

# Public Employees Benefits Board Meeting

March 20, 2019

## Public Employees Benefits Board

March 20, 2019

1:30 p.m. – 3:30 p.m.

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

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**TAB 1**

## AGENDA

**Public Employees Benefits Board**  
**March 20, 2019**  
**1:30 p.m. – 3:30 p.m.**

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

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

**Participant PIN Code: 95587891**

1:30 p.m.*	<b>Welcome and Introductions</b>		Sue Birch, Chair	
1:40 p.m.	<b>Meeting Overview</b>		Dave Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information
1:45 p.m.	<b>Approval of Meeting Minutes</b> <ul style="list-style-type: none"> <li>• July 25, 2018</li> <li>• September 17, 2018 (Combined PEBB/SEBB)</li> <li>• September 17, 2018</li> <li>• January 31, 2019</li> </ul>	TAB 3	Sue Birch, Chair	Action
1:50 p.m.	<b>Legislative Update</b>	TAB 4	Cade Walker, Executive Special Assistant Employees & Retirees Benefits Division	Information
2:20 p.m.	<b>UMP Pharmacy Update</b>	TAB 5	Marcia Peterson, Manager Benefits Strategy & Design Section, ERB Division	Information
2:40 p.m.	<b>Emerging Medications</b>	TAB 6	Ryan Pistorosi, Assistant Chief Pharmacy Officer, Clinical Quality and Care Transformation Division	Information
2:55 p.m.	<b>SmartHealth Update</b>	TAB 7	Marcia Peterson, Manager Benefits Strategy & Design Section, ERB Division	Information
3:15 p.m.	<b>Public Comment</b>			
3:30 p.m.	<b>Adjourn</b>			

**\*All Times Approximate**

The Public Employees Benefits Board will meet Wednesday, March 20, 2019, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8<sup>th</sup> Avenue SE, Olympia, WA. The Board will consider all matters on the agenda plus any items that may normally come before them. This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW. Direct e-mail to: [board@hca.wa.gov](mailto:board@hca.wa.gov). Materials posted at: <http://www.pebb.hca.wa.gov/board/> no later than close of business on March 18, 2019.

## PEB Board Members

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

## PEB Board Members

### Name

### Representing

Tim Barclay  
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Benefits Management/Cost Containment

Vacant\*

Benefits Management/Cost Containment

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[MichaelT4@atg.wa.gov](mailto:MichaelT4@atg.wa.gov)

\*non-voting members

11/28/18



Washington State Health Care Authority  
*Public Employees Benefits Board*

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360-725-0856 • TTY 711 • FAX 360-586-9551 • [www.pebb.hca.wa.gov](http://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 8<sup>th</sup> 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

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

**DATE: August 13, 2018**

**TIME: 8:07 AM**

**WSR 18-17-076**

**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**

July 25, 2018  
Health Care Authority  
Sue Crystal Rooms A & B  
Olympia, Washington  
1:30 p.m. – 4:00 p.m.

**Members Present:**

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

**PEB Board Counsel:**

Katy Hatfield, Assistant Attorney General

**Call to Order**

**Sue Birch, Chair**, called the meeting to order at 1:37 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.

**2019 Premium Resolutions**

**Beth Heston**, Contract Manager, Employees and Retirees Benefits Division. Before Tanya presents the 2019 Premium Resolutions, I am going to answer some of your questions from last week regarding the benefit design changes. But first, I want to point out we are adding a virtual diabetes prevention program administered by Omada for all non-Medicare members to the Uniform Medical Plan.

Slide 3 – Medical Plan Changes. There are several changes under the Kaiser Permanente Plans. They will also be adding a virtual diabetes prevention program, also administered by Omada for all non-Medicare members. It's for non-Medicare members

because Medicare offers their own diabetes prevention program and Medicare won't cover ours.

Slide 4 – Dental Plan Changes. Under the Uniform Dental Plan, the limit on Class 3 restorations (crowns) will be lowered from seven years to five years.

