of Excellence (COE) bundled payment program, which is the payment program for total joint knee and hip replacement (TJR). One question asked about the total spend for

TJR for both non-Centers of Excellence and Centers of Excellence compared to prior years. According to the data, we've actually seen an increase in TJRs in 2017. It's 48 more than in the prior three-year average. The total spend has also increased along with the utilization increase. The differential and average cost between 2017 COE and non-COE was \$25,000 compared to \$32,000. If the additional 48 TJRs had been performed in the non-COE under those rates, the total TJR spend would have been \$22.6 million instead of \$21.9 million.

The second question was about the average out-of-pocket cost for total joint replacement in the Medicare setting. The average between 2014 and 2017 was \$883.12. In 2017, we actually saw that figure drop a little from the prior years to around \$828.00.

The last question was how many Medicare members are in the Uniform Medical Plan. As of May 2018, there were approximately 40,000 subscribers and 53,000 members in the Uniform Medical Plan. The total Medicare population is about 67,000 subscribers and 93,000 members. For non-Medicare UMP, there are about 3,500 subscribers with 6,000 members. The total non-Medicare retiree population is about 5,600 subscribers and 9,400 members.

UMP Value Formulary Follow-up and Proposed Resolution

Ryan Pistoresi, Assistant Chief Pharmacy Officer, Health Care Authority. I will follow-up on questions from the May 21 meeting. Slide 3 and Slide 4 defines the terms "medically necessary" and "clinically appropriate." The Board asked for clarification.

Slide 3 defines "medically necessary," which is derived from the 2018 Certificate of Coverage (COC).

Sue Birch: The last state on the Slide 3 is important. *"The fact that a physician or other provider prescribes, orders, recommends, or approves a service or supply, drug, or drug dose does not, in itself, make it medically necessary."* I think it's important to call that out.

Ryan Pistoresi: Thank you for highlighting that. Slide 4 defines "clinically appropriate." This is not a defined term in the Certificate of Coverage. You won't find "clinically appropriate" used. However, the definition on Slide 4 is used in the Tier 3 exception process. When designing the value formulary, we looked at how we could use existing functions of the UMP pharmacy benefit in this formulary. We looked at the existing Tier 3 exception process for grandfathering and thought that could carry over. Section A is verifying all preferred therapeutic alternatives for a medication failed to produce a therapeutic response and Section B is all preferred therapeutic alternatives provide an adverse event or are otherwise intolerable.

Slide 5 responds to the question of the Tier 3 exception process and why many requests are denied. Moda Health indicated most denials are because the members have not tried the preferred medications. If members step directly into

the non-preferred drug, they don't qualify for the exception process. They don't meet the criteria for a Tier 3 exception and will be directed to take the preferred medications.

A member will also be denied if they don't submit the required documentation that the preferred medications fail to produce a response. For example, if the patient does not take a medication for the anticipated duration to see a response or if they don't titrate up to the correct dose. If someone is starting on Simvastatin, five milligrams, it's not that Simvastatin doesn't work, you need to titrate up until you can find an effective dose. If you reach the maximum dose and it's not effective, you can then switch to another medication.

Carol Dotlich: I have a question about the clinically appropriate slide. Can you define for me what "all preferred therapeutic alternatives" means?

Ryan Pistorresi: Yes. All preferred therapeutic alternatives are all of the drugs in the Value Tier, Tier 1, or Tier 2 within that drug class or drug subclass. For example, for GOP1 agonists, the preferred medication is Byetta. In that class, there is one preferred drug. If someone uses Byetta and either has an intolerance to the medication or it does not produce a therapeutic effect, the member meet the definition of clinically appropriate. In other drug, classes there may be more medications.

Carol Dotlich: What if there are seven different drugs in the Value Tier for a condition that my doctor prescribed a more expensive drug. Do I have to try seven different brands of the same thing?

Ryan Pistorresi: Yes, if they're all in the same subclass.

Dave Iseminger: Ryan, in the current Value Tier, which is different than the value formulary, are there lots of drug classes that have a plethora of drugs or does the Value Tier tend to have a fewer number of drugs and drug classes?

Ryan Pistorresi: Drugs currently on the Value Tier are somewhat limited. For antidepressants, I believe there are three drugs in the Value Tier. In the same antidepressant class, we also have drugs that are Tier 1, Tier 2, and Tier 3. We've identified a couple to be very cost effective. They are in the Value Tier to promote access and adherence, but there are others placed at Tier 1 and Tier 2.

Donna Sullivan, Chief Pharmacy Officer, Health Care Authority. Back to Carol's comment, "Do I have to try seven drugs of the same thing?" To clarify, we won't make you go back and try the same drug over again if you've already tried it. But if there are seven unique drugs within the class, you would have to take those seven unique drugs before you would be approved for the non-preferred. I want to make sure you aren't thinking we would make you take the same drug seven different times. There are five hydrochlorothiazide for diuretics on the market and five manufacturers. We wouldn't make you take each one of those manufacturers to get the branded diuretic.

Carol Dotlich: That was my question.

Tom MacRobert: In our past conversations, we've talked about Tier 1, Tier 2, and Tier 3 drugs. I have not seen Value Tier before. Are you referring to a different class of drugs? We still have Tier 1, Tier 2, and Tier 3, and Value Tier?

Ryan Pistoresi: Yes. In the UMP formulary, there are the Value Tier, Tier 1, Tier 2, and Tier 3.

Dave Iseminger: To clarify, Tom, I think we had Value Tier in our presentations but there's so many presentations between two Boards at this point, I can't remember what words are in every presentation.

Ryan Pistoresi: There are currently four tiers, as well as preventive medications like birth control, which is at a zero dollar cost-share to members.

Dave Iseminger: That's really five tiers: Preventive, Value, 1, 2, and 3. There already exists a Value Tier. Ryan, will you describe what the Value Tier in the current formulary means just to reset for the Board?

Ryan Pistoresi: The drugs in the Value Tier have been identified as very cost effective drugs. The cost-share for that is set at 5% for the member with a \$10 maximum for a 30-day supply. For Tier 1, the cost-share is 10% up to \$25 for a 30-day supply.

Dave Iseminger: Ryan, just to confirm, the Value Tier already exists today as part of the formulary the Board has previously approved. What we're talking about with the value formulary which unfortunately has the same word "value," does not change anything about the Value Tier.

Ryan Pistoresi: Yes, under the proposed value formulary, the Value Tier would still exist.

Tom MacRobert: I have another question from what Carol was talking about. If my doctor decided I should be taking Lyrica, what Tier would that be?

Ryan Pistoresi: Lyrica, I believe, is set at Tier 2 because it is a single-source brand medication.

Tom MacRobert: So is there a Tier 3 equivalent, a Tier 1 equivalent, and a Value Tier equivalent to Lyrica?

Ryan Pistoresi: For Lyrica, since it is a single-source brand, there are no generic alternatives. It is set at Tier 2. Within a drug class to treat the condition that Lyrica treats, there could be a Value Tier or a Tier 1 alternative. For example, Gabapentin has a similar mechanism of action and is a Tier 1 alternative. That could be used in place of Gabapentin if that's appropriate for your condition.

Tom MacRobert: If my doctor prescribes Lyrica, would I then have to try Gabapentin first before I took Lyrica, or would I be covered because it's a Tier 2 drug?

Ryan Pistoresi: I would have to check to see how Lyrica is covered, but for this example, since it is a Tier 2 drug, you could pay for it out of pocket. You don't have to necessarily step through Gabapentin for that medication.

Dave Iseminger: To level set, Ryan, because the value formulary principles we're talking about are addressing the differences between Tier 2 and Tier 3. The exception process gets you from Tier 3 to Tier 2 cost-shares. But because in this scenario, there is no Tier 3 piece for Lyrica, there is no Tier 3 exception scenario to talk about. Is that right?

Ryan Pistoresi: Yes. Slide 6 responds to the question about whether a physician or pharmacist reviews the pharmacy cases for UMP. I was able to confirm that it is a doctor of pharmacy, a PharmD, who reviews the pharmacy cases. These are the prior authorizations, the Tier 3 exceptions, and appeals. These licensed pharmacists are able to work in collaboration with physicians, either medical directors or specialists, on some of these cases. If a pharmacist receives a very complex chemotherapy regimen they are not sure of, they can consult with an oncologist in order to get clarification before making a decision.

Carol Dotlich: I have to take you back again to the decline clinically appropriate slide. I'm looking at part B and the language says, "including the required number of manufacturers of the same generic drug." That sounds like if Johnson and Johnson made furniture wax, some other company made furniture wax, and another company made different furniture wax, I would have to try all of those furniture waxes from different manufacturers before we could agree that furniture wax is not good for me. Am I misunderstanding the language?

Donna Sullivan: You're reading it correctly. But there's a particular situation when that language actually applies. We have some very high cost medications, like Fortamet, which is metformin product. It's an extended release product and it's upwards around \$30 a tablet. There are generics. There's also a drug called Glucophage XR, which is also extended release metformin and there's a generic to that drug. The generic drugs are less than \$1 per tablet. We have created a way to say you can't get Fortamet unless you try five generic manufacturers of another extended release Metformin and then it did not work or you could not tolerate that product.

Ryan Pistoresi: Slide 7 responds to the question of how many UMP members are affected by the inequity issue. Unfortunately, we are not able to determine the exact number of members because we would need to review their electronic medical records to determine how they may fit into this process. We have provided an estimate based on some of our numbers. There are approximately 47,000 UMP members using Tier 3 drugs. If we applied the Tier 3 exception approval process and we assume in this general population, if it's similar to the

population that applied for the Tier 3 exceptions, then that could be an anticipated 14,500 members. However, it's worth noting that only about 3.6% of UMP members using Tier 3 drugs have applied for that exception. This is a limited subset of members using Tier 3 drugs who have applied for this process and an even smaller amount who were granted the exception. It's challenging for us to determine what type of impact the Tier 3 exception process would have on this member population.

Slide 8 is a follow-up to Greg's question about the non-Medicare numbers. The next three slides are the 12 drug classes presented at the April 25 meeting, however, we've expanded this to include the non-Medicare numbers as well as a third column with a total, so summing both the Medicare and the non-Medicare numbers. In Option 2A we would grandfather all Tier 3 drug users in at Tier 2. The Option 2B scenario is if we grandfathered all existing Tier 3 users, and if they applied for an exception similar to the Tier 3 exception process, they could pay at a Tier 2 cost-share. Option 2C is if we did not grandfather any members and required them all to go through the request process.

It's also worth noting that the numbers in Options 2B and 2C are estimates based on the anticipated number of requests, approvals, and appeals that UMP would have. These numbers could increase and the cost avoidance shown would decrease. If the amount of requests and approvals begins to approach 100%, those cost avoidances would become more similar to what is in Option 2A. In the event it was 100%, it would actually be more costly to the plan because the cost avoidance would be the same as Option 2A, but the administrative cost of the requests and appeals would outweigh what would be achieved in Option 2A.

Carol Dotlich: I need you to repeat what you said about 2B.

Ryan Pistoresi: Option 2B is if we grandfather in the existing users but they continue to pay the same cost-share they currently pay. In this situation, members new to the plan who may be stepping into Tier 3 would not be able to use the Tier 3 drugs until they use the preferred products, whereas existing members would be grandfathered on their current medications and continue to pay the same cost-share tier.

Dave Iseminger: I believe the recommendation put forward in the draft proposal in May, and at this meeting, is really rooted in Option 2A. I want to make sure we're clear as to where the proposal comes from and where the primary conversation has been. We're still giving you the thoroughness of what has been provided all along for both the non-Medicare numbers, per Greg's question. We started this journey describing a wide range of options. We've been trying to hone in to give you our official recommendation, honing in on Option 2A.

Ryan Pistoresi: In the tables, the red numbers with the parentheses are negative numbers and the black are positive numbers.

Sue Birch: The red actually is cost avoidance since it's a deficit?

Ryan Pistoresi: Increases the plan cost.

Sue Birch: So just a reminder, the numbers in red actually drive --

Ryan Pistoresi: Drive costs up for the plan. If you look at that top one, you see Ophthalmologic in 2A would increase the plan costs \$312,000 in 2019 and \$136,000 in 2020, to orient you about how this table is presented.

Slide 11 responds to the question of what drug classes would be included in the value formulary? We are still in the process of gathering our current drug spend and utilization. As I mentioned at the last meeting, the model is based on 2017 drug usage and drug spend. This is continuing to change as we approach what the value formulary may be for 2019. Throughout this year, new drugs were approved, and new generics entered the market, which changes the dynamics of the existing drug classes. For example, in the GOP1 agonist class mentioned earlier, the preferred product will be going generic. We are evaluating this to see what this does to management of this drug class and how it would affect the value formulary. We continue monitoring the plan spend and utilization.

Bullet 3. HCA would manage the formulary and direct members to the preferred products. July of each year, HCA will determine which drug classes will be in the value formulary the next plan year. The likely drug classes for the value formulary in 2019 are diabetes, cholesterol, beta-blockers, androgens, blood pressure, antidepressants, psychotherapeutic/neurological, and Parkinson's disease. If you look at Slides 8-10, the twelve drug classes are listed and they have smaller member impact, but have cost avoidance over the two-year period.

Slide 12 discusses members' cost-share. The value formulary has the potential to reduce member cost-share by taking members currently using Tier 3 drugs and changing to a Tier 2 cost-share. The members paying for these drugs could see a reduction in their out-of-pocket costs, especially if they switched to a Value Tier drug, Tier 1, or Tier 2 drug. New members granted appeals would pay a Tier 2 cost-share and would have reduced out-of-pocket costs.

Bullet 2 is an example of what those reduced costs would be, going from a 50% cost-share to a 30%, with a maximum of \$75 per 30-day supply.

Slide 13 responds to a question on the 2013 analysis of capping the Tier 3 cost-share for members. As I mentioned on the last slide, the patients on Tier 3 traditional drugs pay 50% with no cap. We performed an analysis in 2013 about what this would do to the plan. According to our analysis, the cap shifts the cost from the members to the plan. It really only benefits the members using Tier 3 drugs that don't hit the maximum \$2,000 out-of-pocket per year. To help illustrate, a \$150 cap on a Tier 3 drug equates to about \$1,800 per year. If they're spending about \$200 more on other drugs, they will hit the out-of-pocket maximum. This does not impact their overall out-of-pocket costs during the plan year.

Slide 14 was a question about which drug classes have copay coupons. On my review, every drug class that has a single-source or a multi-source brand has copay coupons or other patient assistance programs available.

Slide 15. At the May 21 meeting, I made the comment that the Consortium went into automatic negotiations as a result of the third party audit, showing that the rates were outperforming the contract. A question was asked as to when the new rates go into effect? I was able to confirm the rates went into effect January 1, 2018.

Slide 17 is a reminder of the principles for designing the value formulary. We focused on the drug classes that have cost savings without reducing the quality of care to members, to make a difference to the premiums without sacrificing care, to grandfather members who have used these medications for a long time or who are in refill-protected drug classes.

Slide 18 is the crosswalk to help bridge information from the January 2018 Retreat to the April and May meetings.

Slides 19 and 20 are the proposed policy resolution PEBB 2018-01 - Value Formulary. Some of the language was updated to clarify the concept of grandfathering, specifically in the third and fourth clauses. These two clauses were updated based on discussions at the May 21 Board Meeting. The updates do not change the intent of what was proposed in May.

Dave Iseminger: Typically, when we bring resolutions to the Board, we bring one proposed resolution and ask you to take action at the next meeting. You've seen us working on the iterative process of this one longer because of the nature of the discussion with the Board. This is the official proposal and now we're back in synch with our standard process for presenting resolutions. This is the proposal we will ask you to take action on at the next Board meeting. It's important that you do take action at that next Board meeting regardless of the outcome. That will enable us to finalize the rate process in July. The goal for the June 20 meeting is to be able to implement some sort of value formulary for the 2019 plan year. If you don't pass the resolution that is equally important information for the rate build process.

Myra Johnson: Ryan, thank you for this presentation. Can we go back to Slides 8, 9, and 10? I have one question but I think it's embedded a couple of times. For example, under the diabetes Option 2A, for cost avoidance in 2019, it's \$330,000 in the red, which would end up being a higher premium, correct?

Ryan Pistoresi: Not necessarily a higher premium. It would increase the plan cost \$330,000 for that year and shift into the positive for the plan, so cost avoidance, in 2020.

Myra Johnson: Why such a big change?

Ryan Pistori: What's interesting about the diabetes class is the high utilization in terms of some of the non-preferred drugs. If you look at how we structured the list, it's ordered from the highest member impact to the lowest member impact. The twelve drug classes are ordered by the amount of members using the Tier 3 drugs. The diabetes class is the second most prevalent of the non-preferred drug usage. There are many users using these Tier 3 drugs so there will be a high impact in the cost shift between them. Diabetes is also the highest drug spend class for UMP, traditional drug class. This has the highest cost impact and the highest per member per month (PMPM) for the plan of all the traditional drug classes. We identified this as an opportunity to save the plan money in future years by shifting to the value formulary because there's a lot of this utilization on some of the higher cost, lower value non-preferred drugs. If we're able to direct the member utilization to the preferred lower cost, higher value drugs, we identified there would be that cost savings. In the 2A scenario, we would be grandfathering the existing users on those drugs and shifting the focus on the utilization for future years.

Tim Barclay: Can I throw out an alternative? As I look at the numbers you've provided, I can understand the desire to offer grandfathering for the 47,000 people using the Tier 3 drugs we're talking about making ineligible. That seems very disruptive to me not offering a grandfathering opportunity. At the same time, by your own estimation, 69% of those people, which I think is also optimistic, it's probably higher, would not be eligible for the exception process for the Tier 2 copays. It seems like a substantial price to pay to lower the copays for those 32,000 people for no reason to solve a problem that might exist for people who have not gone through the exception process.

I'm wondering if as an alternative to the proposal you suggested, we offer grandfathering without the copay reduction, still allow the exception process, and do a better job of communicating its availability to people, thereby putting us in the 2B scenario instead of the 2A scenario, whereby we are not directly disrupting anybody's care. We're also not spending a huge amount of state money to accommodate a lack of communication on the exception process. It would also allow us to put additional drug classes into the value formulary, such as the ophthalmologic category, which would then produce savings in both years for the state as well as correcting a problem.

For example, in diabetes, where even two years out, if I read the numbers correctly, the proposal to use 2A would cost the state a half a million dollars, aggregating 2019 and 2020 together versus saving a million and a half. It's a \$2 million swing in that drug class alone to essentially not give away copays to people who have not followed the process of testing feasible drug alternatives. I'm wondering if an alternative proposal for the Board to consider at the next Board meeting would be one that mimics category 2B instead of category 2A.

Donna Sullivan: I want to clarify a misnomer that we probably didn't do a good job of discussing previously. When we talk about grandfathering, there are certain drug classes where we will grandfather a person indefinitely. We also use the

term "grandfathering" when we're going to give them just three to six months to switch to a preferred drug. What we didn't talk about previously was when we would grandfather people forever and when we would grandfather them for a short period of time so they could engage with their provider and talk about the alternatives and then decide whether or not they needed to request an exception.

If you look at the resolution on Slide 20, in the example of diabetes for that particular class, it would be my recommendation to only grandfather for a short amount of time for the exact reason you just mentioned. There are other drug classes like anticoagulants or seizure medications if we were to ever do antipsychotics that I would grandfather everybody forever because there's a clinical reason why you wouldn't want that person to switch just for the sake of switching. I wanted to make that clear that when we say 2B is "grandfathering," it's not that everybody will be grandfathered forever if they're on a non-preferred drug when we go to the value formulary.

Tim Barclay: I appreciate that and that's helpful. I guess I would ask the question again then as to why the reduction in the copay in the interim period. It seems even less important to me than to lower the copay. I guess I'm just not seeing the reason why during this transitional period we're reducing the cost-share. It doesn't make sense to me.

Donna Sullivan: You bring up a good point. I don't think our model is sophisticated enough to look at if we were to grandfather people forever, we're not going to make them ever go through an exception process, maybe for those people we change their copay. If we're grandfathering them for three to six months, do we change the copay for those people while they're in their transition period and then only change it if they get the exception granted? If we keep that Tier 3 cost-share in place, though, we then have the inequity issue where some people are paying 50% of their drug and some are paying as little as \$75, which could be 30% or less.

Tim Barclay: I'm trying to understand the problem if we take your proposal as it sits without eliminating the Tier 3 cost-share in the interim. Does that make sense? It seems like that could be a more fiscally responsible way to transition into the value-based formulary.

Ryan Pistorosi: Are you proposing we change the third clause of the proposed policy resolution?

Tim Barclay: No, not at all. I think one of the things missing from the proposed resolution is really what happens to cost-sharing. It's not mentioned in here that I see.

Sue Birch: Page 12.

Tim Barclay: Well I'm talking about Pages 19 and 20, which are the resolution.

And I don't think what happens to member cost-sharing is mentioned here. It's assumed but it's not mentioned. I think we should be clear that it's our intent not to change member cost-sharing at the same time we implement the value-based formulary and transition to it, doing exactly as you described how we want to transition to it. But we don't do a wave of member cost-share reductions from Tier 3 to Tier 2 as of January 1.

Donna Sullivan: Just a question back to you, Tim. So we have a person that's on a Tier 3 medication that's being grandfathered and given a six-month transition time. I'm not going to use the word "grandfathered." They're paying the Tier 3 coinsurance. They request an exception. It's denied. Do we continue to cover that drug at Tier 3 or is it then no longer covered? I mean, that's kind of the question you'd have to address. What do we do then? Otherwise, what you're suggesting, I don't see much difference in it from what we're currently doing.

Tim Barclay: Well, if I'm reading the numbers correctly, no. We're not communicating. I'm not suggesting that person can continue to be on the Tier 3 drug, which is not what you're proposing either, right?

Donna Sullivan: Correct.

Tim Barclay: We're in agreement on that.

Donna Sullivan: Okay, I just wanted to make sure that when you say we don't reduce their coinsurance in the interim, but the result is if the exception is denied, it results in "not covered" as opposed to "I just get to keep taking it at the Tier 3 cost-share."

Tim Barclay: No.

Donna Sullivan: Okay. So I wasn't sure that everybody else understood that either.

Tim Barclay: No. So I'm saying what the policy resolution says, I'm fine with. But we're just lacking clarity on what happens to the copays. And if we don't reduce the Tier 3 copay for everyone as of January 1, it eliminates a lot of those red numbers and allows us to, like I said, be more fiscally responsible making the transition to the new system as well as implementing additional drug classes that those red numbers are making us shy away from, potentially.

Dave Iseminger: So I'm curious about the other Board members' perspective on this idea as to whether or not to reduce the cost-shares as part of the proposal. We certainly can be more explicit about this in the final resolution that's brought to you, but additional dialogue from the Board would be helpful.

Harry Bossi: This is Harry. If I understand the chart correctly, there's a proposal that eight of these drug classes would be incorporated. I did my own quick math without a calculator that says the cost avoidance in 2019 would actually be an

increase in cost because of those first couple, particularly the diabetes. Of course, the payback would come in 2020, but the payback in 2020 is just over a million dollars. I don't know what the total drug spend is off the top of my head. I don't know what the total spend is for the entire PEBB. But it seems to me a very small savings in proportion for what we're asking folks to go through.