**Dave Iseminger:** Slide 4, says the changes are to the Uniform Medical Plan. It's really the Uniform Dental Plan. We're not adding a crown benefit into our medical benefit.

**Beth Heston:** There was a question on the average inpatient days for SoundChoice. It is 3.17 and the annual out-of-pocket maximum does apply. \$2,000 per individual or \$4,000 per family.

**Tom MacRobert:** That means the maximum you would pay out-of-pocket? It was worded as no maximum.

**Beth Heston:** Correct, but it meant there was no maximum on the stay. When you reach the maximum out-of-pocket, that's it.

**Tanya Deuel,** PEBB Finance Unit Manager. Today, we are going to ask you to vote on the resolutions for both the Medicare and non-Medicare risk pools. I want to remind you these are organized by carrier for each of the risk pools. All plans within the Kaiser Foundation Health Plan of the Northwest will be in that resolution and so on for the non-Medicare risk pool. They are broken down by carrier for the Medicare risk pool.

**Sue Birch:** Slide 6 – Purpose of Board Action. Myra brought to our attention that we need to correct the date on this slide to July 17, 2018, "premiums presented on July 17, 2018."

#### **Resolution PEBB 2018-06 – Non-Medicare Premium**

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

Greg Devereux moved and Harry Bossi second a motion to approve.

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-06 passes.

#### **Resolution PEBB 2018-07 – Non-Medicare Premium**

**Resolved that,** the PEB Board endorses the Kaiser Permanente of Washington employee and Non-Medicare retiree premiums.

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-07 passes.

**Resolution PEBB 2018-08 – Non-Medicare Premium**

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

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-08 passes.

**Resolution PEBB 2018-09 – Medicare Premium**

**Resolved that**, the PEB Board endorses the monthly Medicare Explicit Subsidy of \$168 or 50% of premium, whichever is less.

As a point of clarification on the one-page list of resolutions in your Briefing Book, the fourth resolution listed, PEBB 2018-09, is listed as the Non-Medicare premium. It should read Medicare premium.

**Dave Iseminger:** Correct. The summary sheet in the back says Non-Medicare premium, but the resolution itself, Slide 10, says Medicare. It should be Medicare.

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-09 passes.

**Resolution PEBB 2018-10 – Medicare Premium**

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

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-10 passes.

**Resolution PEBB 2018-11 – Medicare Premium**

**Resolved that**, the PEB Board endorses the Kaiser Permanente of Washington Medicare premiums.

Yvonne Tate moved and Tom MacRobert seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-11 passes.

**Resolution PEBB 2018-12 – Medicare Premium**

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

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-12 passes.

**Resolution PEBB 2018-13 – Medicare Premium**

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

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-13 passes.

**Dave Iseminger:** I just want to say that there's a lot of staff work that went into what was a very quick vote from the Board. It contrasts with the experience of setting rates from last year. I did want to acknowledge the work staff put into bringing something to you that was able to go through such a quick vote from a procedural standpoint. It represents a lot of work the last couple of months by a lot of people in this agency.

**Sue Birch:** Thank you, Dave. And having seen this in action last year, I, too have to say the nearly \$20 million we're saving the state is a pretty great thing to be proud of. I do think it's part of the whole transformation the state has been undertaking. It's fabulous to see. And, Greg, I think you had a comment?

**Greg Devereux:** I, too, want to acknowledge that I think the staff did an incredible job. I know it takes a lot of time to get the rates that we ended up with and we really appreciate that effort.

**Sue Birch:** Great, thank you for those comments, Greg. And, Dave, I know you had an enormous leadership role. Thanks to the whole team. It really is remarkable.

### **Long-Term Disability Insurance**

**Betsy Cottle,** Contract Manager for the current long-term disability product in the PEBB Program. I will also be managing the product for the SEBB Program population.

At our last meeting, we talked about the possibility of an open enrollment and Sue asked what the living wage is in Washington State. Slide 2 is a little complex, but it provides information for Washington. I pulled it directly from the Massachusetts Institute of Technology site. It is a calculation done by this particular scientist. It's a good comparison for what we're trying to cover with disability information.

**Sue Birch:** I actually wanted to see where, for this state, some of the breaks occurred. For example, one adult, three children, \$83,366, and I believe our average household right now is one adult, two children. I think that's the predominant configuration in this state. I recommend we look somewhere between \$65,000 to \$83,000, where many of our folks are living.

**Betsy Cottle:** You're right, because Slide 3 – PEBB Program Subscriber Income actually shows the breakdown of what our state employees make so that connection between the previous graph and what you've just described is correct.

**Tom MacRobert:** If you could go back to that previous slide, I'm assuming the minimum wage is the state minimum wage that's calculated. And then, can you give me the definition of poverty wage, how that's factored?

**Betsy Cottle:** Yes, the state minimum wage is what's calculated. Poverty wage is set by the federal government as a standard calculation being used by actuaries and all sorts of different programs.

To Sue's point, the largest number of people in our employment make between \$57,000 and \$60,000 a year, which is displayed on this slide. Slide 4 – Current Plan Enrollment is what we talked about last time. Who's enrolled and who's in a claim.

We also had questions about the kind of diagnosis the PEBB Program population has with the rest of the country, and that's on the Slide 5 – HCA LTD Diagnosis Comparison. This is a report The Standard provides us every year. It's presented in two different ways. The first is by comparison, how are we against the rest of The Standard's book of business, and by occupation, shown in Slide 6 – HCA LTD Diagnosis by Occupation.

**Dave Iseminger:** The Standard's book of business means nationally.

**Betsy Cottle:** As you can see, by occupation, the largest percentage of people who have a disability claim is in the professional class. It trends downward to service workers, office and clerical, technicians, etc. In general, the Health Care Authority is below the professional, but in almost every other class, we really vary from the national average. We're a different kind of population so our percentages are very different. I actually don't know why that's true.

**Dave Iseminger:** When it says Washington State Health Care Authority, that's the benefit that's administered by the agency on behalf of all employees. This is synonymous with the PEBB Program in this context. It's not agency specific, it's a reference to us as The Standard's client for the PEBB Program. Just for complete clarity.

**Betsy Cottle:** Slide 7 – LTD Claim Trends vs. Benchmarks. This slide is the Health Care Authority versus The Standard's book of business. The green and red triangles tell you whether or not we are above or below The Standard's book of business benchmark. Overall, we are very comparable by type of claim to The Standard's book of business.

Slide 8 – Benchmark Source Information, is about enrollment. This is the base information for data presented in the two previous slides.

Slide 9 – LTD and Social Security Disability. Sue had a question about how long disability and Social Security disability can interact with each other and this slide responds to that. Very briefly, long-term disability has an application process that is much shorter than Social Security disability. You can get to your long-term disability product more quickly than you can Social Security disability. What The Standard and most long-term disability vendors do is, in an effort to make sure the member is getting the best benefit from both products, coordinates the effort to assist the application process.

Most people don't need Social Security disability during their disability claim period. If they do in fact feel they are going to end up on a permanent disability claim with Social Security disability, there is going to be some overlap during that application process. So you're on long-term disability, you and your physician determine you are probably going to be disabled for quite awhile, you and The Standard, or your disability insurance carrier, will work together to get your completed application into Social Security disability. By the time that happens, you will have collected extra money from LTD that is going to be retroactively collected by the first Social Security disability payment. That period can be very disruptive and confusing for members because it can take a great amount of time to make that bridge. That's where a lot of confusion, fear, and complaints are happening because it's a very technical process.

**Carol Dotlich:** Can you describe for me how that works? So, you get some money you're not really entitled to when your Social Security kicks in, right. So, they take it back how?

**Betsy Cottle:** You will have received long-term disability payments and then you begin your social security disability income payments. Your long-term disability vendor will collect the Social Security disability coming in, balance your payments, and then pay you the remainder. Once that bridge has happened, you're on Social Security disability.