Ryan Pistoresi: You were right on both numbers. Under the current proposal, the plan increase would increase under the first year by a few hundred thousand. Then it would switch to a plan savings of about \$1.3 million in 2020 for those eight drug classes. We could always continue to evaluate other drug classes and add them into the value formulary as we're looking to implement. Right now, the current proposal is looking at these eight classes, which would impact about 2,100 members. There are about 86 total drug classes with Tier 3 drugs. We're only showing you the twelve we identified as having a potential for cost avoidance in the future. We could continue to look at some of the other drug classes as well, especially in the future as new drugs are approved and costs shift. As we continue to look at specialty drugs, those could be other options.

Dave Iseminger: Ryan, can you also describe what our model projects in further outlier years, potential cost avoidance for the plan? I know the further out you project, the fuzzier the lines get. But if you could describe a little bit more about the potential trend that comes from the outlying years in the model.

Ryan Pistoresi: We only presented the numbers for 2019 and 2020. We have looked at what occurs in 2021 and 2022. The plan does continue to have cost avoidance in these future years. As we're able to direct these members earlier by 2019, it saves the plan the cost avoidance in future years. It would continue to increase, especially as drug costs continue to rise and we continue to see new drugs come out with a potential for a member to shift utilization or create new drug utilization.

Sue Birch: In response to your call, Dave, I have two comments. I like, and this is back to Page 12, the notion that we're creating a potential reduction for the member cost-share for medication. I like that principle. I think the second issue of evening out the payment is what I'm struggling with because I thought I had it until Tim talked about his proposal. I'm trying to reconcile in my mind, Tim, what you're proposing because I think it is at the heart of how they would pay 30% cost-share with maximum of \$75. I think you're proposing something but I guess I need to understand what you're proposing. Is that correct? I like the principles of trying to even things out and get greater value to the member but I'm struggling with what Tim is proposing.

Donna Sullivan: The math of it is, we're going from paying 50% of the cost of the drug to 70% or more of the cost of the drug on the plan side because of the copay. If the drugs cost the same, they both cost \$500, the member's going to pay \$75 for the Tier 2 drug and we're going to pay the \$425. For the non-preferred drug, we're going to pay \$250 for that drug. That's why the cost goes up but the member cost goes down.

Tim is proposing not doing that, of just keeping the member's cost-share at 50% until we make them switch, if we're going to make them switch.

Sue Birch: I see. That was the bullet I was trying to get my head wrapped around.

Tim Barclay: My point was people have been cruising along for years, taking this drug, paying the cost-share. We're going to force them into this transitional phase where they need to do something, right? Why at the beginning of that transition would we crank down their cost-share as we head into it? Just let the train keep going into the transitional phase; and then how it resolves itself, it will resolve itself based on them and their physician and their care plan. It's this interim tweak to the cost-sharing that doesn't make sense to me.

Sue Birch: And you're suggesting taking the 50% and force everybody through the –

Tim Barclay: My suggestion isn't to make them do anything different than the proposal as is.

Donna Sullivan: So for those patients that are going to be grandfathered forever, their copay would immediately change to the Tier 2. For those patients given a transition period until they get to switch, they would continue to pay the 50% coinsurance. If they requested an exception and it was approved, they would then get the Tier 2 cost-sharing. If it was denied, they would have to change medications or pay for it out of pocket themselves.

Greg Devereux: I guess I'm with Harry in terms of \$1.5 million on a \$1.5 billion spend just seems miniscule. I mean I appreciate all the tweaks that help members out, but it seems like not even a dimple on the back of an elephant in terms of what we're trying to do. It seems like our time would be better spent in other areas really pushing the pharmaceutical companies in other ways.

Dave Iseminger: I'm going to borrow a phrase that I hear Sue say a lot: there's no silver bullet but there's lots of silver shrapnel here. Although in the projection that's happening right now based on the drug spend of a year ago, the additive effect looks like \$1.5 million in year two, with growing cost avoidance in future years. We've tried not to convey to the Board that we think this is the only piece of the puzzle. There are other strategies we've talked about along the way but we've been focused on what are things the Board could put into place in 2019 to get things in motion. I hope the Board doesn't think this is not the only piece and that after June 20, whatever happens with this resolution, we're done talking about pharmacy. I think Ryan, Donna, and I are going to be attached at the hip for years, along with all of you as we try to tackle this in a couple of different arenas.

Greg Devereux: Dave, I appreciate that very much. But I think this size of the shrapnel matters and working on getting other Consortium partners in might have way more impact than this.

Sue Birch: Greg, I guess as a nurse, I would argue that this does create a shift in thinking in the drive towards value. It creates the shift with the providers, the members, the plans. I do endorse moving forward. I still want to see if there's anything more creative we can do between Tim's proposal and staff proposal. But that is just my opinion. Other thoughts or did you want to respond? I do think the movement towards value-based is very important.

Donna Sullivan: I would like to respond to Greg's comment. How the manufacturers price their drugs to groups purchasing together, it's not just on volume. It's about how closely you're monitoring the formulary and what is their potential market share. The more restrictive formulary, if you want to use a bad word for calling it a formulary, the more likely the manufacturers are going to give you a bigger discount on their drugs. If they're the only drug in that class that's preferred or they're one of two drugs that are preferred, they're going to give you different prices depending on how you have your formulary positioned. I would say to you that moving to this formulary would position us to get better pricing from manufacturers should other companies or programs join and we were to try to get a common formulary.

Carol Dotlich: I want to be on the record stating that for the members I represent, the retirees, anything they can save in terms of their pocketbook is critically important. The coupling of the increase cost of living plus the increase in premium that UMP members have paid was very significant to their ability to manage their health care. If you can save them money, that's what I'm in support of. Anything that increases their cost, I'm opposed.

Ryan Pistoresi: To respond to Greg's comment, another aspect is this provides us another tool in which we can continue to monitor and manage the pharmacy benefit. To Donna's point, it would allow us to have, potentially, better pricing. But it's also a question about turning the dial. To your point, if you want us to turn up the dial, we can look at potentially adding even more drug classes in the future and continuing to move towards that.

Greg Devereux: I guess what I'm saying is \$1.5 million for the amount of disruption seems a high price. And moving the dial even more causes more disruption. I just think there may be other things we can do. I understand Sue's point about this sends a message to pharmaceutical companies, but I think there are other things we might be able to do that would have more impact than this, financially.

Carol Dotlich: I also remain concerned about putting people through multiple manufacturers of the same or similar drug. I think grandfathering the people that have been compliant and responsive to the medications they're on is really important. I don't want to see people have to change their medication numerous times to prove that they need the medication they're already on. I can understand if somebody has a new condition and their doctor wants to start them out on the television advertised brand and you'd like to see them do something similar at less cost. I can understand that and I could support that. But to take people who are

already successfully being treated on a medication they've been on for years and force that move, I'm opposed to that.

We did a survey of our membership. It's only been in the works for a couple weeks. We have a good response but not 100% response that we'd like to see from our membership. From the results that we've gotten so far, many, many of our members, most of them, are already using the generic brand of the medications they're on. The people not using the generics probably are not for a good reason. As I said, the members we represent already struggle financially. They're not going to take expensive drugs if they feel they can do well on something less expensive. That's proven in the survey results. I don't want this kind of disruption for the other members who are taking drugs already that have been working for them for years.

Dave Iseminger: Sue, I'd like to go back to the question Tim put on the floor, which is being clear in a final resolution that we ask the Board to take a final vote on next meeting. Being clearer about the cost-share pieces. Tim's question is, there's the dial and there's the extra added twist of the dial of not changing the cost-share in the short term. The question for the Board, if you want to go forward with this value formulary, how hard do you want to turn that dial? I think what we're hearing, and this is one of the challenges, is we've been talking about this for over a year and a half. Donna's been talking about it here at the agency for over two years. We've been talking about it and it's a tough issue to crack and to get consensus among a body about how to move forward on different pieces. All of you have good faith efforts with what you're bringing to the table and the positions that you have.

The question really is, is there a consensus among you about whether to move forward on this piece of the puzzle that can be put in place for 2019 or not put something like this in place for 2019. Then we continue to work on the other pieces of the puzzle. It would be helpful for us because it sounds like we should be bringing you back in the final resolution something that is clearer on cost-shares.

Yvonne Tate: I like to give staff broad flexibility. I look at these as policy issues and I don't like to drill down the detail that much. I like to look at it more from a broad policy perspective. I think there are 50 bazillion ways to look at this and I don't want to drill into all of them. I guess what I'm saying is I'm comfortable with what you've recommended here. I recognize all of this work is very, very difficult and there really isn't a silver bullet. It will continue to be difficult as we go forward. I like to be able to give staff flexibility. But from a policy standpoint, I'm comfortable with the resolution as proposed.

Tim Barclay: I agree with Dave's comments. I hope we can come away today with a general idea of what it is this Board expects so we can have a productive discussion next time and have a productive vote on a resolution. With that in mind, I'd like to take Carol's point and drill into it a little further because I think it's a very good point. I want to be clear because I think I'm hearing a different answer

today than what I heard the last time we met. The expectations for someone who is on one of these Tier 3 medications that we're saying we're not going to cover in the future, is the expectation the same for them as it would be for a new person coming into the program? The fact that they would have to revert and try all of the alternatives? I thought I heard last time there was, what I might call an expedited process by which they could stay on that Tier 3 medication as opposed to essentially behaving exactly like a new member, essentially. I want to be clear on what it is we're asking people to do. Are we really going to disrupt 47,000 people or not?

Donna Sullivan: It depends. Some of those patients have already tried the preferred alternatives. If they were to submit a request for an exception and submitted documentation indicating they tried all the other drugs and they didn't work, that would be approved. If they were just started on the drug two days before they entered the plan and they hadn't tried all of the preferred drugs, we would make that person go back and try all of the preferred drugs first.

Tim Barclay: You and I had a conversation ten minutes ago about the transitional aspect, whether people could stay on Tier 3 and pay the Tier 3 copay forever. You and I were on the same page and said no. I'm wondering if in light of Carol's comments if a better answer isn't yes. I'm curious to hear your thoughts on why that's a bad idea.

Donna Sullivan: I want to clarify. To make them pay Tier 3 forever, that puts us in an inequity position where if a new person was approved for that drug, they would be approved at Tier 2. They'd be paying \$75 and this other member would continue to pay \$250.

Tim Barclay: Well, they could always go through the exception process.

Donna Sullivan: Yes, they could go through that exception process.

Tim Barclay: I'm wondering, and Carol, this is a question for you, too if this would solve your concern. If we say it's our intent to transition to this value formulary, it's going to apply to new people, which I think you said was okay, new people come in, we want you to try the lower cost alternatives first, and we encourage people to transition off. We advertise the process by which they can transition to a lower copay and stay there. We allow them, but for whatever reason, they don't want to, they don't have the documentation, they don't want to try other drugs, rather than a hard line in the sand, which is how this is written and you and I agreed, no, after six months, you're done. It's not covered at all. We give them an out and say you can stay with this Tier 3 copay as is today and grandfather them forever. Just thinking out loud.

Donna Sullivan: That's no different than what we currently do.

Sue Birch: So, then it's unfair because of the differential on the cost-share, \$250 versus \$75.

Yvonne Tate: Exactly.

Donna Sullivan: I think to Tim's point is that maybe it's not widely known enough in our membership that there is this exception process, that if they have tried all of the preferred drugs and can't take them for whatever reason, they have this opportunity to take an exception. If we grant those exceptions, they'd get a lower cost-share tier. If they choose to stay on the drug because they want to switch, they would have to pay the higher cost-share. That's what we currently do today. The fairness would be making sure everybody's aware of it and has the option so when we make our formulary changes, they know they have the opportunity to request that exception and it's made loud and clear.

Tim Barclay: In terms of thinking what's in the best interest of the member, when I think about Carol's illustration, I've got this person who's on a drug that we're about to say is not covered. It's working for them, they don't want to try the other drugs. Are we being a little bit more compassionate if we tell them you can stay on the Tier 3 copay? Or as the proposal's written, six months from now, no, we're not covering it at all. You're paying 100% if you don't want to go down this other path, which is the hard line we're uncomfortable with. I wonder if as they transition into this new world, if we don't have to offer the lifetime grandfather clause on some of these things.

Donna Sullivan: Would a newly diagnosed user who hasn't tried any of the non-preferred drugs go to a non-preferred drug and do they get 50% coinsurance or do they go through the formulary exception process?

Tim Barclay: I would say new users, it's not covered. That's why this is grandfathering. They have to go through the process.

Donna Sullivan: Okay, got it.

Yvonne Tate: Well, my question would be whatever strategy we use, does it actually achieve the objective of reducing the overall cost of purchasing drugs? That's my concern. If you let somebody stay on forever without having the opportunity to try cheaper options, are we really going to achieve the overall goal that we have, which is trying to reduce the costs of our drug spend?

Greg Devereux: I think under Tim's latest scenario, there still would be savings. Just not as much.

Tim Barclay: And to Greg's point earlier, it's not like we're solving the problem here, right? We're trying to move in the right direction. We're trying to create a tighter formulary. And my initial point was I'd like to not spend more in doing it. To Carol's point, we don't want to inconvenience everybody and make them uncomfortable who's comfortable in their drugs. What I'm trying to do is finagle a scenario where we save something, we're not unreasonable to our membership, we're moving in the right direction, we're creating another tool where we can manage our formulary. We can tighten things down. I'm trying to come up with a

solution that satisfies everybody without negative consequences. It's very difficult to do that. I guess I'm sympathetic to Carol's point about what we're going to be telling people that have to do with their care.

Donna Sullivan: As a follow-up comment, with that proposal, what would happen over time is through attrition, people would transition off those Tier 3 drugs. Eventually, we would get to a situation where we were in our value formulary without this Tier 3. I think several years out we might be at that position. I think this does help get us to where we're trying to go without causing a lot of disruption.

Sue Birch: I want to be very clear. Tim's proposal is for anyone new coming in, no grandfathering, but all current folks grandfathered continue and phase out over time.

Tim Barclay: I think I would be clear on what we mean by new coming in. I think new coming in is, what you mean is not new to the plan but new to the drugs.

Sue Birch: Yes. So is everybody clear about Tim's proposal?

Donna Sullivan: I think I want to caveat what you said. Tim's proposal is not that everybody gets grandfathered. It's some people will get grandfathered forever and we agree they will get the lower cost-share up front because there's a clinical reason not to make them change. The people that would have been in that transition phase, their copays will not change during the transition phase. If they're approved, it'll go down, if not approved, they will continue on the Tier 3 coinsurance indefinitely.

Sue Birch: It sounds to me like we are achieving the value of savings that we were in pursuit of and the value movement. It sounds like we've got an equity position. It sounds like we've got compassion for the client satisfaction, the least client disruption. Is that fair to encapsulate?

Dave Iseminger: Sue, to Donna's point, the bullet might have gotten a little bigger in the outlying years under that proposal.

Sue Birch: Yes. I think the Board needs to take a hard and fast look at no grandfathering three or four years out. This Board might have to decide if that is serving us well because I think we'll have client disruption in those out years. There's an exception process so it's uniform and it will be more well known.

Tim Barclay: I hope through this process we can market this as something very different and can push that exception process. There are people in Carol's cohort who could qualify for the exception process. It would be nice if they knew it. They could pay 30% instead of 50%. That would be a good thing.

Carol Dotlich: I would like to know looking into your crystal ball, do you see an opportunity for the monthly premiums people pay for health insurance to decrease at some point?

Ryan Pistori: At the last meeting, we did present what cost avoidance we would need to target in order to reduce the premiums based on our initial estimates. If we continue to pursue this option, we'll be able to have that cost avoidance continue to grow in future years and that should help reduce premiums in future years.

Dave Iseminger: I do want to caveat when you say "premiums." The cost of drugs for the Medicare retiree population is the current part of the pie that's exploding plan cost - and plan cost equals premium cost. There are a lot of moving parts. The value of the retiree subsidy from the Legislature is one piece. There's medical trend, although it's not the big piece right now. For Medicare, the plan is the secondary payer, so Medicare retirees are feeling the full brunt of increased drug costs. I think Ryan could have oversimplified it because he's looking at it from the optics of the pharmacy piece of the puzzle. That's the current flavor of where the plan costs are exploding. Ryan is looking through a lens of a part of the benefit structure.

Greg Devereux: Just to add to that, I think Carol was referring to the overall premium. What you're saying is Ryan was addressing the pharmacy piece. I could see this reducing the increase. But I don't see premium overall going down. I wish that were true.

Dave Iseminger: Correct.

Carol Dotlich: Our president has been on television talking about reducing the cost of drugs. The Legislature granted a little increase to the subsidy. That should have impacted the premiums for the retirees to some degree. There's talk of expanding the size of the Consortium. What other measures can we take to reduce the costs of the overall premiums for the members?

Dave Iseminger: Carol, you have highlighted a couple pieces of the puzzle. Again, this is just one component for the short term. Another area that I think there's been a lot of focus, and our Legislature's been trying to tackle this issue, is transparency in drug pricing. Even that simple step of exposing the light on where exactly drug costs are these days. There have been bills proposed in the Legislature and debated for the past couple of years that really increases transparency on drug pricing, which can help inform.

Another piece, at the federal level, if there was the ability for the federal government to have direct drug negotiations on the Medicare drugs. That's not something this Board can control. Sometimes there's lobbying from states and often Legislatures pass resolutions saying we hope the federal government takes action on x and y. There's a strong belief that would be a significant piece to help crack this nut. I'm not sure if there's other pieces that you think you could add to the list.

Sue Birch: I think looking at administrative simplification and cutting waste. There's a study by the Health Alliance showing there's nearly \$400 million a year

in unnecessary preoperative testing and blood testing. A new engaged consumerism, people to say, no, I don't want that or I just had that x-ray, I don't need a second one. Creating some of the efficiencies, administrative simplifications, and efficiencies, the use of telehealth. There's a multitude of other strategies, Carol. But it's going to take a lot of time. Obviously, there's just an enormous amount of effort in this state building up more prevention in primary care, lessons in over-institutionalization, less over medicalization. A number of other strategies but I don't see it happening quickly.

Tom MacRobert: Does Washington State have a gag rule or not? The gag rule, as my understanding, is that pharmacists are not allowed to tell you what a cheaper alternative is to whatever drug it is you're taking.

Donna Sullivan: What you're talking about is what some pharmacy benefit managers put into their contracts with their pharmacy networks. The Northwest Consortium, our vendor, MedImpact, who negotiates our network, does not have those gag clauses in our Consortium contracts. There are PBMs in the state of Washington that operate outside of our arena that do have gag clauses in their contracts. I think you might see legislation around that.

Tom MacRobert: Let's say I live in Spokane and there are all these different places I can get my prescription filled. Do we identify the cheapest places in Spokane? In other words, if I go to Fred Meyer, I go to CVS, I go to whatever the different places are, and this one pharmacy is the cheapest by far in the area for most of my medications, do we know who those companies are and can we identify them and get them to our membership?

Ryan Pistoresi: The way that the pharmacy reimbursement is set is we are contracted with the different pharmacies for the different rates. If you go around to different pharmacies, they may have different cash prices but the contracted rate for the network pharmacies is agreed through contract through those pharmacies. Paying through the UMP benefit, it's not different between those pharmacies.

Donna Sullivan: There is a price check tool on our website. You can actually type in your drug and select the drug you're taking. It will bring up a default pharmacy. I thought you could actually change the pharmacy and select the actual pharmacy that you want to go to and it will tell you the difference. You'd have to search each pharmacy differently, but you will be able to tell if there's going to be a significant difference from pharmacy A to pharmacy B on that price check tool.

Ryan Pistoresi: As well as mail-order pharmacy.

Sue Birch: Dave, at this point and with our pharmacy staff, do you feel like you have enough direction from this Board for us to close this issue and for the Board to be prepared to take action at the next Board meeting? Do you feel like you've received enough feedback and guidance about how to come back for a proposed resolution?

Dave Iseminger: Short of asking you to take a straw vote right now, I think we've gotten most of the insight we can get. It did seem there was a lot of possible consensus around what I'll call Tim's proposal for purposes of shorthand that Donna understands very well now. I think there was good insight.

Sue Birch: Just to encapsulate, I saw a lot of head nods and everybody feels strongly about the least client disruption and some empathy and compassion about the transition, correct? We'll call that the Carol amendment.

Dave Iseminger: Yes.

Sue Birch: I think there was agreement about the value proposition and getting the best cost containment strategy, moving towards value-based design. The second element, a uniformity or fairness about the copay. Is that correct? I think we agreed to those three principles, what I think Tim brought forward. Copay was in our years more consistent and uniform. Anything to add, change, or edit about that?

Emerging Medications Update

Ryan Pistoresi: Another pharmacy-related topic, although separate from the value formulary. Emerging medications are new drugs approved by the Food and Drug Administration (FDA) that can have the potential to impact member health care and UMP plan costs. Today we'll provide information about our new process as well as providing the potential cost impact of a new drug approved earlier this year.

Slide 2 is the purpose for providing this information. There is growing concern about rising drug spend, not only within the Uniform Medical Plan, but around the state and around the nation, especially with how new drugs and new drug classes may impact UMP. After rates are established, you'll be talking about in July when you're approving your rates for 2019, new drugs will continue to be approved throughout 2018 and 2019 that can impact how plans spend for those years. It's difficult to look out and project what drug may be approved in August of 2019 that could be impacting the rates you may be looking at next month. One of the major challenges is that we don't necessarily have cost information for drugs until they are approved by the FDA and on the market. While we can anticipate new drugs coming to the market based on clinical trials and when the FDA anticipates their approval, we don't necessarily know what the cost impact will be until the drug is actually approved and on the market.

The Legislature placed a provision in the 2017-2019 operating budget requiring HCA to perform comprehensive cost impact analyses of any new drug placed into a new drug class. The cost impact will be presented to the PEB Board to promote transparency about emerging drug classes and their fiscal impact to UMP costs. Our plan for today is to present some basic clinical information about these new drugs and the potential cost impact to the Board. We do have one drug to highlight at the end of this presentation. It's important to understand the

underlying context of this and how new drugs and new drug classes are reviewed and approved by the FDA.

Slide 3 – Background. There is no set time for when the FDA is reviewing and approving new drugs. In fact, every day at some point, they are in the process of reviewing all the new drugs submitted to them, whether they're Tier 3 drugs, new generics, or new strengths. In 2017, the FDA approved 46 new drugs, which is almost one per week and 80 first-time generics. A new generic means a first-time generic for that medication. They're also doing other reviews so we're also seeing new combinations of drugs. Existing drugs are approved for new indications. If they're being studied for a different disease state, their labels can get updated. There are new formulations so there could be extended release products. There could be new strengths.

The new drugs can impact plan spends because they can change the cost we're currently spending on other drugs as alternatives. They can shift the utilization from existing drugs to the new drug, or they can create new drug utilization and new drug classes. Drugs that meet previously unmet therapeutic need have the greatest potential for changing that utilization and spend. As these drugs are undergoing review, HCA is researching these drugs and determining how they may be covered by the health plan.

The process is outlined on Slide 4. Each week, HCA receives a report, a weekly drug file of all the new drugs loaded into the pharmacy claims system. These systems are how drugs are able to be billed at the pharmacy to the health plan. Each time new drugs are added into that system, we get a report to know they are on the market and ready for members to potentially use.

It's the job of the HCA pharmacist to review these new drugs and determine whether they constitute a new drug class. To clarify, new drug class really is a term of art. Drug classes can be very broad. It could be as broad as the organ system for which they treat, cardiovascular or neurological, the disease state for which they treat, hypertension, or insomnia. Or it could be as narrow as the specific mechanism of action of how the drug works in the body. That drug, its site of where it works, and how it improves the condition. It could be angiotensin ii receptor blockers are a drug class. Or it could be the non-benzodiazepine sedative hypnotics as a drug class. It's up to the pharmacist to be able to look and evaluate, is this really a new drug class.

Once new drug classes are identified by an HCA pharmacist, we begin to perform that comprehensive review, really looking at the safety, the efficacy, the relative effectiveness of these drugs, as well as the cost and potential value of these medications to HCA leadership. As part of this, we'll be looking at the cost analysis to see what type of impact it might have to the UMP budget. Once that process is complete, we'll be able to present a summary of these new classes and the projected UMP budget impacts to the PEB Board, which is where we are today.

Slide 5 is the first of the drugs going through this new process. The medication we're highlighting today is called Ibalizumab-uiyk, also known as Trogarzo, which was approved by the FDA on March 6, 2018. This drug is a new drug class because it treats a subset of HIV patients that had very few treatment options available to them. This drug is approved for patients who have multidrug resistant HIV and who have failed other drug classes of HIV treatment. Patients have tried multiple other HIV treatments. Their HIV is not under control. They still have viral load in their body. This medication is approved for these types of patients. In our cost analysis, we anticipate maybe two to four UMP members may be appropriate for treatment after reviewing the safety and efficacy from the clinical trials. Our cost estimates to treat these two to four members could cost UMP between \$200,000 and \$400,000 in 2018. This is a lifelong treatment because HIV is a lifelong disease and this treatment would continue for these patients in future years.

Carol Dotlich: Is that an annual cost or is it a six-month cost, this \$200,000 to \$400,000?

Ryan Pistorosi: The cost projection is for 2018. It is anticipated some patients may start treatment this month and others may start treatment in November. It's looking at the annualized cost for 2018. This budget impact is looking at how members may be transitioning into using this drug.

Harry Bossi: What's the dosage and what's the cost of the dose?

Ryan Pistorosi: That's a good question. The cost of an annual dosage is about \$100,000.

Harry Bossi: If there's ever any good news like something coming off of patenting on a generic and it's a big one for us, throw that in there too! [laughter]

Ryan Pistorosi: We'll look to present good news for the plan, too.

Dave Iseminger: Donna passed me a note for clarification. Earlier today there were drug examples discussed and Donna confirmed Lyrica is Tier 3 not Tier 2, as was discussed earlier. I want to correct that on the record.

Carol Dotlich: When I asked you about the cost per year, I should have asked you, what is the copay for these members for this drug?

Ryan Pistorosi: The drug is administered under the medical benefit. It depends on where the member is in their medical deductible, and potentially what the out-of-pocket maximum is. I believe for this medication, it is 15%, although I can verify that for you.

Sue Birch: Donna is saying yes.

Ryan Pistorosi: Okay, yes, 15%.

Dave Iseminger: We'll try to include member cost-share information for future emerging drug updates. That's a good update for future presentations.

Proposed Annual Procurement Plan Changes

Beth Heston, PEBB Procurement Manager, ERB Division. We are in the annual procurement phase. We received proposals for the fully insured plans. I'll start with Kaiser Permanente of Washington, formerly Group Health. They have come to us with a proposed bundle plan change. The first bundle is to expand the network for SoundChoice. SoundChoice currently operates in Snohomish, King, Pierce, and Thurston Counties and they would like to add Kitsap and Spokane Counties to their coverage areas. They would also like to make the following SoundChoice plan changes:

- Lower the deductible from \$250 to \$125 per person and from \$750 to \$375 per family. For wellness participants, if they received the \$125 incentive, the individual would have zero deductible.
- Lower primary care visit coinsurance from 15% to a zero dollar copay.
- Change inpatient hospital services from \$200 per day up to \$1,000 maximum. They want to change that to a \$500 per admission with no maximum.
- Remove massage therapy from the traditional physical therapy, occupational therapy, speech therapy category, which has restrictions on the number of visits and make it unlimited number of visits.

Harry Bossi: Beth, about the massage therapy. They want to remove it from a limitation?

Beth Heston: Yes.

Harry Bossi: But charge the same price? There's a copay so it's the same way, right?

Beth Heston: Yes. But there would be no limit. Now, I believe you get twelve.

Harry Bossi: But is it not coded and billed as specialty as opposed to --

Beth Heston: Yes, and that's what they would move it out of.

Sue Birch: I want to ask a clarifying question about the massage. It's medical massage.

Beth Heston: It has to be prescription.

Sue Birch: It still needs to be a medical necessity.

Beth Heston: Yes. Exactly. It would still have to be approved by your primary care physician. It wouldn't be self-referring. Also, those changes are a bundle package they've offered us.

Slide 5 – Plan Design Changes. Please ignore the first bullet under the Classic Plan because there is an error.

Dave Iseminger: Except, Beth, would it represent a change, impact members, or is it really clean up?

Beth Heston: It's clean up. It's a mistake in the benefit chart. Their next plan design change is to add a virtual diabetes prevention program offered through Omada. It's the one with the wireless scale available for people who don't have a YMCA nearby. They already offer the in-person diabetes prevention program at the YMCAs. This would be in addition to the in-person program.

Carol Dotlich: If you live near a YMCA, would you not be eligible for the virtual?

Beth Heston: You could still choose to use the virtual. It would be whichever one you prefer.

Kaiser Permanente of the Northwest changes. Their first proposal was to add Lane County, Oregon to all plans. I've received an update from them that I missed two words in their response, "Medicare to follow." They've applied for permission from Centers for Medicare and Medicaid Services (CMS) to offer this in Lane County to Medicare subscribers but they haven't been approved yet. For now, this change would only apply to active employees and to the plans active employees are enrolled in, so CDHP and Kaiser Classic. We have about 101 members, the majority of them are Medicare but I believe there are 47 active members who live in Lane County. This would enable them to see local doctors.

Slide 8 – Plan Design Changes. They would like to add a fitting fee of \$30 to all contact lens exams. KP Washington already does this. The UMP pays \$65 and any amount over that for the fitting is out of pocket. It's not really a set amount. It depends on the Optometrist, Ophthalmologist. They also would like to add a prescription drug tier and cost-share up to a maximum of 15%, and that is after deductible on CDHP for self-administered chemotherapy. That was to align themselves with legislation that was passed.

Slide 9 is the change to durable medical equipment (DME). They would like to add a 20% coinsurance to these durable medical equipment items: antral pump, formulas and supplies, continuous ambulatory drug delivery pumps, osteogenic phone simulators, osteogenic spine stimulators, and ventilators. There is a 20% coinsurance in KPWA. We believe there's 15% in UMP, but UMP also has a preferred network for DME. We'll have details at the next meeting.

Tom MacRobert: Beth, is the CADD, is that for a diabetic where they wear --

Beth Heston: That's an insulin pump most often. There are other drugs it could be used for, but insulin pump is the one we're most familiar with.

Sue Birch: I want to clarify. I don't think it's the continuous glucose monitor part. I think it's the pump part.

Beth Heston: Yeah, it's the pump.

Sue Birch: Two different devices.

Beth Heston: Yes, as opposed to monitor.

Sue Birch: I think I'm correct.

Dave Iseminger: We'll follow up at the next meeting.

Beth Heston: Yes, to make sure it's the pump and not the monitor.

Greg Devereux: How does the 20% compare to now?

Beth Heston: There's no cost-share now.

Dave Iseminger: KP Northwest Plan design right now is zero. There are cost-shares in some of the other plans.

Beth Heston: Yes. The other changes are ones you're familiar with from the January Retreat. We spoke to you about adding to the Uniform Medical Plan a virtual diabetes prevention program. For the Uniform Dental Plan we wanted to reduce the limit on Class III restorations from seven years to five years. Those are this year's proposed changes and we are still negotiating.

Greg Devereux: I'm going to show my ignorance because I have never used contact lenses. Back on Slide 8, would this be a \$30 charge every time you get fitted?

Beth Heston: Every time you get a new prescription, they fit your contact lenses. If your prescription doesn't change, you wouldn't have to pay the fee.

Greg Devereux: It's just \$30?

Beth Heston: Yes.

Katy Hatfield: May I say something before you go to public comment? I wanted to correct one thing on the agenda and correct something Chair Birch said at the beginning of the meeting regarding Executive Session. It was only to discuss proprietary and confidential non-published information. We did not have any discussion regarding any current or litigation with council. There are two things listed on the agenda of why we met in Executive Session, but it's only one of them, that was the actual reason for Executive Session. I wanted that to be clear.

Dave Iseminger: For the record, you actually said it the right way. It's the agenda that's wrong because I have my annotated agenda, which you read that sentence. And I remember correcting it for the annotation.

Katy Hatfield: I just want to make it clear we did not talk about litigation.

Public Comment

No public comment at this meeting.

The next meeting of the PEB Board is June 20 from 1:30 p.m. to 4:30 p.m.

Preview of June 20, 2018 PEB Board Meeting

Dave Iseminger: At the June 20 meeting, you are going to take a vote. That's one of the primary parts of that meeting. I do want to be very clear, whatever your decision is, it is critical to have a decision on June 20 to be able to complete rates and bring you rates during the July process. Whatever your action, we will know the answer to the UMP value formulary question that we've been talking about for several months and several years at this point. We will bring back follow-up questions that Beth was eluding to regarding the fully insured plan proposals.

Carol Dotlich: Will we receive well in advance the amended resolution?

Dave Iseminger: We will provide the Briefing Book on the same timeline we always do.

Carol Dotlich: I'm not asking about the Briefing Book in total. I'm simply asking about the resolution itself.

Dave Iseminger: We'll see what we can do to provide the proposed resolution to the Board as early as we possibly can.

Sue Birch: But certainly, it will be the Friday before the meeting at the latest.

Meeting adjourned at 3:31 p.m.

Public Employees Benefits Board
Meeting Minutes

D*R*A*F*T*

June 20, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 4:00 p.m.

Members Present:

Sue Birch
Greg Devereux
Tim Barclay
Carol Dotlich
Yvonne Tate
Tom MacRobert
Myra Johnson

Members Absent:

Harry Bossi

PEB Board Counsel:

Katy Hatfield

Call to Order

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

Meeting Overview

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

UMP Value Formulary Follow-up and Policy Resolution

Ryan Pistori, Assistant Chief Pharmacy Officer, Health Care Authority. I will respond to questions from the June 7 meeting and then ask you to take action on the policy resolution before you today.

Slide 2 – Questions. The first question was on the current structure of the UMP formulary. I have listed the five tiers for the UMP formulary. There is Preventive Tier, Value Tier, Tier 1, Tier 2, and Tier 3. The Preventive Tier are drugs required under the Affordable Care Act, or recommended by the United States Preventive Services Task Force (USPSTF). The Value Tier are the specific high-value medications to certain chronic conditions, like hypertension, cholesterol, diabetes, depression. Tier 1 are primarily the low-cost generic drugs. Tier 2 are the preferred brand name drugs, as well as any high-cost generics. We do have some staggering of the generics between Tier 1

and Tier 2. Like the generics where we have the staggering, the same applies for the brands where the preferred brands are in Tier 2 and then any non-preferred drugs, primarily the non-preferred brands are in Tier 3.

Dave Iseminger: We wanted to make sure we brought what the current formulary is because there were some questions about the use of the phrase "Value Tier". The Value Tier Ryan just described was put in place by Board action in 2012. That unfortunately has the same word "value" in it, but that's not to be confused with the value-based formulary principles we've been presenting to the Board.

Ryan Pistorresi: Slide 3 - What would happen to some of the drug classes? How would they be impacted? We brought two different drug classes today that we previously proposed as part of the value formulary, which are the androgens and the insulins. Slide 4 is a table showing the current structure of the androgen drug class. You'll notice we have a few different drugs listed. Most of the different drugs are listed under the testosterone. Across the columns are the different tiers. This slide shows how the drugs are placed within the androgen drug class. With the value formulary, we would be affecting the drugs that are currently in Tier 3 and requiring members to use Tier 1 or Tier 2 alternatives prior to allowing the Tier 3 drugs to be covered.

Dave Iseminger: Ryan, to be clear, that would be new diagnoses being treated.

Ryan Pistorresi: Correct. You'll see a little later we do have the edited clause in the policy resolution that will grandfather members on the current cost-share based on suggestions from the June 7 Board Meeting. Newly diagnosed members would be directed to the Tier 1 and Tier 2 alternatives prior to Tier 3.

Dave Iseminger: Ryan, let's plain talk this. If you are currently taking a Tier 3 testosterone drug listed, and if the Board passes this resolution, what would happen to you?

Ryan Pistorresi: I would continue to take it at the current cost-share.

Greg Devereux: If a generic came on the market, do you get switched to that?

Ryan Pistorresi: Yes. The policy resolution states that when a drug becomes a multi-source brand, members switch to the generic alternative. It's the same drug, same strength, same dose, same route and it's approved by the FDA to be interchangeable. At the pharmacy, it's the same drug. State law requires that there is generic substitution for drugs.

Dave Iseminger: Ryan, will you clarify for the Board, if they don't take action today, my understanding is what you just said applies in today's current formulary. Regardless of their action today, it is exactly what would happen. If you were on the testosterone drug that went generic and there was a generic version with the same exact mechanism, the same exact strength, you would be switched to generic. That's already the current policy of how the UMP formulary works.

Ryan Pistorosi: Correct. Drugs that go from single-source to multi-source are automatically moved to Tier 3. In this, the drugs are already Tier 3 so they would stay Tier 3.

Dave Iseminger: Another example: I go to my doctor in February 2019, the Board has passed the resolution, and I have a need for one of these testosterone drugs. My doctor wants me to have AndroGel. What would happen?

Ryan Pistorosi: In that example, you are a member newly diagnosed and being treated. At the pharmacy they would say, "This medication is not covered but there are alternatives for you to use first." The Tier 1 drugs are injectable testosterone and Tier 2 has a few different topical testosterone. You would be directed to these different testosterone products.

Dave Iseminger: If I go through those and they don't work for me, then my doctor can request AndroGel?

Ryan Pistorosi: Yes. If you try the lower-cost alternatives and you don't get the right therapeutic effect or you have adverse events related to them, your doctor can submit a request saying, "My patient has tried these and is requesting this non-preferred product." You would be granted an approval after a review.

Dave Iseminger: The only reason what you just described applies to me is because I'm a new diagnosis. I would have been grandfathered if I already had been taking a Tier 3 drug.

Ryan Pistorosi: Correct. We don't want to interrupt members who are currently stable on their drugs.

Sue Birch: Can you clarify the copays in this scenario?

Ryan Pistorosi: As a member that was currently using the drug, I was paying Tier 3 or 50%. After January 1, 2019, I would continue to pay 50%. I could still qualify for a Tier 3 exception. I could go through the process and try to qualify for a Tier 2 copay in that example. For Dave's example, he would be directed to either the Tier 1 or Tier 2 drugs first, which would be about \$25 per month copay, or for the Tier 2 drugs, \$75 per month copay.

Tom MacRobert: Using Dave's example, he was just diagnosed. His doctor says that he should take AndroGel. Does he have to test all five of drugs before getting AndroGel?

Ryan Pistorosi: In this example, it may depend on Dave's situation. In Tier 2, we have the gel and the gel pump. They are the same drug. If Dave tries the gel, we wouldn't force him to take the gel pump. If he had a reaction or it wasn't working for him, he may not necessarily need to try the gel pump. He would need to try the topical solution because it may work differently. There may be something in the gel that reacts with his skin. It doesn't necessarily mean the testosterone's not working for him. We would direct him to the topical solution as another alternative for a transdermal testosterone product.

Sue Birch: I want to clarify. Being a nurse, I believe the physician would be working with those routes of the medication anyhow. It's not, in this particular case, because one being topical and the gel pump being a different -- or is that topical too?

Ryan Pistorresi: Both of those products are topical. The gel and the topical solution are both placed on the skin. The pump is like a moisturizer pump.

Slide 5 has a different drug class. The insulin drug class has different types of insulins. There are short acting insulins, when administered, provide insulin that works immediately. There is also intermediate insulin, when administered, has a longer duration of action. There are long-acting insulins, typically administered once a day and mimic a basal insulin, that baseline insulin you have running throughout your body throughout a normal day.

Within this drug class, there are many different products spread between the Value Tier, Tier 2, and Tier 3. In this example, Tier 3 products are considered long-acting insulins. The long-acting insulin in the Value Tier is Basaglar. In the case of the value formulary, the only insulins impacted are the long-acting insulins. Members taking short-acting insulins, intermediate insulins, and mixed insulins, which are a mix between intermediate and short, would not see a change. Members currently using Tier 3 long-acting insulins would not see a change. Those impacted are newly diagnosed members that need to be on a long-acting insulin. In this example, there is a Value Tier option available to them, which is Basaglar. There are a few other insulin glargines, but in case it's not effective, or there are adverse events - injection site reactions or other issues - they would be able to step to Tier 3 products.

Greg Devereux: How many total drug classes are there? A dozen?

Ryan Pistorresi: At the last meeting, we showed eight drug classes from the twelve presented.

Greg Devereux: So is that a dozen or eight? My question is how many drug classes and how many total drugs within those classes?

Ryan Pistorresi: We are proposing eight drug classes now.

Greg Devereux: In Tier 3?

Ryan Pistorresi: In all of Tier 3, I believe there are 350 drugs.

Carol Dotlich: When you say there are 350 drugs, is that the number of drugs impacted by this proposal?

Ryan Pistorresi: No. That is what I believe are the number of Tier 3 drugs in the UMP value formulary. I would need to get back to you on that number.

Dave Iseminger: Ryan, for clarity, are you saying there are 350 drugs total in Tier 3 across all drug classes? Is that your estimate?

Ryan Pistorosi: That is my estimate but I would need to get back to you to confirm. There is a number from the model that lists Tier 3 drugs as 350. I don't know if that's the drug classes we were looking at or across all drug classes because we were not evaluating all drug classes in the last iteration of the value formulary model.

Carol Dotlich: Can you give us an assessment of how many drugs would be impacted by this current proposal?

Dave Iseminger: Perhaps we take all the questions and have Ryan check the formulary as we move on to another presentation and come back with accurate answers for your decision today.

Greg Devereux: To follow-up on Carol's question, what I was asking earlier, are we trying to avoid people using Tier 3? How many? I think it's the same question -- how many are in that category of the classes that we're going to impact -- so 350 sounded like everything in Tier 3.

Dave Iseminger: Ryan's going to confirm: a) if 350 is the right number, b) if it's the entirety of the Tier 3 formulary, or c) if that's just the subset for the eight drug classes; and if it's not the subset for the eight drug classes, the number of drugs related to the subset of eight.

Tom MacRobert: So that 350, I thought you said 353, actually, not 350. Did I hear that wrong? Anyway, are the drugs in that category for the eight ones that we're looking at, not any of the four that we're not looking at? So that 350 represents the eight classes that we're considering?

Ryan Pistorosi: I'll check. I will be able to confirm that later in this meeting.

Carol Dotlich: For clarity's sake, the 47,000 people already on Tier 3 drugs would experience no impact from this proposal. Is that correct?

Ryan Pistorosi: Yes. The 47,000 people currently using Tier 3 drugs would not see a change with the value formulary because they would continue to receive the medications they've been prescribed at the same cost-share.

Dave Iseminger: To dovetail onto that, there is that piece, when a drug goes from single-source to multi-source and members moved to a generic. That's happening already under the current formulary and isn't something that would change on the policy proposal that's before you. I just do want to be clear, Carol, that if one of the drugs that those 47,000 members are taking, there is suddenly a generic that comes out, those people would experience a change. They would experience that today regardless of what the Board does on the resolution today.

Sue Birch: And that's because we're a generic-mandated state. When something goes generic, we are already mandated to move them into that provision of generic drugs.

Dave Iseminger: Ryan's going to go confirm numbers and we'll keep going through the presentation. Slide 6 you have seen many times. It's a quick overview of the general

principles the agency used and discussed with the Board as the basis for bringing forward a value formulary design for the Board's consideration.

Slides 7 and 8 have a refined version of the resolution we've been working on with the Board. Slide 7 doesn't have changes so I'll focus on Slide 8 where there were modifications to both bullets based on the discussion the Board had on June 7. If we focus on the third bullet - members who have been taking a non-preferred drug will be grandfathered at the Tier 3 cost-share unless they receive, or have already received, a cost-share exception. The refinement is based on concerns Board Members had about grandfathering being a permanent state. That last clause ensures individuals who have already gone through the Tier 3 exception process and paying a Tier 2 cost-share are not inadvertently moved back to their Tier 3 copayment rate. This modification essentially leaves individuals in a grandfathered status who are already taking a Tier 3 drug, those 47,000 members that Carol was referring to a few minutes ago.

The fourth bullet is reinforcing the policy that already exists when a drug goes from a single-source brand to a multi-source brand where individuals move to the generic alternative. We want to be clear and transparent about how those 47,000 members, if something goes generic, they transition to the generic at that point. Both provisions have had slight modifications to account for that. This makes it a prospective application policy for individuals newly diagnosed, directing them to preferred drugs at that point.

Carol Dotlich: Is bullet 4 already in place?

Dave Iseminger: Yes. That concept already exists within the UMP formulary. We actually struggled with whether we should reinforce it and leave it on the page, but we thought it was important for the context of the discussion to be very clear that if an individual is already on a Tier 3 drug, any time a generic comes out, they move to the generic setting.

Tim Barclay: Can we add language on the first bullet on Slide 7? Correct me if I'm misunderstanding something, but I believe this is the definition of what someone needs to do to qualify for a Tier 2 cost-share instead of Tier 3. Can we make a point here of when a person has met this criteria and eligible for the Tier 3 drug, they would pay the Tier 2 cost-share? There's some value to the member for having followed this process of trying the non-Tier 3 drugs before moving to that point. Can we make that point in this resolution that it actually has a positive impact on the member from a cost-share perspective?

Sue Birch: Tim, so could you clarify for me? You're suggesting we insert a second bullet point or a third?

Tim Barclay: No, I think this bullet point just needs enhanced.

Sue Birch: Please read what you're proposing.

Dave Iseminger: We're creating a record now that stands the ravages of time. If the Board is clear, I understand the point that you're making, and it provides that additional context to individuals who are reading the slide, so to speak. If the Board understands

the intent of it and that is really the underlying inference of the impact to the member who might go back and read this, I would suggest that you could also develop that understanding in the record, as well as an alternative to modifying the words on the page.

Tim Barclay: And that's fine. I think it is important, though, that when we communicate this, at some point, the communications team is going to have to present this to members.

Dave Iseminger: We have three communication team members in the audience taking diligent notes.