**Carol Dotlich:** So the money from Social Security is going directly to the vendor and the vendor pulls their money out and then gives you the money?

**Betsy Cottle:** That's right.

**Sue Birch:** For the record, I want to clarify we're talking about SSDI – Social Security Disability Insurance.

**Betsy Cottle:** Yes. Social Security Disability Insurance. Not your general Social Security.

**Carol Dotlich:** Understood.

**Dave Iseminger:** Typically with SSDI, there's a lump sum that comes because it's a retroactive determination. That's why there's this true up that occurs.

**Carol Dotlich:** Is there a point when the consumer is harmed? In other words, if the consumer is getting a set amount per month that they're counting on, when this change happens, is there a point at which the standard monthly amount is reduced?

**Betsy Cottle:** Depending on your plan. If you are finally on Social Security Disability, you may or may not be completing your long-term disability claim because disability insurance and Social Security disability insurance coordinate, but I would have to look at a specific claim and a specific set of circumstances to give you a very clear answer. But in general, there is a lump sum that comes from SSDI that goes to your disability vendor. They may see they've been paying you for three months too long so they're going to take that out before you get the rest of your income.

**Sue Birch:** For a little clarification. I do think there are certain medical conditions that impact the progression, the timeline, and the process. For example, certain types of cancer and things will either accelerate or slow down the process. I think that gets factored in some way shape or form. Probably muddying the waters, but it's very complex. But they true up over time and the time intervals can be very different based on the person's diagnosis.

**Carol Dotlich:** The reason for my question is I've dealt with overpayments and other circumstances, and sometimes, the taking back of the money paid is pretty painful for the person. That's why I'm asking. Is there an abrupt edge of the curb where people fall over or no?

**Betsy Cottle:** I really can't speak to it in a general way. It's extremely specific to each claim. If you are ever in the position that you find a PEBB Program member you feel has been harmed, I would love to hear about it.

**Dave Iseminger:** Carol, in general, the system's set up so that the member gets the payment from their long-term disability carrier and then that true up occurs. If you had a claim for \$2,000 a month, you'd be getting your \$2,000, on the separate track you would have your SSDI application that's going through. Once that's approved, the true up occurs. But, the whole while, you'd be getting your \$2,000 from your long-term disability carrier. The true up would occur, and going forward, you might get \$1,500 from Social Security Disability and a \$500 check from The Standard. But at all points, you would be continuing getting the claims. That's why I think Betsy would be surprised and would want to hear if there's a member that you are aware of, or any of you are aware of, to bring forward as an issue. That's how the system's supposed to work.

**Betsy Cottle:** Slide 10 – Decision #1 – Offer of a One-Time Opportunity. There are two decisions to be made. One is an opportunity for a one-time offer to our eligible employees to purchase optional long-term disability, increase their optional LTD, change the waiting period for their optional benefit. The offer is open to every eligible employee, even if they have previously been denied optional coverage. Premium rates will be guaranteed until January 1, 2021.

**Dave Iseminger:** Betsy, before you move on, I had some feedback this past week on second item in the first bullet, increase optional LTD. This could be confusing because, the reality is, this is a salary-based plan. You either have the optional benefit or you don't. Your choices are to purchase the LTD benefit or change your waiting period. Originally we were thinking about the macro payment an individual receives, and you're increasing your payment that you're getting if you're going from just basic coverage to both basic and optional. But that overly complicated things for folks. We actually have a revised resolution for you to take action on today that deletes the reference to increasing your optional LTD, because, again, as a salary-based plan, you either have it or you don't. You're not electing a different coverage amount like you would in another benefit such as life insurance.

**Betsy Cottle:** Slide 11 – Proposed Schedule. We would begin marketing almost immediately this year and offer an open enrollment event in quarter one of 2019 with a plan effective date in quarter 2 of 2019.

Slide 12 – Decision #2 – Increase Monthly Maximum Benefit. The second decision that that Board has available to them is to increase the plan maximum from \$6,000 per month to \$10,000 per month.