Tim Barclay: To them I would say please make sure we emphasize the point that there is a cost-share value to members for having followed this process. Then that's good enough. Thank you.

Yvonne Tate: I see that as more of a procedural issue than a policy issue. I agree. If you do it, you suggest, that'd be fine.

Carol Dotlich: I would like to state for the record that it's always better for the consumer, the member to know exactly what the resolution says. I think it's important to have that language and I don't think it's very troublesome to just put a sentence in place. I would like to see that change.

Sue Birch: I would like to hear the specific language change you're both suggesting because if we were going to put it anywhere, to me, it would be in the beginning portion. But I believe that it's already inherent in this notion of moving forward with value-based formulary. For example, Tim, are you suggesting, in the opening preamble, Resolved that, beginning January 1, all UMP plans require the use of value-based formulary so as to increase member's value orientation? Are you suggesting we put it there? Or how exactly are the two of you suggesting it be reworded?

Tim Barclay: It almost needs to be a subordinated comment underneath the first bullet that says, "After following this procedure, the member would pay the Tier 2 cost-share instead of the" -- that's not the right language but, "instead of the Tier 3. Grandfathered members taking that drug will continue to pay the Tier 3 cost-share. People who follow this process and end up in the Tier 3 drug will pay the Tier 2 cost-share." And the reason I think it's important is because as we've talked before, we're not really clear about this exception process in our communications to members now. It's not clear on the website that this exception process exists. I fear this is going to be perceived as a take-away and it's not, right? It's a procedure. We're not impacting existing members. People who follow this process actually get an advantage at the end of the day. I'd like to make it clear so we're not sending an incorrect message that somehow this is a big restriction, a big take-away of benefits.

Sue Birch: I hear the intent of what we're proposing. I'm just struggling with how you want to word it and I'm trying to see a third bullet point, if there's a way we could modify that.

Yvonne Tate: Again, I think these are procedural issues more than policy. Generally speaking, your policy statement is very broad based and your details around that policy are included in procedures and communication documents. I'm just afraid we're crossing the line between procedure and policy. That's my two cents.

Myra Johnson: Would something like a footnote at the very bottom of it, saying something about grandfathering? I'm not sure about language, but something about Tier 2 or Tier 3 or even grandfathering maybe, just a small footnote so it's not a loss for members. Would something like that work, Tim? I don't know. Instead of placing it actually in a bullet, maybe a footnote at the end of all the bullets?

Tim Barclay: It would work for me.

Myra Johnson: Would that still make it more of a policy, because it would be more like informing?

Yvonne Tate: Well, the agency puts together a whole packet of open enrollment information for employees that clarify not only this proposed policy but other policies by which the agency operates under. I just think it's more procedural and fits better in any open enrollment communication you're going to give the staff.

Dave Iseminger: I would say we've received quite a lot of suggestions about how we can beef up the description of the exception process and our communications teams will be working on that as well. I want to reassure the Board that is also in the works. We've had quite a lot of feedback about ways to improve that communication and that's in our pipeline as well.

Sue Birch: I see heads and staff members over here, I think, wanting to help assure the Board about the member orientation process. Is there something staff want to add to clarify that this is taken care of in the procedures?

Barbara Scott, Policy, Rules, and Compliance Section Manager, ERB Division. I think what Renee Bourbeau's staff are saying is that as we roll these things out into open enrollment communications, there is a good amount of plain talking done to help this type of detail make sense to members. They are in the back thinking how best to write this which will look plain talked from what the resolution will look like today. In some instances, we pick your resolutions up and drop them in, especially when it comes to rule. But when it comes to our communications, Renee's team is very used to plain talking things so it makes sense to the members.

Scott Palafox, Deputy Director, ERB Division. The other piece I want to add to hone in on Tim's and Carol's concern, as well as add strength to what Yvonne is saying, is that when we communicate this type of information in our newsletters and open enrollment material, and often plain talk it, we also use those communications as a means of substantiating the policy side of it. If anybody has a question of whether or not that was in or out, they can refer back to that newsletter or communications that holds value to not having it in a policy. But at the same time, making sure we shed light on it.

Tim Barclay: Scott, could you talk about the timing of the release of that information relative to the public availability to this Board resolution? How much of a gap in time is there between the two?

Scott Palafox: By the time decisions are made in July, we start to formulate the communications for open enrollment. We'll have a September newsletter and, in October, information goes out to all members explaining the changes made as a result of the decisions approved by the Board.

Dave Iseminger: Tim, those are direct member communications that occur for open enrollment. But we've been working very hard this past year as your sister Board takes actions, of having news releases on the website that plain talk versions within a couple days. This is really the first action the PEBB Board will take this year so I can imagine as we develop a newsfeed within the next two to three business days, we would have a preliminary plain talk version that goes along with it rather than leaving just the resolution out there. Now, anyone in the public could see this resolution and the words, which is where I think your concern is coming from with the delay from member communications that hit people's mailboxes in October versus an action taken today. We do work on plain talking our language and talking about actions the Boards are taking in part of our newsfeed. I can see a more direct upfront plain talking that comes out in the next couple of business days, to give context to the Board's action today.

Sue Birch: Dave, has staff or you received any concern to this point of confusion? Has anything come in as we've posted publically and people know that we're working on the construct of the value-based formulary? We receive input at Board Meetings, but has anything further come in to your knowledge?

Dave Iseminger: None that I'm aware of.

Carol Dotlich: I've received responses to the survey that we did. Are you interested in hearing those or not?

Sue Birch: I think it would be important to share that.

Carol Dotlich: Okay. We put the original proposal out to the membership and asked for feedback. I have a couple of examples of what I'm hearing back. "I'm unable to travel to Olympia for the hearing on this proposed change to our medical benefits. As a retiree with health problems, I'm concerned about what this proposal will do. It looks like it puts a decision on our medication in the hands of the insurance company instead of my doctor. It's my opinion that my doctor knows more about my needs than an unknown medical insurance provider. 'Medically necessary and clinically appropriate' puts an unreasonable burden on the physician to justify every medical drug decision they make on my behalf. Many generic drugs have caused undue stomach and bowel disruptions that required a change to either brand name drug or in some cases, no drug at all. My doctor is already too busy to see me without a month or two month wait for any appointment. The required documentation that these changes require will make further demands on his time that will prevent timely appointments. I hope this makes my position clear." It's signed by the retiree.

Dave Iseminger: Carol, the way the Board's conversation went on June 7 and how this resolution changed I would think addresses many of the concerns. This individual would not have to go to their doctor to maintain the current drug they're under. They could continue on their Tier 3 drug. The resolution as it's written now is prospective only and affects me when I get my new testosterone diagnosis and asking me to try the earlier tiers before the Tier 3 drugs. Hopefully, there are assurances to the concerns raised in that particular --

Carol Dotlich: I'd like to read a second one, if I might.

Sue Birch: Go ahead and proceed. I do think it's important to understand the timing. I'm unclear of the timing of when this survey went out, but go ahead.

Carol Dotlich: "I have a major concern with the new proposal in the email that was sent out yesterday." This one came in June 19, to give you sense of date. "At one point, somebody at a desk in the insurance office decided that there was another similar medication that I should use instead of the one my doctor prescribed. Insurance would not pay for my medication, which already had a very high copay unless I followed their mandate to try something else. I became very ill and still had to argue with them to go back to what my doctor and I knew was working for me. It scares me that someone who's never met me has so much power over deciding what medication I'm allowed to take. That decision should be between me and my doctor. Currently, I'm trying a new drug that is beginning to show results and I'm fearful that someone in an office will decide it's not medically necessary. What works for one person may not work for someone else. Medicine is both art and science. And treating patients as numbers in a formula is damaging and degrading. I pay nearly \$700 a month out of my own pocket for medical and I expect to get my care based on what my doctor feels is best for me, not what a bureaucratic desk thinks is medically necessary for the average person. Please do whatever you can to protect those of us who have medical issues that are not average and need medications that may not be the same as everybody else."

I just want to reiterate, on behalf of the retired people I'm here to represent, 60% or so are already using the generic medications available in place of the preferred drugs. That's over half. I think that tells you pretty well that people are trying to save money where they can on their medications. I understand the problems we're facing with the pharmaceutical companies and the costs. I just wanted to share some perspectives of some of the people that have contacted me.

Dave Iseminger: I appreciate that you've gone to the efforts to bring more perspective of the individuals you're representing, the members and those situations. I do want to reiterate the way the policy has changed because of the Board's discussion. The individuals currently taking Tier 3 drugs are not impacted. The only way they're impacted is if something goes generic, which already would happen to them today under the current policy. I understand the sentiments you've raised through the members that are responding. But I want to make sure the Board knows the proposal before them wouldn't result in some of the concerns people reading the slides may think will occur under the policy, which gets back to plain talking and helping members understand the impact of a policy decision today.

Carol Dotlich: I think it's important that the resolution contains plain talking language, which is why I supported Tim's idea about putting the advantage to the member into the resolution itself, because whatever happens, it's a public document. They're not going to read all the notes around it. They're going to read the resolution and understand it as the resolution is written.

Tom MacRobert: The original draft of the resolution and subsequent draft said that people who were taking a Tier 3 drug and had been taking it for more than a year, would be grandfathered. And people who were taking it for less than a year would not. Has that been removed from the resolution and there's no timeframe? If you're taking it now and you've been taking it for a week, you're not going to be affected?

Dave Iseminger: Tom, you've hit the nail on the head as to the functional change of that third bullet. Before, there was a year grandfathering clause and a description of a transition period. This is a permanent grandfathering clause, so to speak.

Sue Birch: Tim, I would again ask for your specific recommendation. Or if you're asking staff to craft in a value statement, that's a different recommendation. I need to know.

Tim Barclay: Let me give you a first draft and we can dismiss it or edit as you see fit. I would propose adding a new second bullet point to the resolution that reads, "Non-grandfathered members that have qualified for Tier 3 drug coverage are eligible for reduced Tier 2 cost-sharing."

Sue Birch: Could you repeat that again?

Tim Barclay: "Non-grandfathered members that have qualified for Tier 3 drug coverage are eligible for reduced Tier 2 cost-sharing."

Sue Birch: Where do you want that placement on the resolution?

Tim Barclay: I would like that to become the second bullet point placed between what is now the first and second bullet points on the resolution as it sits.

Tom MacRobert: Could you read that one more time, please?

Tim Barclay: "Non-grandfathered members that have qualified for Tier 3 drug coverage are eligible for reduced Tier 2 cost-sharing."

Sue Birch: Thank you, Tim, for that clarification. We don't have a motion on the floor or an amendment. We are in discussion, so I would now like to ask staff to take us back through the testosterone example and help show that this language would either clarify, confuse, or how it might impact the examples that have been portrayed.

Ryan Pistorosi: It may help to move back to Slide 4 where we have the names of the drugs. To walk through this example with Tim's amendment, we'll be using Dave. Dave would be the example of the non-grandfathered member. Dave has tried the Tier 1 and the Tier 2 testosterone products and they're not working for him. Dave's provider requests one of the non-covered drugs, the Tier 3 non-preferred drugs. Dave qualifies

because he has tried those products and qualifies. Dave could also request the Tier 3 exception. And the Tier 3 exception requires that the members try the other products and if they don't work for them that then they can qualify for the Tier 2 cost-share. Is that what you intended with your amendment?

Tim Barclay: Yes.

Yvonne Tate: That just sounds so procedural to me. It's not policy.

Sue Birch: Yvonne, thank you for your comment. That was the purpose of asking these gentlemen to go through that process because it's still not very plain speak. I still don't think members are going to get it, but I see what you are trying to do. As Yvonne is pointing out, we're trying to figure out how best to help our members to assure that. It appears staff support this idea if it helps members be clearer. Yvonne, would you be okay with it? It's highlighting this value proposition.

Yvonne Tate: Yes, but if I were highlighting the value proposition, I would be using paragraphs and pages, more than just a sentence in a policy to highlight what the change is and to help people understand that. I just think it requires more interaction, more information than what the policy is typically designed to do. That's just my two cents. This isn't going to clarify it enough that you still won't have to have conversations with people to make it clear.

Sue Birch: So in the interest of time, I think it's important we keep discussing this but also move forward because we need to get public comment.

Dave Iseminger: Ryan is back with data for some of the prior questions.

Ryan Pistorosi: To respond to the questions asked earlier, there are a total of 758 Tier 3 drugs. The 350 that I said earlier is the number of single-source brands on Tier 3. To Carol's question, there would be 143 drugs impacted in the eight drug classes proposed at the last meeting. 71 of those are single-source and 72 are multi-source.

Sue Birch: For the proposed change to the resolution, Yvonne, I know it's somewhat procedural but I think it gives some of our Board Members more comfort and clarity. Would you be opposed to moving forward with Tim's suggestion?

Yvonne Tate: I want to do what's best for the good of the order.

Sue Birch: I would suggest at this point, we move forward with Tim's amended language.

Katy Hatfield: Probably the easiest way to proceed is to have somebody motion to approve it as written and then seconded. Tim can move to amend it. We will vote on the amendment. If the amendment passes, we will vote on it as amended. If the amendment fails, we will vote on it as originally stated.

Sue Birch: Katy, can you advise us at which point it's best to take public comment on all of those iterations?

Katy Hatfield: I would suggest we take public comment before each vote, before a vote on the amendment and then public comment before a vote on the ultimate resolution, regardless of whether or not the amendment passes or fails.

Tom MacRobert: Katy, two votes, correct? First on the proposed change, adding it in, and then second on the whole resolution whether it's amended or not?

Katy Hatfield: Correct.

Sue Birch: Let me restate that. I'm going to read the resolution as staff had originally prepared, ask for a motion to adopt and a second, Tim will come forward with his amendment to the motion, and we will continue to proceed through that process. Correct?

Katy Hatfield: We can take a five-minute recess for staff to type up the amendment so everyone can have it in front of them as they vote on the amendment. Then if it passes, we'll vote on the whole thing with that amendment. If it fails, we'll delete that amendment and vote on the original.

Myra Johnson: Isn't that the opposite of what we said? I'm so confused right now.

Sue Birch: So I think at this point I would like to take a five-minute break so that we can get the commensurate written documentation so people aren't just hearing it but they're reading it.

[recess]

Sue Birch: At this point, I'd like to read the original resolution, and ask for a motion to adopt and a second. Then we'll have discussion, and I imagine Tim will request an amendment. I'll ask for public comment at that point.

Policy Resolution PEBB 2018-01 – Value Formulary.

Resolved that, beginning January 1, 2019, all UMP plans require the use of value-based formulary with:

- a select mix of drugs within a drug class that are covered only when medically necessary and all preferred products have been ineffective or are not clinically appropriate, and
- Multi-source brand drugs being covered only when medically necessary and clinically appropriate, and
- Members who have been taking a non-preferred drug will be grandfathered at the Tier 3 cost-share unless they receive or have already received a cost-share exception, and
- The grandfathering for brand name drugs ends when a generic alternative or an interchangeable biologic becomes available (the drug becomes a multi-source brand and is subject to medical necessity)."

Yvonne Tate moved and Tom MacRobert seconded a motion to adopt.

Tim Barclay: I move to amend the proposal to add the additional bullet point that non-grandfathered members who have qualified for Tier 3 drug coverage are eligible for reduced Tier 2 cost-sharing.

Myra Johnson: I would like to make an amendment to Tim's amendment. Is it a friendly amendment? Is that procedural? I would like to add the word "automatically" in front of "eligible" so it doesn't imply they would still have to apply for it. It would be an automatic given, which I think is what we're trying to clarify and make clear.

Dave Iseminger: Can I make a parliamentary inquiry, Katy? I believe if the mover and the seconder of the amendment accepted as a friendly amendment, nobody has to vote on the friendly amendment. Is that correct?

Katy Hatfield: That's correct.

Dave Iseminger: Thus, for my parliamentary inquiry, if Carol and Tim agree with Myra's point, then it's automatically incorporated. I think the parliamentary question is, do they agree.

Tim Barclay: I agree.

Carol Dotlich: I agree.

Sue Birch: I'd like to restate the amended resolution for the second bullet point which includes Myra's friendly amendment.

- The non-grandfathered members who have qualified for Tier 3 drug coverage are automatically eligible for reduced Tier 2 cost-sharing.

Is everybody clear?

Yvonne Tate: Just for clarifying purposes, can't you just say they will receive reduced cost to the Tier 2 cost-sharing? Isn't that what you're really trying to say is they'll get it, because even if you say "automatically eligible," it still implies there's another process or something else they have to go through to get that Tier 2 cost-sharing.

Sue Birch: It's my understanding you're looking for an alternative to "eligible." You want "automatically entitled" for reduced Tier 2?

Yvonne Tate: No, just that they will get the reduced Tier 2 cost-sharing. Isn't that what we're really trying to say?

Tim Barclay: This is Tim. I agree. I think if you eliminate the words "are automatically eligible for" and replace it with the word "receive" I think that meets Yvonne's point.

Sue Birch: So let me be clear. It's my understanding that I'm hearing the language would read: "Non-grandfathered members who have qualified for Tier 3 drug coverage receive reduced Tier 2 cost-sharing."

Tom MacRobert: Will receive?

Sue Birch: Will receive.

Dave Iseminger: Point of order for parliamentary purposes. I believe the question now is Yvonne's made another friendly amendment and do Carol and Tim agree with it?

Carol Dotlich: I agree.

Tim Barclay: I agree, also.

Dave Iseminger: I believe the amendment before the Board for discussion and then eventual vote is now adding a bullet: "Non-grandfathered members who have qualified for Tier 3 drug coverage will receive reduced Tier 2 cost-sharing." As the current motion, as friendly amended twice, is before the Board.

Katy Hatfield: Yes, and so the discussion from the Board and from the audience will be only about whether or not we should add this amendment. It's not about the entirety of the rest of the motion. There will be a second chance to vote. Right now, we're only voting on Tim's motion to add this proposed amendment. We should have discussion and public comment on that.

Sue Birch: I would ask for the Board to have any further discussion on just this proposed amendment that is inclusive of both Myra's and Yvonne's improvements. Any further discussion from the Board? I will be asking for comments from the public next if you've exhausted all of your comments.

I would invite public comment specific to this proposed amendment.

Yvonne Tate: Just a point of clarification. On the amendment, not the overall resolution, right?

Sue Birch: Correct, on the amendment. Seeing no further public comments and no further Board discussion, I would call for the vote.

Voting to Approve: 6

Voting No: 0

Sue Birch: Amendment to Policy Resolution PEBB 2018-01 passes.

I'll now read Policy Resolution PEBB 2018-01 in its entirety.

Policy Resolution PEBB 2018-01 – Value Formulary.

Resolved that, beginning January 1, 2019, all UMP plans require the use of value-based formulary with:

- a select mix of drugs within a drug class that are covered only when medically necessary and all preferred products have been ineffective or are not clinically appropriate, and
- non-grandfathered members who have qualified for Tier 3 drug coverage will receive reduced Tier 2 cost-sharing, and

- multi-source brand drugs being covered only when medically necessary and clinically appropriate, and
- members who have been taking a non-preferred drug will be grandfathered at the Tier 3 cost-share, unless they receive or have already received a cost-share exception, and
- the grandfathering for brand-name drugs ends when a generic alternative or an interchangeable biologic becomes available (the drug becomes a multi-source brand and is subject to medical necessity)."

I would like to call for discussion from the Board. Seeing none, I'll call for public comment.

Fred Yancey: I'm here on behalf of school administrators and school retirees. I'm in support of this policy but you alluded and Carol's testimony from the emails really point out the problem and that is that this system is not user friendly. You outlined a resolution that says what you can do, how you can grandfather, and how you can get your materials. But point of fact, I left my email and Dave alluded to the fact that I think they're working on a better communication scheme. But if you are a user of a prescription medication, first of all, the newsletter you got, what did you do with it? You read it when it came and then you filed it somewhere, probably in the recycle bin. You can't reference the resolution that's been publicized already. You can certainly read your policy, but I challenge -- I don't challenge the Board because this is your expertise. You probably read your policies. I certainly have never ready my policy defined for coverage.

So my doctor gives me a prescription. I go to the pharmacy. The pharmacy says, "Your insurance doesn't cover it," or "Here's what you pay." Pharmacy doesn't know anything about the tiers. My doctor doesn't know anything about the tiers. And I don't know what I can do as an alternative to paying that. I would just urge the most important step is not the passage of this resolution, but is a clear, FAQ section on the website that helps users work through affording their medication. If you've checked the website, and I have, and I pretended that I'm somebody that wants to figure out how to save money on my drugs, I can't do it on the website. I just can't. It is not user friendly for determining that question. I would share those thoughts that the members are telling us about. Thank you very much for your time, and again, your hard work on this very technical field.

Sue Birch: Thank you for your comments. We'll now vote on the resolution with the amendments.

Yvonne Tate: Yes.

Tom MacRobert: No

Well, first of all, I want to thank Dave and everybody who's done a lot of work changing this and making it much better than, I think, where we started. But unfortunately, I still have some deep concerns.

Tim Barclay: Yes.

Carol Dotlich: No

I also would like to thank the hard work that went into this and tell you how deeply I appreciate how you received the input that I provided from my membership. I think my membership is not ready for this yet and so I'm forced to vote no. But I'm hoping that as time goes by, we will find that the membership is more in support than it is today.

Greg Devereux: No.

Sue Birch: Yes.

Voting to Approve: Yvonne Tate, Tim Barclay , Sue Birch

Voting No: Tom MacRobert, Carol Dotlich, Greg Devereux

Sue Birch: Policy Resolution PEBB 2018-01 – Value Formulary is not approved.

Dave Iseminger: I want to remind the Board that what this means is we will go forward with no change to the UMP formulary, or no change fundamentally to the pharmacy benefit for the 2019 calendar year. We will go forward with the rate development process knowing the outcome of this vote and bring rates back to the Board in July.

Yvonne Tate: Unfortunately, I think what the impact of this is going to be is that for the next rating period, drugs are going to be more expensive. That's the outcome of this.

Sue Birch: Thank you for those comments, Yvonne. I do want to reiterate my thanks to the staff. I know you worked hard to drive a greater value for the clients. I guess we'll be back at it in other ways to look at how we're going to curtail the premium increases.

Policy Development

Barbara Scott, Policy, Rules, and Compliance Section Manager, ERB Division. As a reminder about the process, typically, we introduce policy resolutions to you for discussion at one meeting and bring them back for a vote at a subsequent meeting.

Slide 2 – Introduction of Policy Resolutions. Today I'm bringing three policy resolutions for discussion and plan to bring them back for a vote on July 17. At the same time, we'll have a rules briefing so you can see where we're at with rule making for the PEBB Program for this year.

Proposed Policy PEBB 2018-02 – Enrollment Error Correction. The error correction policy has evolved over time, especially the last several years. I've brought a change to the Board's policy in a meeting for each of the last several years. This year, we had a case brought to us identifying a gap in the Board's policy as it stands today. It doesn't handle instances where an individual is not eligible for coverage. The agency enrolls them in coverage and doesn't find the error until later. This policy provides guidance to agencies in order for them to correct this error. For the most part, the PEBB Program uses a decentralized system for enrollment to occur. Staff at state agencies and higher education institutions across the state make eligibility determinations and key in the information. When they get something wrong, the error correction policy provides them guidance.

In this case, the policy is recommending that if coverage is entered in error, that coverage would not be removed retroactively. Instead, coverage would be removed prospectively and any premiums that would have been deducted from the employee's

pay would be refunded to the employee. For example, if I hire an employee who's not eligible for benefits on June 1 and accidentally enroll them in benefits, and I don't discover my error until September 15, coverage would be removed effective September 30. If premiums had been deducted from the employee's paycheck June through September, the agency would need to refund the employee dollars equivalent to what was withheld from their paycheck. At the same time, Health Care Authority, because coverage isn't retroactively removed, would not be taking premiums back from the carrier.

Yvonne Tate: During the time the error occurred, the person is covered, right? So if they had a major illness or what have you, they would get whatever the coverage was, right?

Barbara Scott: Yes.

Yvonne Tate: So why refund their premium retroactively?

Barbara Scott: Because they weren't responsible for the coverage being enrolled. A case from last year identified a gap when an employee enrolled in benefits. They received the letter from their agency saying they were not eligible for benefits so they weren't anticipating being enrolled in them. They were enrolled in coverage elsewhere. The agency didn't discover the error for a number of months. When the employee brought it to their attention, they didn't fix it because they didn't really know how to fix it. Because of that, it sat for a number of months. They did end up giving the employee their money back what was withheld from the employee's paycheck, but the employee had to ask for it to be resolved a number of times. By the time the error was corrected, enough time had gone by, the plans had already been paid, and plan changes had been in place. The employee didn't use the services, but they still ended up getting their money back.

We didn't retroactively take dollars back from our health plan who would have paid claims, had a claim occurred. In this case, the employee really did have claims. They've had to clean up the mess of the claims processing because there was confusion around which plan should pay primary. We were the primary insurer for the employee, because they were our employee and were covered as a dependent on the other plan. The employee was trying to correct the issue. At the same time, the agency didn't know exactly how to resolve it. They tried a number of different attempts trying to clean it up. This policy would have cleaned it up so the employee wouldn't be out any dollars. At the same time, we wouldn't take dollars back from our health plan, who would have paid claims and who ended up paying claims in this instance. It is somewhat of a penalty to the agency for not cleaning up the error. The statute does allow for the Board to put in place penalties. We haven't actively put those on the table. In many cases, the penalty has been that the agency is out both the cost of the coverage for them and the employee, and on top of that, refunding the employee dollars taken from them.

Yvonne Tate: Well, it's confusing because I can understand where the employee's actually been paying two sets of premiums. But what about a situation where they're only paying one premium and getting the benefits? It's hard to anticipate all situations that will occur as a result of this. But clearly, the example you gave is understandable.

Barbara Scott: We tried to include in the resolution that it wasn't a misrepresentation by the employee or fraud in order to protect the agency to some degree. But at the same time, I would be amiss if I didn't say this is applying a penalty to agencies where they have errors.

Tim Barclay: I want to make sure we're not setting ourselves up for a problem. In a sense, it feels like we're retroactively disenrolling the person and I would hate to put ourselves in a position with the insurance carrier. Let's say they pay a large claim and come back to us and say, "This person wasn't eligible. You refunded their premium. We would like you to pay us for the claim that we shouldn't have paid for this person." The carrier can then claim they shouldn't have been covered and they shouldn't be out the dollars. I'm not the legal expert. I just want to make sure we're not setting ourselves up for a claim refund as well as a premium refund.

Barbara Scott: That's why I described that we wouldn't take the coverage away retroactively. We'd take the coverage away prospective, the refund to the employee would not be that premiums had been taken back from the health plan. It would be out of the agency's own dollars. For example, if Health Care Authority enrolled my daughter in coverage who's not eligible for coverage under me and that error was not caught. I didn't ask for her to be enrolled. I didn't turn in an enrollment form, but accidentally, somebody enrolled her. Say she was enrolled for a number of months and then it was found. Under this policy, coverage would have to be taken away end of month, in which the error was discovered, not retroactively taking away coverage.

Dave Iseminger: To clarify, coverage wouldn't be rescinded, it would be the premium that's refunded. Coverage would be canceled prospectively because under federal law, coverage couldn't be rescinded. Barb, the part that you were just describing isn't the words on this page. Could you clarify that's elsewhere in the error correction rule that already exists based on prior PEB Board policy decisions? You were describing first of the next month is when coverage ends. It doesn't say those words in this resolution. That's elsewhere in the enrollment policy that exists today. Isn't that correct?

Barbara Scott: Today, coverage in the policy is removed prospective rather than retroactive. That does exist in the current Board error correction policy. It is more overlaid, though, by the mere fact that you can't rescind coverage once given based on federal regulation. Part of what supported this was the federal regulation. If an employee wanted to. I were to say it's okay for you to take my coverage away retroactively. That is okay and is not considered a rescission because the employee voluntarily did it. If an employer were to coerce them in any way, it's a violation of federal law. It's difficult to put in place a policy for correcting an error that would allow for it to be taken away in some instances and not in others unless we were to clearly write it in a way that says if the employee voluntarily authorizes the employer to retroactively rescind the coverage. The Board could have a policy that reads that way under federal law. Instead, the entirety of the policy really is a prospective effect date for changes. Most of the policy the Board has in place today effects enrollment rather than disenrollment. That's why it's written prospective. I'd be happy to write it into the policy, though if that adds clarity for the version that I bring before you next time.

Tim Barclay: I wasn't asking for a policy change. I just wanted to make sure we weren't in a position where the carrier could come back to the Health Care Authority and claim

the member wasn't eligible and responsibility of the claim cost shifts to the Health Care Authority. Not anything to do with the member. It's a transaction between the Health Care Authority and the insurance carrier. That's all I was trying to clarify and you clarified that. So thank you.

Barbara Scott: Proposed Policy PEBB 2018-03 – Retiree Term Life Insurance Eligibility. This policy addresses eligibility for retiree term life insurance for state agency and higher education retirees who lose eligibility for PEBB benefits due to not paying their health care premiums or due to not maintaining their enrollment in Medicare Parts A and B.

The requirement to maintain enrollment in Medicare Parts A and B, if eligible for it, is a portion of PEBB retiree eligibility. It's one of the criteria for PEBB eligibility. The requirement to pay your premiums is a given, but when we made the transition to move the administration of life insurance over to MetLife, we stopped keeping life insurance enrollment within our own Pay1 System. We broke the link to the retiree account that we maintain here and the retiree account that's maintained by MetLife. Because of that break we haven't been sending termination notices to MetLife for retirees enrolled in retiree term life insurance when we have terminated their coverage here on our end because they stopped paying their premiums for their health care coverage or because they didn't maintain their enrollment in Parts A and B of Medicare.

The number related to maintaining enrollment in Parts A and B of Medicare are probably fewer than retirees termed for non-payment. Even those termed for non-payment, because there are a number of months and processes that they go through before they lose their coverage. The one thing we wanted to get your direction on is whether to allow them to maintain their enrollment in retiree term life insurance with MetLife. It's my understanding from the contract manager that MetLife is happy to allow them to stay on coverage even though they're no longer eligible for PEBB health care coverage through the PEBB Program. That is what this policy resolution is here to do.

Sue Birch: The payments for the ongoing term life just go to the retiree and are between MetLife and the retiree, correct?

Barbara Scott: Yes, we no longer get them here at all.

Sue Birch: I certainly don't have any problem with allowing that business arrangement to roll forward because we've delinked the account and it becomes the retiree's decision. But I don't know if there are other comments or thoughts from Board Members.

Barbara Scott: Proposed Policy PEBB 2018-04 – Retiree Insurance Coverage Deferral - ChampVA. The last time we met, you provided direction to go ahead and pattern this policy after what we've done with TriCare. We looked to see if ChampVA coverage was somewhat comprehensive in services and supplies. It appears it is. The only services that seem to be at question were preventive care services. Under the regulation, not all of those would have been covered, but when staff took a closer look at the operational manual used by Veteran Affairs, those services are being covered and they are trying to get their regulation amended so those will be covered like they are for TriCare. So right now, those services are provided. It just wasn't clear in the regulation itself.

The other piece we looked at was who's eligible for the coverage to get an idea of the population, and especially if there are periods of time when they would lose coverage and then want to come back. We patterned it after the one time back in pattern that we use for TriCare. It looks like the surviving spouses and surviving children, up to a limiting age, would be eligible. The survivors of the veteran who passes away. In addition, there is some eligibility for primary family caregivers. These would be folks caring for an eligible veteran who is disabled but not deceased. That eligibility appears to end when the veteran passes away. If they utilize this provision, they would probably want to come back into PEBB coverage at the point when the veteran passed away and they lose eligibility. The limiting age for children was age 18 unless they're a student. For the most part, they're not going to fall into this population who would be deferring coverage anyway. It's mainly surviving spouse that you're going to see.

As far as the proposal today, I did go ahead and put the effective date as January 1, 2019. Ms. Svette, who testified the last time, it's my understanding her retirement date is August 1. It is within the Board's authority to decide a different date. As we explained before, typically, we use a January 1 effective date. It's consistent with the new plan year, allows for us to get rule making and communications out the door and done for the coming plan year. But it's something the Board could change. If that were the case, I would need you to tell me what effective date you want and we would amend the policy in order to reflect that.

Greg Devereux: So her date is August --

Barbara Scott: I'm going to look back at her and confirm the effective date of her retirement, but I believe it is August 1, 2018.

Irene Svette: That's the effective date.

Greg Devereux: So this would not cover her if we kept this date?

Barbara Scott: Correct.

Greg Devereux: And the whole point of this --

Barbara Scott: She would have to keep a different coverage in place in order to secure her PEBB eligibility until January 1, 2019 if you did not choose an earlier date. Do you want me to explain what we provided to her earlier today?

Greg Devereux: I just want her to get coverage and anybody after her. That's all. As long as she's happy, I'm happy.

Barbara Scott: Then you could choose to move forward, but with the August 1, 2018 effective date. It is not your norm, but you could choose to do that. It's within your ability.

Greg Devereux: Then so moved.

Yvonne Tate: Could we just say effective on signing or approval, effective approval?

Barbara Scott: Yes.

Dave Iseminger: We brought forward what has been the standing practice. It's the responsibility of this agency to remind you of your standing practice, and make sure if you made a separate effective date, you went into it with open eyes and knowledge that it is a deviance or a change from your normal practices. We have brought forward to you the effective dates and standing with your normal practices. But as Barb highlighted, you do have the authority to vary from that practice.

Sue Birch: Thank you, Dave, for that clarification and the action will be taken at the next Board meeting. We have time to consider the solution. I hear that there's likely Board Members directing staff to consider an exception to the process or recommended language.

Yvonne Tate: Right. I think it's a fairness issue versus what is our normal procedure. I think most of us lean on the side of fairness in this situation.

Barbara Scott: I hadn't planned on you voting on it today. Are you asking to amend it and vote on it today or amend it and bring it back on the July 17? And the date you would like on it is August 1, or as of the date you vote, which would be July 17?

Yvonne Tate: I think that would make more sense, July 17, when we vote.

Barbara Scott: I can bring it back that way next time around.

Tom MacRobert: It's not a question but you keep mentioning our next meeting, July 17. Our next meeting is July 11.

Sue Birch: We'll be discussing that timeframe. It's clear the Board is signaling that they'll want resolution prior to August 1.

Procurement Overview Questions and Answers

Beth Heston, PEBB Procurement Manager. I'm here to talk about follow-up questions from my last presentation. The first question was whether the durable medical equipment (DME), continuous ambulatory delivery device under discussion was the pump or the monitor for diabetes. It is the insulin pump. The monitor is a separate piece of equipment and not included in this list of DME.

The second question was what is the UMP rate of coinsurance for DME? In network it is 15% and out-of-network is 40%. The situation was that Kaiser Northwest is asking to go from 0% coinsurance to 20% coinsurance to match Kaiser Washington. UMP has 15% in network.

Dave Iseminger: As Betsy comes up to discuss Long-Term Disability Insurance, I want to say I'm excited to be able to start this conversation with the Board. It's been a long time since we've focused on possible changes within the long-term disability benefit. I'm happy Betsy has an opportunity to start the discussion with you. We will bring more analysis because we've been working on this for the Board in the past couple of weeks, really solidifying a proposal to bring to you. I know you'll probably have a variety of

questions and we're working on materials for the next Board meeting, but I wanted Betsy to come forward and give you an introduction on this topic.

Long-Term Disability Insurance

Betsy Cottle, Contract Manager, ERB Division. We haven't talked about long-term disability in a very long time. I have a very brief description of what long-term disability insurance provides for members. It's income replacement. If you are determined to be disabled from your job, a disability insurance program provides you with a percentage of your pre-disability earnings at a tax-free basis. Our current long-term disability program is administered by The Standard Insurance Company and replaces up to 60% of the first \$400 of a monthly income on our basic plan. Our optional plan currently replaces 60% up to \$6,000 of your monthly income.

Long-term disability insurance is available only to employees. During their initial election, employees are able to elect optional LTD without answering any health questionnaires. Presently, our population has 31% enrolled in optional long-term disability. Optional long-term disability is very critical to employees because our basic really does not provide enough protection. In the meantime, I've been able to figure out a way to offer all of our employee subscribers a new opportunity to purchase optional long-term disability.

Slide 4 is a graph that shows what I was talking about. The proposed future plan in basic is unchanged at this time. We're hoping for big and wonderful things in the future. But for right now, we propose offering our subscribers an opportunity to replace up to \$10,000 per month of their income. This is an opportunity to offer everybody a new enrollment without evidence of insurability. I've already mentioned that the offer increases the maximum monthly benefit from \$6,000 to \$10,000. The offer is open to every eligible employee, even if they had been previously denied. If 10 years ago you attempted to increase your optional long-term disability and were denied because of a health issue, that employee will be eligible for this benefit. Premium rates for this new opportunity are guaranteed through 2021. We propose to start working on this immediately and offer it to our subscribers in Winter 2019. Plan effective date would be shortly thereafter because this is a unique open enrollment and there's a lot of work that goes into enrolling people. We're trying to give our agencies extra time so there'd be an enrollment one month, a month pause to do data entry, and then the plan would become effective on the third month. If we did it in February, it would be effective April. If we did it in March, it would be effective May.

Greg Devereux: Betsy, the difference is 60% of \$6,000 versus \$10,000. It goes from \$6,000 to \$10,000, 60%? And what is the difference in the premium the person's paying for this completely. What's the difference in cost?

Betsy Cottle: Yes. Between \$6,000 and \$10,000? I did not calculate it in that way. But I can tell you the rate they would be paying has been the same for all optionals for the almost ten years. I can bring back math the next time and we can explore how it would change things, depending on how much people insure. I don't have that calculation and I don't want to say the wrong thing because I want us to all understand what our employees will be paying.

Greg Devereux: Thank you.

Tim Barclay: I have a slightly different premium question. If I'm an employee making \$60,000 a year salary, \$5,000 a month, this policy change would not affect my coverage. However, with all of the bells and whistles of letting people enroll who previously declined, and all the other things that are happening, I would like to know what happens to that person's premium, so the person who's not getting any enhanced benefit. If we do this, what happens to their premium?

Betsy Cottle: It stays the same.

Tim Barclay: It does stay the same for sure?

Betsy Cottle: You are only able to insure the income you make. You cannot replace income you do not make. I can't insure myself for twice my salary.

Tim Barclay: I just didn't know if the rates per thousand of coverage would be changing as a result of the new open enrollment process. Thank you.

Betsy Cottle: No.

Dave Iseminger: I'll just add, as Betsy said, they would be guaranteed until December 31, 2020. After that, the entire rate schedule could change. The rates currently existing would not be impacted by this open enrollment, nor for the year after this open enrollment.

Myra Johnson: My question is back on the 31% are eligible. Is that subscribers are enrolled in this long-term --

Betsy Cottle: It's not 31% who are eligible. It's 31% of our subscribers who are taking advantage of the optional long-term disability. Our goal is to increase that because we feel our population is not financially protected.

Myra Johnson: Okay. Do you know why, or in your crystal ball, only 31%?

Betsy Cottle: It's a very complex and odd benefit. It's important and for many people, it's just a detail lost in the original election period. After 31 days, you have to fill out a questionnaire and that is a barrier for a lot of people, even though most of us would generally pass initially.

Dave Iseminger: Myra, I've told this story many times to staff and I don't care about saying it publically. I still have my original enrollment packet from when I joined state service and I wrote on my life and LTD packets "look at this later." I still have those packets. After 31 days, I was worried about failing underwriting and I didn't want to be blackballed so I've never touched it. If we learned anything from our life insurance refresh two years ago, there was a lot of pent up demand. We had an amazing uptake with people having an ability to elect additional coverage in life insurance without having to go through underwriting. That's when our partner, The Standard, started a discussion about whether there would be an opportunity to do same thing on the disability side. When people start their state service, they go, "I'm going to focus on this medical and dental thing," and they put the others to the side. Time creeps by and they get diagnoses, life happens, and then they go for it, and realize they may not pass

underwriting or they have something that will not allow them access to the insurance. I think many people start off in state service, many of them young and invincible and not thinking about the potential of lack of insurability later.

Yvonne Tate: I just wanted to say, I think this is a really good thing. I'm really excited to hear it. To the notion of how fickle employees can be, my employer had a dollar for dollar match in a 401K plan and not all employees were contributing in enough to get the full match. It's free money and they weren't going for it so you never know. But I'm very impressed with this.

Betsy Cottle: We expect to spend a great deal of effort educating people because this product is not well understood.

Public Comment

No public comment received.

Sue Birch: Our July 11 Board Meeting is likely to be canceled due to rate negotiations. As we get closer to that date, we'll confirm.

Pending the decision of the July 11 meeting, our next meeting is July 17, 2018 in this room from 1:30 p.m. to 4 p.m.

Preview of Upcoming Board Meeting

Dave Iseminger: We always over-schedule in July not knowing when rates are coming in. We usually cancel at least one meeting. At the likely next meeting, July 17, Betsy will bring more information, member examples, and walk through some of the advantages and additional information about the long-term disability benefit offering before you, and bring you a proposed resolution to consider, and hopefully take action on at a subsequent meeting this season.

Hopefully the rate process will be finalized and the finance team will bring information about what the rates are looking like for 2019 on both the Medicare and non-Medicare side, and bring proposals for you to take action on at a later meeting in July.

We will bring the resolutions Barb presented today up for action. Staff will do an overview of the rule making process and remind everyone as to after the policies are passed by the Board, what the process is that the agency goes through to roll those into rules.

At the last meeting, we had an emerging medication update on Trogarzo. We will probably have another update on other drugs that are in the pipeline to keep you informed.

And finally, we're preparing to bring you information about the K12 retiree study. In House Bill 2242 with the enactment of the School Employees Benefits Board Program, there was a requirement for a legislative report about the possible future of risk pool arrangements for K12 retirees. Nothing changed with the creation of the SEBB Program legislation to K12 retirees. They stay in the PEBB pool but there was the requirement for a legislative report. It's due at the end of the year and the legislation

requires consultation with both the PEB and SEB Boards. We're planning on having those discussions with both Boards in July.

Greg Devereux: I think both Carol and I are in Boston on the July 17 so I would love to call in. I assume we would get on the line together. Okay, thank you.

Sue Birch: Thanks for letting us know.

Meeting adjourned.

Public Employees Benefits Board
Meeting Minutes

D*R*A*F*T*

July 17, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 4:45 p.m.

Members Present:

Sue Birch
Tom MacRobert
Tim Barclay
Harry Bossi
Yvonne Tate

Members via Phone:

Greg Devereux
Myra Johnson (joined late)

Members Absent:

Carol Dotlich

PEB Board Counsel:

Michelle Robert, Assistant Attorney General

Call to Order

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

Meeting Overview

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

Dave announced that Governor Inslee appointed Harry Bossi as a voting member since the last Board meeting. Harry moved from his non-voting position to the voting cost containment position vacated by Marilyn Guthrie.

Long-Term Disability (LTD) Insurance

Marcia Peterson, Benefit Strategy and Design Section Manager, ERB Division and Betsy Cottle, Procurement Manager, ERB Division. We want to talk about an opportunity regarding long-term disability insurance.

Slide 2 – Decisions for the PEB Board. The Standard, our current LTD vendor has agreed to do an open enrollment for current PEBB Program members even if they've

previously been denied coverage. The Board has two decisions in front of them. Do you want to take advantage of this opportunity for the members, and if so, what level of benefits should be offered at?

Slide 3 defines long-term disability insurance. It's used to replace your income when you become temporarily disabled or can't work. Long-term disability insurance acts as an incentive to get you back to work. That's why there's only a portion of your income that's replaced. Slide 4 defines disability. In the PEBB plan, disability is defined a bit differently than social security's definition. We want to point that out as it can create confusion. For the PEBB plan, a disability means being unable to perform with reasonable continuity the duties of your job due to sickness, injury, or otherwise during the benefit waiting period. Social security disability provides a benefit for different circumstances. The PEBB plan is specific to you being able to perform the duties of *your* job during a time when you're temporarily disabled. Social security refers to a disability that prevents you from performing *any* job during that period. It's a much longer term disability period and generally thought of as permanent.

Slide 5 – Current PEB Board Plan. As PEBB Program members, we have two options for long-term disability insurance. First, the basic LTD that's employer paid. It offers members 60% of the first \$400 of their monthly pay, a minimum of \$50 up to \$240 a month. It starts after 90 days or after the duration of your sick leave balance, whichever is longer. The benefit we're talking about today is the optional benefit. It's voluntary and employee paid. This covers 60% of the first \$10,000 of your monthly pay, a minimum of \$50 up to \$6,000 a month. It starts after the end of the benefit waiting period that you choose. The maximum benefit is based on your age when you become disabled.

The important part and what's relevant for today, is that members must enroll within 31 days of being eligible without providing evidence of insurability. After that, you're providing evidence of insurability. Only about 30% of PEBB Program members take advantage of this optional benefit at the time of enrollment. We did some research and discovered that is actually higher than you're seeing in the industry overall. The survey we're quoting from, the Life Insurance and Market Research Association (LIMRA), we thought was probably illustrative of the way people think about this benefit. In short, when people were asked if most people needed disability insurance, 65% of respondents said, "Yes, most people need disability insurance." We all need disability insurance. When asked, "Do you personally need disability insurance," only 48% said yes. When asked, "Do you actually have disability insurance," the number drops to 20%. It's a great benefit for other people is the conclusion.

According to social security, one in four people age 20 will experience a disability before they reach age 67. It's supposed to cover your salary should you become temporarily disabled. I say "temporarily," but the average duration of a claim is about three years, which is a long time to not be drawing a salary of any kind. Since half of all adults say they wouldn't be able to cover their salary for three months, and almost half don't have cash to cover a hypothetical \$400 emergency expense, this is of some concern.