Slide 13 – Claim Fluctuation Account (CFA). Our long-term disability accounts, both basic and supplemental, are protected by a claim fluctuation account. This slide is a description of the account and how much The Standard keeps in ours. The Standard does maintain separate claim fluctuation accounts for employer-paid basic and employee-paid optional.

**Dave Iseminger:** We wanted to make that crystal clear on the record for the Board at the last meeting. We were 99.9% sure, and we double checked that last week. We wanted to be clear that if the Board were to take action and authorize an open enrollment on the optional benefit, it wouldn't impact the premium reserves on the basic side. It shouldn't influence the ability to take steps to work on the basic benefit and change that benefit in the future.

**Betsy Cottle:** Slide 14 – Decision Considerations. Offering a one-time opportunity to PEBB Program employees could impact the optional plan's claim fluctuation account. There is the possibility for more claims if more people are enrolled. Increasing the maximum monthly benefit could also impact the employee-paid optional plan claim fluctuation account. By increasing the maximum monthly benefit, it becomes more attractive and could increase claims. If the Board chooses to offer a one-time open enrollment and increase the maximum monthly benefit, the impact to the employee paid optional CFA is assumed to be higher as is the possibility of a rate increase in the near future.

**Dave Iseminger:** It's only been one week and this was a very big topic to bring at the end of Board season, so we wanted to make sure we went through a fairly similar presentation with some added information from last meeting because it was something that we hadn't brought the Board on the journey this season. I wanted to be clear as to why we went over a lot of the same information again. Our actual recommendation is to go forward with the open enrollment piece and not have the Board take action on increasing the benefit maximum. We think that balances the variety of interests and is an appropriate use, without too much risk, of reserves. Our recommendation is what is before you in this resolution. This is a minor tweak from what was presented last week. There is no reference to increasing the optional benefit because, again as a salary-based plan, you either have the benefit or you don't.

**Greg Devereux:** I appreciate that distinction very much. And I appreciate Tim's comments from last time. I'm pleased with this.

**Harry Bossi:** I have a question regarding the open enrollment itself. That would be just a change – the enrollment? Somebody already had it and was satisfied with their waiting period they had already chosen and they can be passive and don't have to do anything?

**Dave Iseminger:** Yes, we'll work with the vendor to ensure nobody gets harmed, meaning that just because they don't raise their hand during the open enrollment that they don't lose anything. It's only added people. If people are happy with what they have now, they don't lose anything. It would only be changes they affirmatively ask for.

**Tim Barclay:** Dave, I just wanted to thank you for your work on this. I think it's important that we can give this opportunity to our members in light of that fact that our basic benefit is frankly inadequate. Maybe this will draw more attention to that and we can use this and leverage that and communicate to a broader audience the need to enhance that basic benefit.

### **Sue Birch: Resolution PEBB 2018-05 – LTD One-Time New Enrollment Opportunity**

**Resolved that**, during Q1 of 2019, the PEBB Program will offer all eligible employees an opportunity, without providing evidence of insurability, to purchase optional LTD insurance or change their benefit waiting period.

Greg Devereux moved and Tim Barclay seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-05 passes.

### **School Retiree Risk Pool Analysis Follow Up**

**Dave Iseminger:** We don't anticipate this as the last time we talk about this topic with the Board, even this calendar year. We note this is a particularly sensitive and important topic and a very important legislative report. The agency has been tasked with doing an evaluation and bringing forward information. I want to be clear that when

Kayla described some scenarios at the last meeting, we described some of the considerations. I've heard in the last week that some people may have been trying to read into what Kayla was saying and looking for tea leaves as to what the agency was thinking, or what Kayla was thinking and saying. You described a more thorough analysis on one option, or one scenario than another scenario. We were just responding to questions. We're evaluating all the scenarios as thoroughly as we can for both fiscal and non-fiscal impacts. I don't want anyone on the Board to have the impression that there is a specific piece, a decision that has been made, or leaning towards a specific scenario. We really are evaluating as robustly as possible all the scenarios that Kayla described. I heard a lot of things in the last week about people's perceptions of the presentation from last week. I wanted to level set that we really are evaluating everything thoroughly and taking our role as an agency and reviewing this topic very seriously.