In fact, within the ERB Division, staff had a very lively debate about this topic when putting this slide deck together. Some felt very strongly that they couldn't afford the benefit, particularly since they're still trying to pay off their student loans. Others just

hadn't thought about it since they joined state service many years ago, they were very young, and they weren't thinking about that but wishing they could apply now. And then there were those who knew someone who had suffered a disability and signed up as soon as they could. Some of us are just incredibly risk-averse and hate not being covered for unexpected expenses. We're all over the map. The fact is that we're all really pretty bad at estimating our individual risk. It's for this reason a lot of employers offer the optional employee paid benefit, but they're offering it as an opt-out benefit, which is to say you're automatically enrolled in it.

Betsy Cottle: I'm going to tell you more about our current long-term disability plan and the opportunity in front of us for our members. Slide 9 – Current Plan Enrollment, shows we have 133,000 eligible subscribers. Of those, 41,000 enrolled in optional long-term disability. Of those 133,000 eligible subscribers, we have a total of 5,500 people on a claim. Some have just basic, some have optional and basic. There are 610 people with a basic-only claim. This represents about 2.29% of our population, the number of people on a claim now. It's very low utilization, in general. It is an important benefit because if you don't have it, the financial implications are dire.

Dave Iseminger: One other piece, people ask, "What does 'subscriber' mean?" I want the record to show that the 133,000 number is active employees regardless of their Medicare status. It does not include retirees, because as a retiree, you're not at work. You don't have income to replace because you presumably have a pension.

Sue Birch: Betsy, do we have information on what percentages are related to sickness, injury, or pregnancy?

Betsy Cottle: I could certainly find out. I did not bring that with me, but I've definitely got that. Would you like to have a conversation about that before we vote next time?

Sue Birch: I was just curious. It might be good for the Board to hear that information if we have it.

Betsy Cottle: Slide 10 shows income state employees make. The table shows the number of people inside each income bracket. Our current plan covers up to \$120,000 of income per year. That's the majority of our state employees. There are approximately 2,000 people over \$120,000 at this time.

Dave Iseminger: Just for clarity, Betsy, you said 2,000. That was just the top band of over \$150,000.

Betsy Cottle: You're right. Thank you.

Dave Iseminger: I believe you meant to say about 4,800 who are over the \$120,000 amount. That's the magic line as we get to the recommendations and decisions for the Board later, of who might benefit if you increase the maximum optional benefit. Everybody up to \$120,000 could reach the current maximum benefit.

Betsy Cottle: Slides 11 and 12 show different kinds of claim examples and the associated premiums that relate to the coverage provided to each of these members. Slide 11 is an example for 38-year old Sally. She only has basic long-term disability.

She makes \$50,000 a year, receives \$240 a month, and pays no premium for this benefit.

The second example is Joe, also 38 years old, but he purchased optional, long-term disability coverage. He experiences a disabling condition and receives \$2,260.20 per month during his disabling period. The table shows possible premiums for the three most popular waiting periods available on our plan. If he were in the higher education group, his premium could be as low as \$17.50 a month, or as high as \$55 a month. If he were in the state employee group, it would be as low as \$15 or as high as \$45 a month.

Dave Iseminger: Betsy, I want to provide one more piece of clarity in example two. The box that says \$2,260.20 per month is the payout of just the optional benefit. The employee is still receiving a \$240 basic benefit. In real time, the employee is experiencing a \$2,500 benefit, with \$240 of it coming from the basic benefit and \$2,260 from the optional benefit. From the employee's experience, they're actually getting \$2,500 assuming they meet all the eligibility requirements, they don't have any other income disregards, lots of caveats.

Harry Bossi: On the upper end, the max is \$6,000 for the optional. So that person is earning - the high wage earner - would they be capped at \$6,000 for A and B or are they going to get \$6,240?

Betsy Cottle: They're capped at \$6,000.

Harry Bossi: So they really don't have the \$6,000 option. They really have a \$5,760 option, technically.

Dave Iseminger: And the state's picking up the premium for the first \$240, correct.

Betsy Cottle: Correct. The basic and optional work together to make the replacement percentage.

Slide 12. Example three is more complex. Henry, 48 years old, purchased optional long-term disability. He is a longer term disabled person and has qualified for social security disability, which is deducted from his optional payment. The note at the bottom of the slide that talks about deductible income and when it comes into play, depending on how long you are disabled and if you have income from other sources other than your disability product. Some income is deducted from your disability payment.

Dave Iseminger: The same thing as example two, what you're seeing here is \$460.20 is the value of the payment coming from the optional benefit because Henry elected optional, he would be getting \$1,800 and a check from the federal government under social security. He'd get a \$240 payment from the basic benefit from The Standard. He would actually be getting \$2,500 from these three sources. This is trying to show you the value of the optional benefit. If Henry had not elected an optional benefit, he would have received \$1,800 from the federal government and \$240 in the basic benefit.

Sue Birch: It's important to clarify that the social security disability process is up to two years. What payment could Henry expect during that two-year wait period?

Betsy Cottle: I can explore that in an illustration because you're right. There can be payments in the interim that end up going back and forth between the companies and social security. It's an iterative process and very complex. I can look for an example to show that.

Sue Birch: I think the point I'm trying to make, having been a nurse and seeing this play out time and time again, is that somebody like Henry would get the benefit of the payment during the two-year wait period and then they true-up and take back. I do think it's important because the idea here is to make certain people have income preservation so they're not destitute. This depicts that because of the timing issues on this sort of thing.

Betsy Cottle: Slide 13 shows our long relationship with The Standard Insurance Company and the premium history since 2002. Our premiums have varied, but not a lot. Regardless of what group you're in, this slide shows the continuity and good management by The Standard.

Dave Iseminger: You might ask why premiums dropped for a while and why they went back up. Betsy will discuss claims, but I think it's called the Claim Fluctuation Account (CFA), which is basically the premium reserve account. We've had very favorable experiences some years where the reserve gets a surplus and it's used to temporarily buy down some of the rate. The surplus was spent down and around 2015, the Board made a decision to buy up into the plan, changing the date of social security retirement. It used to be 65 but as we all know, not everybody's social security retirement age is 65 anymore. It changes based on when you were born. That was a change in the plan and buying up to what's called the normal age of social security. The surplus has been completely utilized so we're now back to the "original" rates from a decade ago.

Betsy Cottle: Slides 14-16. The Board has two decisions to consider. Decision one is to determine whether or not this is a one-time opportunity to all eligible employees to purchase their optional long-term insurance, increase the value of their current coverage, or change their waiting period. The premium guarantee is through December 31, 2020. The proposed timeline is to offer an open enrollment in 2019 for a plan effective date in quarter two 2019. We would begin communications immediately after the Board vote if approved.

Decision two is whether or not to increase the plan's monthly maximum benefit. We now offer up to \$6,000, which covers the first \$10,000 a month of income. We could increase that maximum to cover up to the first \$15,667 per month or \$188,000 a year. Our current plan covers \$120,000. We could also increase the maximum to a \$10,000 payment per month.

Dave Iseminger: Betsy, it's a \$10,000 payment per month, which is 60% of that \$15,000 number you said. Which then annualized is \$188,000 salary.

Betsy Cottle: Slide 17 – Claim Fluctuation Account (CFA). Part of your decision making is to consider the impact on the CFA. It is an account maintained by the vendor to stabilize the claims experience, as well as the premiums. Overall, long-term disability vendors generally keep between 25% and 50% of the annual premiums in a claims fluctuation account. The Standard Insurance Company maintains a CFA for our

optional long-term disability equal to 50% of annual premiums. We're talking about the value and percentage of the CFA because your decisions have an effect on the balances of those accounts.

Offering a one-time opportunity could possibly incur additional claims because more employees will enroll. Increasing the maximum monthly benefit could impact the CFA. The open enrollment could impact it. By doing both options, the risk of impact is at a higher percent. There's risk overall, but by doing both, we are likely to have a higher percentage impact to our CFA.

Slide 19 is our recommendation. We recommend authorizing a one-time open enrollment for optional LTD and retain the current benefit maximum of \$6,000 per month.

Tim Barclay: It seems to me that in the past if we've done underwriting and people have been turned down because they're higher risk, we do an open enrollment without requiring underwriting that these people should, I would expect, purchase coverage. I would if I were them. I would expect that means a deterioration in our risk pool. When we come around to the next renewal, we should see an increase in claims, I would expect, which is great from a perspective of those getting coverage. But from a financial management perspective, I would expect our rates would go up as a result of this action. Have we had any conversation with Standard to estimate what the result of this decision would mean on the premium increase for the pool as a whole when we renew in 2021?

Betsy Cottle: What you're saying is exactly the explanation of the risk. I can tell you the number of people still in our pool previously denied is just over 1,000 people. I'm hoping that will reassure you it's such a small number our experience should not be outrageously different next year or the year after we offer this opportunity.

Yvonne Tate: Coupled with the fact that your experience number is really small to begin with.

Dave Iseminger: We have talked with The Standard. There are a couple of challenges. Just because somebody signs up doesn't mean they're going to have a claim, let alone in the immediate future. It's one of the things Marcia and I were talking about. These people went through underwriting, presumably for whatever reason. That doesn't mean they necessarily predicted they were going to have a disability. They may have seen value in the product without necessarily experiencing the disability. If all 1,000 of these people flood in at the same time, it doesn't mean instantaneously there'll be 1,000 new claims.

In recent years, we had several years where we had what Standard has called exceptional claims or exceptional experience, where the experience for the pool for a couple of years was actually growing a surplus while we were trying to spend it down because we were having lower claims experience. We have a very well managed pool. What their expectation is, going forward with this type of recommendation of just having the open enrollment, the reserves, the CFA, could take somewhere between a 2% to 4% hit. Beyond that kind of rough range, there are too many variables for them to get

more specificity or more granularity at this point. They have guaranteed the rate through the end of 2020.

This plan would go live sometime in Quarter 2 2019. There would be some time to assess the risk over that 18 months. The Health Care Authority just went through a similar type of opportunity with life insurance. We saw a massive increase, but as staff discussed, people think about life insurance differently than disability. Marcia highlighted quite a bit of that. There are some people like me; my family utilizes insurance. The one day I didn't have medical insurance, I sat on my couch and didn't leave my home because I was afraid something was going to happen that day. I'm risk-averse. I'm always going to buy insurance. But, for some reason, ten years ago, I wasn't paying attention to this form. I was worried that maybe I'd fail underwriting and didn't want to get a bad mark on my history. I just stayed away from it all.

We have those type of people who are, for whatever reason, looking at their insurance in different lenses. We think people value LTD somewhat differently than life insurance. We don't expect the massive increase that we saw in life insurance but we do think there will be a lot of interest from some people. We can work with Standard to see if there's additional pieces we can bring to the Board for context next week.

Tim Barclay: How long has our basic LTD benefit been \$240 a month?

Betsy Cottle: Since its inception, as far I understand it.

Tim Barclay: Which was when?

Dave Iseminger: Roughly 1977.

Tim Barclay: Seems to me that benefit's a little inadequate. I'm worried about taking action now that could impact our experience. It seems to me we can make a case, based on our history and our current experience, which is very good, that at minimal cost, we could increase the basic LTD benefit, which, to me, has much more value than altering the optional benefit. Again, just brainstorming out loud. I don't want to take action today that impacts our ability to maybe enhance the basic benefit going forward. That's why I'm concerned about this issue with Standard and what a no-underwriting open enrollment does to our experience two years from now. My guess is if we started pushing today, it would take two years to be able to change that basic benefit. Just throwing that out as food-for-thought. Personally, I think that basic benefit is terrible. I don't know who can live on \$240 a month. If we could just think about that a little, but in terms of where do we really want the program to go in the long term, and what's in the best interest of our employees. I feel like if we can hit that basic benefit, we're going to be a lot better off than tweaking the optional benefit. That's my concern. I don't want to do something that impacts that ability.

Harry Bossi: I think Tim was very insightful in his comment and I think everybody would like the amount the state provided to be higher. How we do that within our financial constraints, I don't know. I think that deserves study. I don't necessarily have any heartburn with part of the proposal but I'm not sure it's a solution in search of a problem, in that I don't know relative to other comparable employers whether our enrollment rate is good, bad, or indifferent. Is 25% good? Are we trying to tell employees, "You need to

have more," so therefore, we created this on your behalf and it's worth the effort to go through all of this and have a rate hike? Again, I'm all for giving employees opportunities, but I'm not certain that it's an opportunity they've come forward and said they want.

Greg Devereux: I really like Tim's idea as well. I think it provides much more value for more people at the low end than we really need for people at the high end. I would love if the Health Care Authority could explore that further.

Dave Iseminger: We know we have to bring to this Board a discussion about the basic long-term disability benefit. One of the advantages we have to launching the sister program SEBB is that we've just completed a procurement on a disability benefit for a population similar in size. It has different demographic information, but our plan is to learn from that procurement experience and see what we can bring back to this Board after we've scoped a similarly sized population and see what the options are.

At the same time, this opportunity presented itself, in part because we were presenting information to the SEB Board the end of last calendar year, and doing comparisons of the current HCA administered benefit. The SEB Board wanted a procurement performed on a disability benefit. The Standard approached us with an opportunity to consider enhancements in the short term. As you've indicated, Tim, there is a multi-year road to changing the basic benefit. This could be an opportunity for some employees in the interim, to get coverage now that they otherwise couldn't get. Although it is an employee paid benefit, it's at least an opportunity to get additional coverage until that more systemic piece can be done on the basic benefit.

Taking action on this during this Board season doesn't preclude any changes to the basic benefit or a discussion on the basic benefit. It could have some of the financial implications you're concerned about, Tim. That is a multi-year road to work on the basic benefit. That is something the agency has in its plans to bring to the Board. It's an area when I joined the agency I was really concerned about, the value of the basic benefit. We're at a place where we're learning more about this benefit from the market and how it's changed since 1977. We're going to be working with Standard. They did the procurement on the SEBB side so we have a good partner who understands this relationship with PEBB and will be able to give us insight about how the benefit that's launched in SEBB, how much it would cost and what we might expect to experience in PEBB. It is in the near future plan to talk with the Board about the basic benefit. This is the short-term option that could give some relief on this benefit and give people an opportunity if they want to pay for additional coverage to have that opportunity. As Marcia pointed out at the beginning, the value of being able to get a benefit without going through medical underwriting has inherent value and is a unique opportunity. We learned that with life insurance and we think it is worth bringing to the Board for discussion, taking advantage of that type of opportunity.

Sue Birch: Thank you for that information. One of my questions, could we ask Standard and/or have staff dig into the livable wage for this state? I believe that just shifted and that would impact my decision between the \$6,000 and \$10,000 per month. I'm curious what baseline we're working with on a livable wage, even though it's an intermittent period, I think that's important information for the Board to have.

Greg Devereux: I thought one of the points Tim was making was that if we took action now it might influence the rates by 2021. I couldn't tell whether Dave was trying to make an alternative case to that. I would be concerned about rising up rates now and then not having as much leeway for changing the basic later on, even though it might be two years on.

Dave Iseminger: I was providing additional context for the Board's consideration on the topic. Remember this proposal comes with a rate guarantee through the end of 2020. Currently, the optional LTD benefit is under a rate lock through the end of 2019, and along with this, if the Board were to approve a one-time open enrollment, it would extend the current rates to a third year rate guarantee through the end of 2020. By the end of 2020 we will have launched a SEBB disability benefit and have gone through the exercise for procurements. We will have done the procurement, the contract negotiation, and launched a benefit with SEBB. That would be in the right timeframe during that rate block of an extra year to have the robust discussion about enhancing the basic benefit. Although this information might be a little bit dated from bienniums, I can say that one of the last times the agency evaluated changing the basic benefit, doubling the basic benefit to \$480 was somewhere between \$18 and \$20 million, as a rough proxy for the evaluation of that.

Tim Barclay: If you could ask Standard, it may be they also manage the rates separately for the optional coverage versus the basic coverage.

Dave Iseminger: They do.

Tim Barclay: So the answer may be, at the end of the day if we do this, and a worst-case scenario, our claim experience significantly deteriorates, it may be it has no impact on the basic coverage rates and only impacts the optional coverage. This, again, would be unfortunate for those people currently enrolled in the optional coverage. They would suffer and take a rate increase. I think that's what we're talking about, a risk there that is very different than impacting what they would do on our basic coverage. So if you could just confirm that.

Dave Iseminger: Tim, I was looking at Standard's last annual report 20 minutes before the Board meeting and they are separate rate tables so they are managed separately. I'm glad you actually raised that point. I should have thought to say that to answer your question, but the risk is managed separately for basic and optional. In fact, I don't like to put a vender on the spot but I turned around and Jennifer just nodded her head yes.

Tim Barclay: Thank you.

Yvonne Tate: I just want to say, I think it's a good idea to go ahead and offer that in lieu of not having any additional long-term disability coverage. I also think it's a good idea to try to improve the basic rate. I was on this Board for many, many years before the basic life insurance increased at all. I know it takes a while but I think they're both good ideas.

Betsy Cottle: Slide 20 – Draft Resolution PEBB 2018-05 – LTD One-Time New Enrollment Opportunity. During Q1 of 2019, the PEBB Program will offer all eligible employees an opportunity to purchase optional long-term disability insurance, increase

their optional long-term disability insurance, and/or change their benefit waiting period without providing evidence of insurability.

Dave Iseminger: To summarize, we will come back with information about the livable wage. I don't believe there's really any other questions that we have.

Betsy Cottle: Sue also wanted an illustration of the intersection of social security and disability insurance.

Sue Birch: And you're going to break out the claims we have by sickness, injury, and pregnancy.

Uniform Medical Plan (UMP) Plus Update on Grays Harbor County

Michael Arnis, Account Manager, Uniform Medical Plan Plus. There are approximately 26,000 enrollees in the entire plan. Grays Harbor is one of nine counties under UMP Plus. Grays Harbor has been with us since 2017 and offered by both networks in UMP Plus, the Puget Sound High Value Network and the UW Medicine Accountable Care Network (ACN). In Grays Harbor County, both networks offer essentially the same provider, which is MultiCare Hospital, the community hospital in Grays Harbor County.

For 2019, we will no longer offer UMP Plus in Grays Harbor County. The Health Care Authority and both networks have been working with the Grays Harbor area to implement the accountable care network. With UMP Plus, we offer care through an accountable care network and the participating providers in an ACN takes on the financial as well as the clinical obligations of the contract with the network. It is an investment as a provider builds itself into ACN. It usually requires at least one, if not more than one, major health system. In the Grays Harbor situation, it is the community hospital. The financial picture with that hospital isn't in a place where they can take on the required investment. The other providers in the network and the other nine counties play a role. They work together in doing what they can to meet those financial and clinical obligations. But it really takes a medical center in the county to make an investment. Unfortunately, that hospital is just not in the position to do that now. Hopefully, it will get back on its feet someday. We would very much like to bring UMP Plus back into Grays Harbor County when that happens.

Slide 5 – Membership Support Grays Harbor County 2019. There will be plenty of support for our membership in Grays Harbor County in UMP Plus. We will have direct communications to the subscribers to let them know about other providers and plans in that county for 2019. The first letter goes out next week with a follow-up letter in September. We will provide assistance. There are about 150 UMP Plus subscribers in Grays Harbor County.

2019 Rates Overview

Tanya Deuel, PEBB Finance Unit Manager, Financial Services Division. Today's presentation is about 2019 rates and premiums. Beth Heston will join me and go over proposed changes in the benefit designs for plan year 2019. Those changes are included in the rate package.

Beth Heston, PEBB Procurement Manager, ERB Division. Slide 3 shows 2019 plan changes for Employees and Non-Medicare Retirees for Kaiser Permanente of

Washington. As a reminder, for the Uniform Medical Plan, we will be adding the Virtual Diabetes Prevention Program for all non-Medicare members.

For Kaiser Permanente of Washington, there is the introduction of the Virtual Diabetes Prevention Program and some changes to the SoundChoice plan. SoundChoice will be offered in Kitsap and Spokane counties, in addition to the four counties where they are already offered. There will be changes to lower the deductible from \$250 to \$125 per person and from \$750 to \$375 per family. The coinsurance for primary care visits will be changed from a 15% coinsurance to a 0\$ copay. Most primary care visits will be at no cost. The massage therapy will be removed from the bundle that contains physical therapy, occupational therapy, and speech therapy, and set in a separate benefit. It will be 16 visits per year. Lastly, SoundChoice inpatient hospital services will increase from \$200 per day up to \$1,000 maximum cost-share to \$500 per admission with no maximum.

Tom MacRobert: Can you tell me when you say massage therapy visits are going to be separated out how many physical therapy, occupational therapy, and speech therapy visitations will you be able to have?

Beth Heston: Those visits stay at 60.

Dave Iseminger: For those of you who take your slide decks and compare across meetings, I want to be very transparent about the one thing that's different on the slide that Beth's presented from what was presented on June 20. As we went through the rate process, the original rates considered had a potential for unlimited massage in a separate bucket under SoundChoice. The final proposed rates include that maximum of 16. I want to highlight that difference from what was being considered at the beginning of the rate-setting process. There are things that change along the journey and that is one of those changes.

Tom MacRobert: Dave, I know we discussed this but I'm curious. Is what they are proposing for SoundChoice the same for all Kaiser Permanente plans, the separate massage and then the bundle?

Beth Heston: No, it will not be the same. It is only for this Sound Choice plan.

Tom MacRobert: So the massage therapy will be bundled in the other plans?

Beth Heston: Yes, in Kaiser WA, Classic, CDHP, Value, it will remain bundled with 60 visits.

Dave Iseminger: I would not be surprised if Kaiser WA considers whether to present in the next rate-setting year for 2020 aligning all plans. We were too far in the rate-setting process to change all of them for 2019. It would upset the apple cart too much, so they asked if they could change just the SoundChoice plan this year. They would consider potential changes to align their entire portfolio in future years.

Sue Birch: Can you remind me of the Virtual Diabetes Prevention Program name?

Beth Heston: It will be administered by Omada. It will be called Virtual Diabetes Prevention. They will be administering the UMP, as well. The plans should be fairly identical.

Greg Devereux: Dave, I know you probably don't have it, but I would be curious what the average inpatient hospital day usage is for SoundChoice.

Dave Iseminger: You're right, I do not know that off the top of my head, Greg, but we will make sure to follow up and get you the answer between now and the next Board meeting, but also share it at the next Board meeting.

Tanya Deuel: Slide 5 is employee information. It is the split between the employee and the employer premium contributions. There are a lot of numbers on this slide, as well as many slides coming up. I don't plan on reading through each of the rates on each of the lines and columns, but I will orient you to each slide. We can look at the things that stand out.

Slide 5 has plan names down the left and columns with proposed 2018 rates. Column 1 is the proposed 2019 employer contribution for a single subscriber. The middle column is the proposed 2019 employer contribution, and the far right column is proposed 2019 composite rate, composite rate meaning the total of the employer and the employee contribution.

The middle column, the proposed employer contribution known as the state index rate, is the same for all plans. At the January PEB Board Retreat, we said this is the state's contribution towards medical, which is an 85% weighted average. Visuals are included on Slides 28 through 30 of how we calculate the state index rate. I'll walk you through the examples.

Slide 28 is a sample illustration of how we calculate the state index rate. For this example, there are three plan bid rates, which do not match our current plan bid rates. The green box is one plan bid rate of \$550, the orange box is \$500, and the blue box is \$450. We take the number of adult units enrolled in each of these plans and multiply the plan bid rate times the adult units to get the total monthly cost. We take that monthly cost row of \$1,650, \$500, and \$2,700 to get the total cost of \$4,850 divided by the total people enrolled in our portfolio. That amount equals the weighted average of \$485. We multiply it by 85%. That is the state contribution, for a total of \$412.

Slide 29 determines how much the employee will pay, so we take those same plan bid rates across the top, the \$550, the \$500, and the \$450, and subtract the same \$412. You can see across the bottom that the employee contribution is the plan bid rate minus the index rate. That is the amount you are see on the employee/employer premium split on Slide 5.

Slide 30 goes into more detail of how we determine the tiers. We take that employee contribution and times it by the tiers. Tier 1 is a subscriber only. They pay that amount. Tier 2 is a subscriber and spouse. Tier 3 is a subscriber and child or children. It's the same rate no matter how many children you have enrolled in your plan. Tier 4, is the subscriber, spouse, and child or children.

That's how the weighted average is calculated.

Slide 6 is the employee contributions by tier. Again, on the left-hand side is the plan name and across the top are the Tiers. For each of those tiers, we have the 2018 premiums as well as the proposed 2019 premiums. The far right is a comparison of plan year 2018 to plan year 2019 change in a single subscriber rate broken down by both percentages and dollars. You may notice one of those doesn't look like the others. That is the Kaiser Washington SoundChoice plan. This is back to what Beth described for the Kaiser Washington SoundChoice plan and their proposed benefit design changes, having the Kaiser Washington plans being more aligned with the rest of the PEBB portfolio.

Slide 8 is the proposed non-Medicare retiree rates by tier. This will look similar to the last slide we just looked at with the plan names being down the left-hand side, the tiers across the top, comparing the 2018 rates to the proposed 2019 rates. On the far right, again, are the change from 2018 to 2019 and the change in the subscriber rate, both by percentage and dollar. You may notice that on the far right the percentages and dollars don't quite match up to the slide before. As a reminder, the non-Medicare retiree does pay the full rate. They don't get the 85% weighted average state index rate contribution from the state. Percentages may look smaller because it's on the full amount. When we looked at this percentage change in the far right, it is on the lower end of what we've seen over the last two procurement cycles. I looked over the last seven or eight years and we've seen between 3% to 5% average change.

Dave Iseminger: That's Tanya's way of saying "good news."

Harry Bossi: Tanya, does the subscriber rate for the non-Medicare retiree generally equate somewhere near the bid rate?

Tanya Deuel: Yes.

Harry Bossi: So there's not an additional administrative fee?

Tanya Deuel: There is an administrative fee. For plan year 2019, it's \$5.97. That's average, it's been around between \$6 and \$5 for the last few years.

Slide 10 is the Medicare retiree rates. On the left-hand side are the plan names for the Medicare plans. The next box over, single subscriber premium after Medicare explicit subsidy, is the amount the Medicare retiree will pay in premium. Middle column being the Medicare explicit subsidy, and the far right column titled "Composite" being the total of the Medicare retiree premium and the Medicare explicit subsidy. The Legislature did increase the subsidy for plan year 2019 from \$150 to \$168 to provide one-time relief in premiums. Not all of these are \$168 because the language still states that the Medicare explicit subsidy is set at \$168 or 50% of the premium. Only two plans were over that \$336 value so they got the full relief of the increase in the Medicare explicit subsidy.

Slide 11 - Medicare Retiree Premiums. This slide compares the single subscriber premium after the Medicare explicit subsidy from plan year 2018 to plan year 2019. Again, the far right columns have the change in single subscriber premium from plan year 2018 to plan year 2019. This is good news. We're seeing overall decreases. The

numbers in red are, in fact, negatives. They mean a decrease in premiums so the Medicare retirees will be paying less in plan year 2019 than they paid in 2018.

Dave Iseminger: It's counter-intuitive, Tanya, but red means good.

Tanya Deuel: Red means good in this sense. The legislature did increase the Medicare explicit subsidy by \$18 and we saw stable trends this year. Slide 12 is from my last presentation. I wanted to reinforce the impact of the Medicare explicit subsidy on the Medicare retiree premiums. The plan year 2019 column has been updated to include the rates you've seen today. As we walk across from left to right, we've included plan years 2016 through plan year 2019, the blue box being the Medicare explicit subsidy, and the orange being the Medicare retiree premium. As we have the total on the top, you can see it increased between 2016 and 2018, and the blue box in those same years remained the same, meaning the orange box has increased and the retiree premium has borne all of that increase. When we get to plan year 2018 versus plan year 2019, you can see the total across the top has remained relatively flat, as well as that blue box did increase from \$150 to \$168, meaning the orange box has decreased.

Dave Iseminger: Before we move on, I want to highlight something Tanya said, there's been a stable trend. We know pharmacy on the Medicare side is what's driving a lot of cost changes. We've been talking about pharmacy for well over two years. Trend tend to be pretty volatile. One year's trend is not completely predictive of another year's trend. The unfortunate reality is that by the time you see a trend it's like a freight train. It's going to hit you before you can really put on the brakes. When you think about the Medicare explicit subsidy, this past year the Legislature raised it for the first time in roughly six or seven years. We're not going to assume the trend will necessarily be stable again next year. We don't want to put all our eggs in one basket thinking there will be a retiree subsidy increase.

Last meeting we had a value-based formulary proposal that did not pass due to a split vote from the Board. Obviously, many more questions to come. We still plan to bring back and build upon that experience, ask questions, and have more conversations on the value-based formulary from last time. Some of it's good fortune, some of it's managing trend. We don't want to just rest on those laurels of what turned out to be a very good rate-setting year. We want to continue that conversation and reengage additional pharmacy conversations, building on the value formulary from the past year.

Sue Birch: Dave, thank you for that. I think it is impressive that we have as good of news as this. But I think you are absolutely right. When we look at some of the market analysis of what's coming around, especially specialty pharmacy, we would be remiss not to continue to try to drive towards greater value, not just with pharmacy but also as we see more movement in value-based purchasing, payments, and whatnot. We need to be very aggressive about trying to drive towards value. I think it's wise for you all to think about bringing back, again, any proposals that drive us towards greater value so we can protect our members.

Greg Devereux: Dave, your last comment about the formulary, that would be consideration in the future.

Dave Iseminger: Correct. We need to continue having that conversation. Not for 2019 but for as early as 2020.

Greg Devereux: Okay, thank you.

Tanya Deuel: Slide 14 – Dental Premiums. Plan name on the left. Comparing the subscriber rate from plan year 2018 to plan year 2019. Not too much news here. There was a slight increase in the Willamette dental plan rate. Willamette has not seen an increase in their rates since plan year 2014; in fact, they had a slight decrease in plan year 2015 and remained flat to 2018. We are proposing a rate increase for 2019 but it is at a two-year rate guarantee. As a reminder, this amount is paid 100% by the state for employees.

I do have a footnote on Slide 14 that was not included in Beth's presentation, but there is one benefit design change for the uniform dental plan. It's to reduce the limit on crowns from seven years to five years. This aligns with the industry and the other plans we offer.

Slide 15 – Life, AD&D, and LTD Premiums. Not much on this slide because there are no changes to plan year 2019. The basic benefit is employer funded and the optional employee funded.

Dave Iseminger: Essentially, we're in multi-year rate locks on all of those benefits, both basic and optional, state portion and employee portion.

Tanya Deuel: Slides 17 – 24 – Proposed Resolutions. We get into a handful of proposed resolutions you'll be asked to vote on next week. I'm not going to read through them today word for word because they are very similar. I'll let you know the differences.

Slide 17 – Proposed Resolution PEBB 2018-06 Non-Medicare Premium. The PEB Board endorses the Kaiser Foundation Health Plan of the Northwest employee and Non-Medicare retiree premiums.

Premiums meaning the full suite of rates.

Slide 18 – Proposed Resolution PEBB 2018-07 Non-Medicare Premium. This is the same but for the Kaiser Permanente of Washington.

Slide 19 – Proposed Resolution PEBB 2018-08 Non-Medicare Premium. Similar for the Uniform Medical plan.

Slide 20 – Proposed Resolution PEBB 2018-09 Medicare Resolution. The PEB Board endorses the monthly Medicare Explicit Subsidy of \$168 or 50% of premium, whichever is less.

The purpose of this resolution is because the Board does have the authority to set the Medicare Explicit Subsidy lower than what the Legislature set at \$168. We have written it as \$168 and would hope that you would approve as written.

Dave Iseminger: We assume you would not want to exercise the discretion to lower the subsidy. We have traditionally brought this resolution as a ratification of the Legislature's setting.

Sue Birch: There's a lot of non-verbal smiling of that \$168.

Tanya Deuel: Slide 21 – Proposed Resolution PEBB 2018-10 Medicare Premium. The PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare premiums.

Slide 22 – Proposed Resolution PEBB 2018-11 Medicare Premium. Kaiser Permanente of Washington Medicare premiums.

Slide 23 – Proposed Resolution PEBB 2018-12 Medicare Premium. Uniform Medical plan Medicare premiums.

Slide 24 – Proposed Resolution PEBB 2018-13 Medicare Premium. Premera Medicare premiums.

Dave Iseminger: The way the resolutions are written and for complete transparency, we have the Board take action on the premiums and then the presentations Beth has provided the context of the benefit changes that are wrapped up into those premiums. You do not have to take individual action on benefit design changes in these instances because if you were to pass and endorse the premiums, you have inherently accepted the benefit changes built into those rates. You can't de-couple those. We present to you the premium rates and make clear you're aware that you are implicitly including the benefit changes that Beth has overviewed.

Sue Birch: Thank you all for presenting this information. In the environment we're operating in, this is pretty remarkable. I think the pursuit in this state around driving towards value isn't something we would ordinarily see in Colorado. I do want to commend you all for your great negotiations, for our plans, and all the work that's been done. This is a lot to be proud of as we drive towards value. So thank you.

Myra Johnson: This is Myra, just logging in.

Sue Birch: Thanks for letting us know you are on.

Eligibility Policy Resolutions

Barb Scott, Policy, Rules, and Compliance Section Manager, ERB Division. There are three policy resolutions for action before the Board today.

Policy Resolution PEBB 2018-02 is unchanged from what was presented at the June 20 meeting. It adds to the Board's existing policy for error correction.

Sue Birch: Policy Resolution PEBB 2018-02 – Enrollment Error Correction: Resolved that, if any employing agency errs and enrolls an employee or their dependents in PEBB insurance coverage when they are not eligible and it is clear there was no fraud or intentional misrepresentation by the employee involved, premiums and

any applicable premium surcharge paid by the employee will be refunded by the employing agency to the employee without rescinding the insurance coverage.

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

Voting to Approve: 6

Voting No: 0

Policy Resolution PEBB 2018-02 passes.

Barb Scott: Policy Resolution PEBB 2018-03 addresses eligibility for retiree term life insurance for state agency and higher education retirees who lose eligibility for PEBB due to not paying their health plan premium, or due to not maintaining enrollment in Medicare Part A and Part B. It would not extend to a retiree of an employer group who loses eligibility when the employer group stops participating or contracting for PEBB benefits. It's really just for state and higher education retirees who lose eligibility and the two instances where we see that were the two described.

Dave Iseminger: For those not familiar with the vernacular, employer group are those local governmental entities that contract with the Health Care Authority for access to PEBB benefits. Think library district, irrigation district, ports, anything that has the word "district" in it.

Barb Scott: The recommended policy is unchanged from the policy introduced at the June 20 meeting.

Sue Birch: Policy Resolution PEBB 2018-03 – Retiree Term Life Insurance Eligibility

Resolved that, a retiree who is no longer eligible to remain enrolled in a PEBB health plan may remain enrolled in retiree term life insurance coverage only.

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

Voting to Approve: 6

Voting No: 0

Policy Resolution PEBB 2018-03 passes.

Barb Scott: Policy Resolution PEBB 2018-04 would allow a retiree to defer enrollment in PEBB coverage while enrolled in covered through the Civilian Health and Medical Program of the Department of Veteran Affairs, ChampVA. The only change to the policy in front of you from the June 20 meeting is the effective date. It has been changed to July 17, 2018 based on the Board's direction

Sue Birch: Policy Resolution PEBB 2018-04 Retiree Insurance Coverage Deferral – ChampVA

Resolved that, effective July 17, 2018, retirees and survivors may defer enrollment in a PEBB health plan if they are enrolled as a retiree or a dependent of a retiree in ChampVA.

A retiree or survivor who defers enrollment while enrolled as a retiree or dependent of a retiree in ChampVA will have a one-time opportunity to enroll in a PEBB health plan by submitting the required form and evidence of continuous enrollment within the HCA required enrollment timeframe.

Harry Bossi moved and Tom MacRobert seconded a motion to adopt.

Public Comment

Fred Yancey: I represent Washington State school retirees. My only concern with this policy is that if I'm receiving a ChampVA program, how would I know that when I stop receiving it that I had a timeframe for Health Care Authority, that I qualified and that it had a timeframe in order to pick up PEBB? I don't know if you track retirees in terms of what they're doing for insurance. And then you would know and then you could let them know that policy. That's my only concern if I was somebody taking advantage of that. Thank you.

Sue Birch: Thank you, Fred, for your comments.

Barb Scott: When a retiree defers enrollment in PEBB coverage, they do that by completing a form that indicates rather than enrolling, they're choosing to defer coverage. When they do that, we communicate with them to let them know that we have deferred their coverage and during the time they're deferred, they have to be insured in some coverage in order to retain the right to come back. It points them to where they can get additional information about those rules. I would have to look at the letter to see if it doesn't actually state those rules as to your, "it's our understanding you're deferring for this reason and these would be the reasons you could come back." I would have to check that piece. I do know we communicate with our members to let them know that we've got their deferral request, we've taken action on it, and they have a responsibility to make sure they're covered during the time they're deferred in order to be able to retain their eligibility in the future.

Tim Barclay: To clarify to Fred's point, this resolution does not open the door for anyone to come back into the program who did not go through that deferral process at the time they dropped coverage. If somebody didn't do that and they've been enrolled in ChampVA for the last five years, it doesn't make them eligible to come back to PEBB. This is prospective only.

Barb Scott: That is correct.

Voting to Approve: 6
Voting No: 0

Policy Resolution PEBB 2018-04 passes.

Sue Birch: We're going to take a ten-minute break.

[break]

2018 Annual Rule Making

Stella Ng, Senior Policy Analyst, Policy, Rules, and Compliance Section, ERB Division. I'm going to give you high level information on this year's annual rule making, highlight the most significant changes and rule making actions we are considering. No action needed from the Board.

Slide 2 is the rule making timeline. August 2018 proposed amendments and new rules will be distributed for public comment. In September 2018 we will conduct a public hearing and adopt final rules. Amended rules will be effective January 1, 2019.

The focus of this year's rule making is divided into four areas. We are adding clarity to rules to better administer and manage PEBB benefits as identified by staff and stakeholders; making regulatory alignment to implement state legislation and to comply with federal requirements; amending rules on topics within the agency's authority; and implementing PEB Board policy resolutions adopted today.

Slide 4 – Administration and Benefits Management. We are clarifying some of our existing rules to better administer and manage PEBB benefits. This includes amending our COBRA rule to include a note that supports the authority under which dependents, like state-registered domestic partners, are eligible for coverage. We've done restructuring on our deferral rules to describe all populations and clearly define deferral timelines so all populations understand when they defer. We are adding additional language to rules to clarify a retiree who voluntarily terminates PEBB coverage cannot re-enroll in PEBB benefits unless the retiree becomes newly eligible again. We are amending premium payment rules to clearly describe the requirements for retirees and others who are electing to continue PEBB coverage on a self-pay basis and where to send the payment.

Dave Iseminger: Stella, most of the things you've described are just aligning with the current practices and things stakeholders have said.

Stella Ng: Yes, that's correct. We are clarifying requirements related to employees who received a retroactive disability retirement eligibility determination to enroll or defer PEBB retiree insurance coverage. We will include greater details specific to the different pension systems because we found it was confusing for our members. We're amending the election period for survivors to allow a full 60-day election period after the PEBB coverage ends. Currently, survivors get a 60-day election period at the death of the employees realigning with COBRA to allow either a 60-day election period at the death of the employee or when PEBB coverage ends.

Dave Iseminger: This may seem like a Board decision, but because this topic is aligning with specific federal law, we are informing you of that alignment, rather than bringing something where you don't have discretion.

Stella Ng: Slide 7 – Regulatory Alignment. We're making a number of changes to align with changes in regulations, implement legislation, and align with state statutes. This includes amending definitions to align with recent state legislation. For example, due to Engrossed Substitute Senate Bill 6241 and Engrossed House Bill 2242, we are making global changes in rules to be more gender neutral. We're amending language referencing dependent children aligning dependent children's definition and eligibility

rules for dependent child of age 26 with state statutes. We're amending language to incorporate the use of respectful language when referring to children with disabilities and we are amending and updating appeals to streamline the appeals process and improve resolution timelines.

Slide 8 – Amendments within HCA's Authority. This includes amending employee notice requirements related to medical FSA and DCAP to make a technical correction by amending the rule on employee notice requirements to stay 30 days or less. We're modifying it to be more technically accurate with the Cafeteria Plan rules. We're adding a 31-day requirement for transferring employees who are eligible for the state's salary reduction plan to notify the new agency. This will help with the transition of payroll deduction when the employee transfers to a new agency. And we're amending the employer group application process by adding alternative requirements for employers that are unable to provide historical claims data and cost information. We're specifying the \$25 wellness incentive gift card must be claimed within the same year it is earned. This clarification is to match with current practice.

Tim Barclay: I'm just curious, on the bullet point about amending the group application, can you describe what the alternative requirements are?

Stella Ng: There are three alternative requirements. One is a letter from the carrier indicating they will not or cannot provide claims data. This is specifically for the small group applications. They also have to complete an actuarial calculator. We're currently using the spousal calculator to provide information about the plan most employees are enrolled in. And also, we're asking them to provide current premiums of their plan.

Tim Barclay: Okay, thank you.

Harry Bossi: A follow-up question on that. On the employer groups, at one time there was a limitation. I think employer groups less than 100 or 100 or fewer didn't have to provide claims data. Is that still part of it or is there a cutoff point?

Dave Iseminger: The employer group process, and again, employer groups are those political subdivisions, for a lack of a better word, that are contracting with HCA for access to PEBB benefits, has had changes in recent years. Prior to 2016, there was a risk underwriting factor analysis performed by our actuaries to say whether a group that wanted to join and be part of the PEBB risk pool was riskier or had the same or better risk than the risk pool. Only those groups who had as good a risk or better than the PEBB risk pool were allowed to join. In 2016, the Legislature changed those rules and allowed anybody who wanted to join the PEBB risk pool from local governmental status to come in. We do assess, as a whole, the risk that the entire political subdivision population is increasing the overall risk in the pool. There's a surcharge applied to all of those employer groups.

Those changes have morphed over time. There is no specific limit on the size of an employer group at this point. We have some employer groups that are as small as three and our largest just under 1,000. In 2016 when anybody could join, the original rules the agency set up mandated that they provide claims information. There were some very small groups and to protect PHI, and because of a variety of other reasons, the entity wasn't able to get claims information, we came up with a proxy with our

actuarial services for the type of information. But any group can come regardless of their size.

Harry Bossi: Thanks. I'll try to ask the question again differently. Is there a threshold where you don't have to provide claims data? I know at one time, it was if the size of the group was less than 100, you didn't have to provide claims data. You had to provide past history of who you might be insured with and those kinds of things, but there was not a requirement for claims data. Is that no longer the case?

Barb Scott: Staff are confirming now. When it came to looking at real data in making a decision as to whether or not a group could come in, the Legislature set it at a fairly high level because it had to do with a surcharge that is applied for those groups in order to offset, as Dave described, what's going on in the pool. I believe the number where we really start to look at in an actuarial assessment of the group, is 5,000. I think anything below that, we wouldn't look. The reason we go ahead and collect the data is so our actuaries have that available as they try to set what the surcharge should look like.

Dave Iseminger: I think the other part of your question, Harry, is what we're seeing is it's roughly groups that are 25 and under are saying they're having challenges with giving us the original claims data piece. We are generally not seeing a problem, so I believe the way we've set it up is there is a requirement for this and if you can't provide it, there's the exception to that. But the expectation is anybody who can supply regardless of your size of one person or a thousand, if you have it, provide it. If you can't provide it, we go through the process for an exception. There's not a line that everybody under 25 doesn't have to do it. Everybody's expected to do it unless you have a hardship and you show us why.

Barb Scott: Rob, what was the answer?

Rob Parkman: There's no line.

Dave Iseminger: Rob confirmed what I just said.

Barb Scott: Okay, no line. Not even 5,000.

Myra Johnson: I have a question on the \$25 wellness incentive. I see that changing and we're adding it to the new fiscal year, or is it enrollment year, that they have to use the card by? I'm wondering if some people, as soon as they enroll, get excited about it and if they enroll in October or November, it expires in December.

Dave Iseminger: Myra, there is yet a third date that you've entered into the equation via your question, and that's when the gift card expires. Nothing about the policy and the amendment within HCA's authority that's described here has to do with the expiration of the gift card. There's the earning of the gift card, which under the SmartHealth wellness plan eligibility requirements set by the Board, is completing the well-being assessment. That's "earning" it. Then you have to claim it. Claim it is when SmartHealth sends you a link, you have to click on the link to get your gift card. This has nothing to do with whether that gift card expires. We've been very clear in the communications to members that you have to "earn and claim" the gift card within the plan year.

If there wasn't a requirement to claim it within the same plan year, these \$25 gift cards would have to be managed as lost property, contact to the recipient every couple of years for seven years. The administration of tracking this property would be too cumbersome if this requirement wasn't in place. We'd also have to track and help manage which W2 it goes on based on when it was claimed. Then you're trying to track over tax years as to which \$25 came when for each person. It becomes administratively challenging to manage over multiple years. When this was first set up, it was very clear that it was supposed to be earn it and claim, but the rule didn't actually say the word "claim" even though that's how it's all been described to members. It's not a functional change.

Myra Johnson: Thank you.

Emerging Medications

Ryan Pistori, Assistant Chief Pharmacy Officer. Today is the second presentation on emerging medication as part of this new process. The first medication was Trogarzo, which was intended for a very small, select population of patients with HIV.

Today we'll be talking about the Erenumab or Aimovig, which is approved for the prevention of migraines. This medication will affect a larger population. Our cost analysis is slightly different than Trogarzo. Slide 2 is background information about Aimovig. It was approved by the FDA on May 17. This is the first drug in a new class of drugs used to prevent migraines, known as the calcitonin gene-related peptide inhibitors or CGRP inhibitors, as I'll refer to them going forward.

This is a new class of medication and there are other drugs in the pipeline that have not yet been approved but are expected to be approved either later this year or early next year. Those are Fremanezumab and Galcanezumab. With these two new drugs, there'll be three drugs in this class probably about this time next year, potentially even four, if another one comes out. There will be some competition in this class. The common theme about these new drugs is they're all being studied to treat migraine prevention or to prevent migraines from occurring. This medication was studied for both episodic migraines and chronic migraines. Those are for patients who have between 4 to 14 days of migraines per month, or those who have 15 or more migraine days per month. It doesn't matter how many migraines they have per month. It was studied for both and approved for both.