I want to remind you that as the agency is charged in fulfilling the responsibility to describe what it feels would be the appropriate risk pool arrangement, we are also tasked with consulting and getting your insight, as well as your sister Board - the School Employees Benefits Board. The agency is tasked with making the recommendation and the Board is tasked with providing insight.

We know there is more information that would help the Board give robust insight. So, reflecting on last week's discussion, we have some information that Kayla's going to describe today, but, we have worked on and are anticipating calling a special meeting of the Board under the Open Public Meetings Act the afternoon of September 17. We will have information that describes the relative impacts on the scenarios that Kayla presented at the last meeting and that we'll be able to give you more insight on relative impacts of those scenarios.

We will not have honed in and finalized a draft even at that point, so that to us is the best time to get the additional consultation from the Board as we round out and finalize the report. We will put it through the review process that all of our legislative reports go through and present it to the Legislature. Then we'll bring it back and discuss the final results of that report with the Board at the beginning of next Board season.

We feel it's important to provide both Boards with the same information at the same time and have a discussion because it's a topic that could impact both Programs. I want to be clear that the reason for calling a joint Board Meeting is not suggesting a collapsing of both programs. We are on a timeline for producing a very important report that could have profound impact on both Programs. And both are charged under legislation with giving us insight and consultation.

**Kayla Hammer**, Fiscal Information and Data Analyst. I'm providing a follow up to last week's presentation. Slide 2 – Enrollment Data. People were curious about what data we had. The bottom three rows in green, the political sub-division, last week I provided diagrams that had blue and purple bars that discussed the state employees and the school employees that were in the different PEBB risk pools, and also the different scenarios. I don't believe I stated explicitly that the state groups had the political subdivision group lumped in. I specifically wanted to call them out in the data that we shared with you today. The blue rows are state employees and retirees, the purple is

the school employees and retirees, and the green is the political sub-division employees.

**Greg Devereux:** Maybe I'm missing something, but the first purple school employee, 8,300, are these teachers and/or support . . .

**Kayla Hammer:** This is current enrollment in PEBB. So this is the non-Medicare PEBB risk pool and that's the approximate count from June 2018, of how many were enrolled in the PEBB Program.

**Dave Iseminger:** As a reminder, Greg, school districts currently have the opportunity to contract with the agency for access to PEBB benefits just like other political sub-divisions. We've tracked them as a school employee bucket for years because also, in part, at a certain threshold, Myra would become a voting member of the Board. It doesn't look like, unfortunately, Myra will hit that before the SEBB consolidation, but that was one of the reasons we needed to track that information. We have roughly, I believe at last count it was 71 or 72 school districts that have some or all of their bargaining units that access PEBB benefits for their employees. They tend to be smaller districts. It's 72 of them but it's only 8,300 individuals. We also have five of the nine educational service districts that contract for benefits.

**Greg Devereux:** So the legislative discussion, though, is not current PEBB enrollment, it's SEBB – the potential for SEBB and PEBB. Correct?

**Kayla Hammer:** No. What we're looking at is, when school employees retire, they have the option to come into PEBB.

**Greg Devereux:** I understand.

**Kayla Hammer:** So, what we're trying to do is figure out what's the best place for the K-12 retirees.

**Greg Devereux:** I haven't looked at it closely, I thought that the Legislature was interested, eventually, in potentially collapsing the risk pools for education and PEBB - SEBB.