You may be asking yourself, "Are there other medications used to prevent migraines?" In fact, there are. Clinical guidelines from both the American Academy of Neurology and the American Headache Society recommend that certain beta-blockers, anticonvulsants, and antidepressants are used as first-line treatment for migraine prevention. There are other drugs studied to prevent migraines that may not be as efficacious or may be reserved for a very select refractory population. Those patients can use anti-hypertensives or potentially Botox.

Slide 3 is the beginning of the cost analysis where we tried to anticipate how many members could use these medications. Our initial assessment was to look at the entire UMP population, which at the time of this analysis was 256,000 members. We estimate approximately 3,844 may be using medications for migraine prevention. It's difficult to assess how many patients are using these medications for that indication just because

beta-blockers, anticonvulsants, antidepressants can be used for a number of different therapies. You can't tease that out. They could be using that medication for migraine prevention, to prevent depression, or to treat both. Based off of the initial population of 3,844, we are anticipating potentially 1% to 10% of this population may switch their medications, which is between 38 to 384 members who use this drug or a drug in this class in 2018.

Aimovig has been announced to cost approximately \$6,900 per patient per year, or about \$575 per month. This number does not include discounts we may receive as part of the Northwest Drug Consortium. We don't pay the full list price as part of our pharmacy benefit.

Slide 4 is the summary of our cost analysis. Putting that cost together with the population uptake and then adjusting it for the remainder of 2018. The experience that UMP may have with this new Aimovig or the other drugs in this CGRP class may cost the plan between \$113,000 to \$1.13 million in 2018. This really depends on the member uptake. As the members are switching off other medications to this medication, that will impact how much it costs the plan. These two numbers translate to approximately a 7-cent to a 73-cent per member per month cost, so the increase in the amount of monthly cost per member.

It's worth noting that this is what we anticipate seeing in 2018, but as drugs are approved by the FDA, as more enter the market, and as the pharmaceutical manufacturers continue to market them, we may see double the amount of members using it in 2019. We do expect growth for use in this drug class in the future. It's worth noting that Aimovig may not have significant medical cost offsets. The alternative therapies mentioned previously cost between \$7 to \$480 per 30-day supply. To put that in comparison, Aimovig was \$575. There are less costly, equally effective alternatives. There have been no studies on whether these drugs would decrease emergency room use or other medical cost offsets. There are no economic analyses at this time to determine non-medical cost offsets, like caregivers or other ways of compensating or providing patient care not typically calculated in the traditional health care system. The last bit of information I have about this drug is that members would pay \$150 for a 30-day supply of Aimovig. That is our Tier 3 specialty drug cost share, which is capped at \$150 per 30-day supply.

Sue Birch: Ryan, thank you for this information. I know our future is going to be linked with all your pharmacy work because this is the area that's really taking off, all this specialty pharmacy work. Next time you present, can you add two features to the presentation? First, I'm curious if this company has a consumer assistance program and if that's relevant. If there's anything out of the Northwest Drug Consortium that would impact our decision making. And secondly, since you have been doing such a wonderful job bringing us along on value-based pharmacy, if you can think about if this becomes a tier or the implications for that as we continue to look at that as an option in the future. I think we've all become more educated about the tiering and the impacts. I think it's great if you start helping us understand where this would fit into that schema.

Ryan Pistorisi: I'll try to answer both of those questions. For the consumer assistance program, I do believe there is one. When I was reviewing this drug earlier, I believe they did offer some type of patient assistance. I don't know the details of that patient

assistance program, but I do know they are offering some type of assistance for patients who are commercially insured, so not the members who are on Medicaid or Medicare.

For the future tiers, this drug and the other drugs in this class, we are planning on reviewing later this year at the Washington Pharmacy and Therapeutics (P&T) Committee. We will be presenting this to our P&T Committee for their review of the evidence of the safety of their comparative effectiveness. From there we'll be doing a cost analysis on this class and trying to leverage any rebates available. We are planning on managing this class in the near term.

Retired and Disabled School Employees Risk Pool Analysis Legislative Report

Kayla Hammer, Fiscal Information and Data Analyst, Financial Services Division. Slide 3 – What is the Legislative Report? RCW 41.05.022(4) requires that the Health Care Authority, in consultation with the PEB and SEB Boards, complete and submit an analysis of the most appropriate risk pool for the retired and disabled school employees. This analysis is due to the legislature on December 15, 2018.

Tom MacRobert: Is this part of the initial legislation when they created the SEBB that they expected this report to be issued at the end of December?

Kayla Hammer: Yes.

Dave Iseminger: The other thing I want to add for the record is many people ask me why it has the phrase “retired and disabled school employees” instead of just “school employees” or “retired school employees?” It’s the statutory definition made decades ago. It’s the exact statutory language of the reference many people think of as retired school employees.

Tim Barclay: Are you given direction as to the definition of most appropriate, or is that up to the agency to define as they produce their report?

Dave Iseminger: There's no guidance to that. It’s the phrase that exists in the legislation.

Kayla Hammer: Slide 4. Currently, when an eligible school employee retires, they have the option to join the PEBB Program and utilize the retiree benefit offerings. It would become part of one of the two risk pools currently managed by the Health Care Authority, the non-Medicare risk pool or the PEBB Medicare pool.

Slide 5 is a diagram of the current risk pools to help illustrate what the current scenarios are. On the non-Medicare risk pool, there are state employees, non-Medicare state retirees, and the non-Medicare school retirees in the purple box. The Medicare risk pool has Medicare state retirees and Medicare school retirees.

Slide 6 - Current PEB Board Benefits and Subsidies. School and state retirees that utilize PEBB are offered the same benefits at the same rates. The non-Medicare retirees can purchase PEBB non-Medicare plans and the Medicare retirees can purchase PEBB Medicare plans. The school and state retirees both receive subsidies of the same amount to help offset the cost of those benefits.

Slide 7 – Legislative Report Requirements. Per the RCW, the report will include the size of the non-Medicare and Medicare retiree enrollment pools, the impacts on cost for both state and school retirees for any proposed risk pool changes, the need for and the amount of an ongoing retiree subsidy allocation, and timing and approach of any risk pool changes.

In the next few slides, we're going to go over the things that will be considered in order to meet these legislative requirements. Slide 8 – Retiree Enrollment Pools, the following things will be reported on: the total retirees enrolled in the PEBB Program, this would include how many are school versus state retirees and how many are Medicare versus non-Medicare retirees and risk scores for each group listed.

Slide 9 – State and School Retiree Impacts. We must address the possible impacts on cost for both state and school retirees should any risk pool changes occur. There are several options to consider for school retirees. The possible changes are listed on this slide, but I'll go into more detail on the following slides with visual diagrams

Slide 10 – Create SEBB Program Non-Medicare Risk Pool. In this scenario, the school retirees not yet enrolled in Medicare would be removed from the PEBB Program and combined with the SEBB Program employees into one risk pool. They would be rebranded the SEBB Program Non-Medicare Risk Pool. In this particular scenario, the Medicare school retirees would stay in PEBB in the Medicare risk pool.

Slide 11 - Create SEBB Program Non-Medicare and Medicare Retirees Risk Pool. In this scenario, we would do the same thing I just mentioned, which would be to rebrand and create a Non-Medicare Risk Pool under the SEBB Program, removing the non-Medicare school retirees from PEBB into SEBB. We would also create a Medicare risk pool under the SEBB Program, removing those Medicare school retirees from the PEBB Program Medicare risk pool.

Slide 12 - Create Two Additional SEBB Program Risk Pools. In this scenario, there would be the following pools: the SEBB Program Employee Risk Pool, which already exists in the legislation currently; the SEBB Program Non-Medicare Retiree Risk Pool, removing non-Medicare school retirees from PEBB into the SEBB Program into their own risk pool; and then the SEBB Program Medicare Retiree Risk Pool, removing them from PEBB into the SEBB Program.

Slide 13 – One SEBB Program Risk Pool. In this scenario, there would be one risk pool under the SEBB Program. It would contain the school employees, the non-Medicare school retirees and the Medicare school retirees.

Dave Iseminger: On slide 13, in anticipation of questions either during public comment or from the Board, I want to highlight that the purview of this legislative report is focused on school retirees and what risk pool is appropriate for them. There have been discussions and comments from some Board Members, and questions in public comment, about combining the PEBB Program risk pools into a single risk pool like on this slide, having just one green box and one orange box. I want to say that although this report is focused on what to do with school retirees, those individuals interested in what the implications might be for a single risk pool might find this particular scenario

informative for their thoughts or ideas related to PEBB. The report is focused solely on school retiree options.

Kayla Hammer: I also have a note to add. Each scenario I just described, not only does it require an analysis of the impacts on cost, but also of the legality. The current risk pools that exist are legislatively mandated. Any changes would require legislative action. Furthermore, outside of Washington State law, there are federal regulations with Medicare and IRS when it comes to employee and retiree benefits. All of that will be considered as we're working on the analysis.

Slide 14 – Retiree Subsidy. Any risk pool scenario will include consideration of the possible impact to the retiree subsidy allocation, the need for an ongoing subsidy allocation, and the amount of that ongoing subsidy allocation.

Slide 15 – Timing and Approach. Each possible change to the current risk pools have different challenges that will affect the amount of time needed and the approach taken. We will consider required changes to legislation as the current risk pools are legislatively mandated. Any change requires legislative action. There are implementation and administrative considerations. Many work streams go into managing the risk pools, and each work stream has its own set of regulations and timelines needing to be kept and met during any sort of change. Some items listed on this slide are examples. If we were to develop any new risk pools, we would need to procure benefits for those risk pools. There's a lot that goes into procuring benefits and they would also need to be approved by the SEB Board for any new benefit offerings and what's going to offered to their members.

Hand-in-hand with the benefit design is the contract management as far as getting contracts into place. There's also very specific regulatory timelines with that. The rate development, if there were new benefits procured for new groups, we would need to set rates for each of those plans. That has its own timing concerns and things to think about. There are also member communications. Any changes would need to be communicated to members.

Slide 16 is the current report timeline.

Slide 17 – Discussion. HCA is interested in your opinion regarding this analysis. Some things we are interested in are your opinions on the scenarios discussed, the subsidies, implementation, and administrative concerns, or anything else you want to share. I realize it's a little on the spot to be asking for feedback so if you don't have anything today, you can give feedback to Connie and copy Dave up until COB August 10, 2018.

Tim Barclay: I think it's hard to add too many comments without some data and information. August 10 is fairly quick. Would you like a data request from us as to what we'd like to see or are you planning on putting information to give us? Or would you rather we just comment blindly? Where are we headed with this?

Dave Iseminger: For today, comment blindly and if there's specific pieces a Board Member wants to follow up with, asking more questions about data, we can see what we can provide to give more insight in order for you to give more insight by August 10. But for purposes of now, today, unfortunately, it would be blindly.

Kim Wallace: I'm here to support this presentation and share. As a SEBB Finance Manager, I want to share that Kayla's well underway in working with our actuarial consultants to compile relevant data, the members and their experience in the risk pools as we see them currently. We're starting to separate out the SEBB groupings of the various SEBB populations in the risk pools as well. It may be that we can absolutely provide some relevant and meaningful data to the Board in the next week or two. I wanted to note also that we are providing this presentation to the SEB Board on July 30. We will also be offering them the opportunity to ask questions, make any requests that they would like, etc. We're going to be as actively as possible engaging both the SEB Board and the PEB Board over the next two to three weeks. Please do share with us what would be especially helpful and meaningful to you.

Sue Birch: One thing I am hoping you all will bring back is any other relevant learnings from other states that have coverage for SEBB. If there are any leading states that have the construct in what they've done with the different risk pools, I'd like to see that comparison or see if there's anything to learn from them.

Tom MacRobert: Dave, because I do hate shooting blindly, on our agenda for our next meeting, if possible I'd like if we had an opportunity to put this on the agenda in order to give us time to reflect on this information and develop more thoughtful questions.

Dave Iseminger: Absolutely we can. We usually have a very short last meeting but we already have multiple things on the agenda to talk about. We can certainly engage in further discussion on this at the next public meeting if the Board wants additional time for comment. I'm assuming there are seven voting members of this Board and nine voting members of the other Board. That means there's probably at least 16 different opinions. We're trying to figure out the best way to memorialize the feedback and insight. The Board doesn't need to take a position on one pool over another. That's not the role of the Boards in the report, but provide your insight and how we wrap that up into the final report we're working on. Right now we're in the 'gathering your insight' stage of the process. I want to make sure it's clear we're not expecting the Board to take a vote on one pool over another. There's no specific value in that. Like I said, I'm sure there's 16 different opinions between the 16 voting minds on this particular issue. We can certainly put something on the next agenda for further discussion and allow you the week to reflect between now and the next meeting, and still have that follow up time through August 10 of additional things you want to submit for the agency to review.

Tom MacRobert: Thank you.

Harry Bossi: I don't know if it's a question or a comment, but the school retiree and the school component is relatively small. Is that correct? It's going to grow significantly in the future. I think when assumptions are made for the future it's critical because it may look entirely different when there's a ramp up to the enrollment. I don't know what the makeup is, of the groups -- the schools that are currently enrolled. But it'll be significantly different in a couple of years, I would guess. The age factors, the prior history, the claims history, and trying to project what that is going to look like in a couple of years with a considerably larger group, I'd be really interested in focusing on what kind of -- I don't think we can just say, "Well, claims data analysis this," so we'll just multiply that times a certain factor and that's what it will look like down the road. I don't have a solution to that, but I think it's something that needs to be carefully analyzed.

Kim Wallace: A couple thoughts as I hear you share, Harry. Of course the K12 employees who retire now, their state retiree option is in PEBB. Kayla has an overall statistic to share about the percentage of state retirees, what we would consider state employee retirees, in the Medicare retiree pool, the big pool compared to K12 retirees. We affectionately refer to one big pool of all the state and school retirees. We do have a lot of experience, and the data that Tim was referring to with the K12 retirees along with the state, it's actually not a small number. It's a sizeable group.

One of the dynamics we also are aware of, and I think other people can speak to if needed more deeply and expertly than I can, but we're also aware of the dynamic of just communicating and people -- do K12 employees currently understand their PEBB benefit options in the PEBB Program? You may be thinking or suggesting something that we are aware of and with the advent of the SEBB Program, it's going to be clearer to K12 employees across the state that they belong to this consolidated benefits program, one big statewide program. I think it will be clearer to them that their move over to PEBB as a retiree or their option to stay in SEBB as a retiree should that come to pass. That's going to be more understandable to them. We could see some changes in terms of people moving into coming into the PEBB or SEBB retiree pool from their K12 employment. But rest assured, right now we have many, many K12 retirees currently under the managed PEBB pool.

Harry Bossi: And that's a misunderstanding on my part. I came from a different place in a different part of the country that wasn't the same. I misunderstood. And so I just retract the question.

Kim Wallace: Well, isn't it about 50/50 actually, right now?

Kayla Hammer: Yes. In the Medicare pool, specifically, it is about a 50/50 split of retired state Medicare retired school. However, in the non-Medicare pool, there's a smaller population.

Tom MacRobert: Kim, is it fair to say the non-Medicare school retirees is the smallest group of the ones you're talking about? The active school employees, the Medicare school retirees, and the non-Medicare would be the smallest of those groups, correct? Is one of the things you have to complete in this analysis as people that are currently active school retirees retire, it's what pool they would then go into whether it would be SEBB or PEBB? That's a major concern going forward. I would assume that were those groups separated, you would get quite a small group moving forward. I don't know if I'm making myself very clear on that.

Kim Wallace: You are, Tom. One of the things we're aware of and we want to track carefully in this analysis, is what the experience is. There's financial analysis, of course. But it's very important to us that we understand what the experience is for all of the employees and retirees that we're responsible for their benefits. If you start thinking of an employee and then you imagine they retire and they are not 65, as they are retiring and does it make sense for them, from a member experience, what benefits do they have to choose from, etc., currently K12 employees who are, say 55, retire and have the option to join PEBB benefits. Those PEBB benefits are different than the benefits they have as a K12 employee, of course. You might imagine a future where a K12 employee is receiving benefits under the SEBB Program. They retire and they're 55.

They stay in the SEBB Program as a non-Medicare retiree. They don't change perhaps over to PEBB until they're 65. I guess I'm just saying I think that's what you're raising is that we're not only running numbers, we're also looking at this from what makes the most sense to all of those folks out there and to administer efficiently and effectively. There are a number of different angles that will go into this, the study and the analysis, numbers being one piece.

Tom MacRobert: Thank you.

Greg Devereux: I think this is a lot to chew on. I hope to do it before August 10 and get back to you. I must say, I have to comment that Kayla's use of simple boxes and visuals was really good.

Sue Birch: Absolutely. When Tom began to speak, we all flipped to page 13, going, "Wait, which box? Yellow? Green?" So thank you. That's going to be really important as we go forward.

Tom MacRobert: I'd like to know what the numbers are at our next meeting for the after school employees, the non-Medicare school retirees, and the Medicare school retirees. If you could provide those numbers, that would be great.

Kayla Hammer: I don't have the active school employee numbers but I do have the most recent, June 2018. I have the non-Medicare retired K12 and it's about 4,000.

Tom MacRobert: Medicare school retirees.

Kayla Hammer: Medicare, June 2018, 48,000.

Tom MacRobert: 48,000.

Dave Iseminger: Tom, we'll follow up with the actives, but I know it's roughly between 3,000 and 5,000.

Tom MacRobert: I'm talking about the entire pool of active, like you would be the SEBB pool of active school employees.

Dave Iseminger: The future pool? The future third pool?

Tom MacRobert: Yes.

Dave Iseminger: We can answer that now, too. The best we can estimate at this point, the number we've been using is from the S275, the report that I believe is OSPI's report, and the estimate is roughly 134,000 subscribers that would be part of that pool.

Kim Wallace: Eligible employees.

Dave Iseminger: Eligible employees. And then once you add in dependents, that is part of the grand question with the consolidation is because the premium variability and the tiered ratios that exist in K12, there is not uniform accessibility to adding dependents.

We're trying to use dental data as a proxy. Our best estimates we've used is the entire pool would be somewhere from 200,000 to 300,000.

Tom MacRobert: Did you say you knew or you had a guesstimate on what the PEBB enrollees are that are active school employees now?

Dave Iseminger: Yes, currently, it's roughly 3% to 5% of the K-12 employee population. I said 3,000 to 5,000 earlier, I meant 3% to 5% and it's actually 4,000 to 6,000 employees. It's roughly 72 school districts and five of the educational service districts. It's not all of the bargaining units in all of them either. Roughly half of the school districts that have opted to join PEBB at this point include all bargaining units. The other half is just a few of their bargaining units. As a reminder, there's somewhere between 900 and 1,000 bargaining units amongst the 295 school districts.

Tom MacRobert: Okay, thank you.

Kayla Hammer: Just to add to this sort of 134,000-ish estimate from the S275 data Dave was talking about, that does not include substitute teachers. There is definitely a bit of unknown there, but we're doing our best to get to the bottom of it.

Tom MacRobert: Thank you.

Sue Birch: We'll have lots more information coming back at us. Then we can keep adding questions and directing you to go find out more information. That's why we have plenty of time to get this report done by December. Kayla, you're going to have a busy next few months.

Kayla Hammer: That's the truth.

Public Comment

Fred Yancey: I represent the Washington State School Retirees Association. I just want the record to reflect that I'm disappointed with the process here. You're asked to deal with this very significant issue as to what to do with retirees and where to place them and what to do with K12 school employees together. And you have absolutely no information. A decision you have less than three weeks, or August 7, you know, or August 10, whatever the timeline is to give feedback on this important concept, but you have no data in which to make a judgment based on it. So I have real concerns, you know? When you're asked your opinions regarding the analysis and initial thoughts on this, all I could give you is shooting in the blind, which is what you had referenced. And so I'm disappointed that the process doesn't start with information before you arrive at a conclusion. You're getting information after you've been asked to come to terms with some sort of conclusion.

Sue Birch: Fred, thank you for your comments. I do want to clarify on behalf of what I heard from staff, which was we are beginning a process. They're going to gather their own kind of information and bring it forward and share it with both Boards. The report is not written. We're going through a process. I think they're asking Board Members to please start thinking about what other information is going to come forward. So please submit your questions or comments in writing so we can be aware of that or contribute those to Board Members as we get further into the process.

Fred Yancey: And that's exactly my point. Questions and comments when you have no data under which to generate questions or comments. I mean, I can tell you what I think about risk pools and which of the seven scenarios I would prefer. But I have no data, you know, to justify that choice. And you're going to analyze, I assume, seven different scenarios. And according to this and maybe I've misread this, presentation July 30, an internal review, which I take as an internal agency review through September through November, which is probably the development of the very same information that I am saying you need upfront. OFM review and then December 15, report due. So with all due respect, I don't see where this is an evolving process that will come repeatedly before the Board. I understand this meeting a week from now, the next meeting will call for your conclusions, if you will. I'm just concerned.

Sue Birch: Thank you for your comments, Fred. We so note those and as we go through the process and have information, we will be sharing that information as transparently as possible and involving the public and calling for comment as we go through the process. So thank you.

Tom MacRobert: I do have one more question. This OFM review, so after you have developed your data I'm assuming you are going to have to submit that data to the Office of Financial Management and they're going to include some data as well, what their analysis is of the cost?

Dave Iseminger: Formal legislative reports like this one, and this agency has at least 48 due this calendar year alone, have a formal process that they go through in order to make it on the legislature's desk. Part of this agency's commitment to getting our homework in on time per the legislature's request is to produce draft reports that OFM reviews and provides us insight and feedback. That's a standard part of any legislative reports process. It's not necessarily them doing an independent review. It's them looking at the report that we have crafted and giving us feedback. We finalize the report and turn it into the Legislature. It's just a standard part of all legislative reports that this agency does.

Tom MacRobert: Good. Keeps you busy. [laughter]

Sue Birch: Our next meeting is July 25 from 1:30 p.m. to 4:00 p.m.

Preview of July 25, 2018 PEB Board Meeting

Dave Iseminger: Typically, the next Board meeting only has one agenda item, the conclusion of the rate setting process and asking you to take action on those rates. But as you see, our Briefing Books continue to grow every meeting. We have three other topics for July 25. We'll bring back long-term disability and answer additional questions related to that, and ask the Board to take action on that piece. We're also going to include additional discussion of the K12 retiree report after your ability to take this presentation back and think about some of the pieces we just discussed and see what other information we can bring to the Board.

The fourth agenda item, I'm fairly confident very few people remember January's retreat, but we began having a discussion about the broader Medicare retiree portfolio options. There have been discussions from the Board in prior years about different benefit option structures for Medicare retirees. The Legislature this last budget cycle

allocated funds for some analysis that doesn't rise to the level of the legislative report about some of the retiree plan options. We're going to have a presentation about that, picking up where we left off in January. This will also set the stage for a significant conversation with the Board during the 2019 Board season. So those are the four things: rates, long-term disability, more discussion on K12 retiree report, and Medicare retiree portfolio analysis.

Sue Birch: Meeting adjourned at 4:15 p.m.