**Dave Iseminger:** Greg, there are members of the Legislature that have a lot of ideas. I do want to point out a couple of clarifications. These three purple bars, that first one, that school employee bar, that exists in PEBB right now. All of those people move over to SEBB on 1/1/2020 and become part of the SEBB population. This report is about those bottom two rows, the school retiree non-Medicare and the school retiree Medicare, and discussing what the most appropriate risk pooling is going forward for those school retirees that currently are in the PEBB risk pools. Whether it's appropriate to maintain that current risk pooling arrangement or different arrangements.

Two years ago, when HB 2242 passed and established the SEBB Program, that was probably the most recent time there had been discussion about having a single benefits program for state and school employees, but the Legislature opted to establish the separate SEBB Program rather than combine programs. And now, whether that is what

the Legislature determines is the best risk pooling arrangement for school employees going forward. They still have that option before them. That was the long standing debate within the Legislature and within the options described by the Health Care Authority and its K-12 school employee reports over the past couple of decades. They opted for the separate school benefit program and now this report is about those two bottom lines and what is the best risk pooling arrangement for school retirees.

**Greg Devereux:** I appreciate that clarification very much.

**Tom MacRobert:** Kayla, can you give me an example of a political subdivision employee group?

**Kayla Hammer:** Political subdivision groups are like fire districts and city government groups and groups that opt in to and have the opportunity to purchase PEBB benefits.

**Dave Iseminger:** We have approximately 300 employer groups. Basically, if it has the word district in it, irrigation district, water district, hospital district, fire district, library district, and counties and cities.

**Tom MacRobert:** And it's their choice to opt in or not.

**Kayla Hammer:** Yes.

**Sue Birch:** And you are referring to it as like a political sub unit

**Kayla Hammer:** Yes. That's where the term political subdivision that we use in our counts comes from.

**Tim Barclay:** I think it would be helpful, Dave, if you could articulate what you think the significance is of defining a risk pool. What does that mean? And from your perspective, what are the consequences of pooling employees together and to a risk pool? What does that mean? I think that would be helpful so that everyone is on the same page as we think about this heading into that September meeting as to what it really is we're looking at and what that means.

**Dave Iseminger:** Actually, Tim, I was anticipating this question and Megan and I discussed it before hand. I'm going to invite Megan to come up and provide insight to the Board. Know that she's not being put on the spot.

**Megan Atkinson,** Chief Financial Officer. Tim, I think there are a couple different things to think about when we think about the risk pools we have and operate. First, we have certain statutory requirements and certain statutory direction around our current risk pools. We have the two risk pools for PEBB that Kayla's walked you through of the active employees and the non-Medicare retirees, or early retirees as we often refer to them. And then the Medicare risk pool for Medicare retirees. In addition, we will have, as Dave was just mentioning, a SEBB active employee risk pool when we start offering the SEBB benefits January 1, 2020.

One of the things we think about with risk pools, is it mathematically possible to bifurcate or divvy up the population within a risk pool. I often associate the risk pools

with how we're offering the plan portfolios, as well as how we're doing the rating of the population. There's an overall legislative requirement around our risk pools then we also have an organizational way we look at the risk pools and we think about the populations in the different risk pools and then we deal with that, the mathematics part through various rate adjustments, subsidies, and such. For example, with the non-Medicare retirees being part of the active employee risk pool, as you all are familiar, we calculate the value of different rate subsidies that pieces of the population in that risk pool are receiving, as a result of being in the risk pool.

It is possible, and there are no Affordable Care Act provisions or OIC provisions around how we structure the risk pools. We have flexibility, but I think there are things for us to consider. There are operational costs to managing different risk pools and then you hit a point of diminishing marginal returns if you have too many risk pools. In addition, we think about plan continuity for members as they are getting rated in different risk pools for access to certain plans versus, for example, like the Medicare retirees accessing the different Medicare plans. Other than current legislative direction around our risk pools, there isn't any other policy, law, or codification of even our agency practice. Those are the things we're talking about as we undertake this study. Pushing on each other's assumptions around why we have certain populations grouped together.

A conversation we had earlier this week was why we have our self-insured active members in the same risk pool with our managed care active members. We could divide those out and people could move between the risk pools based on their enrollment decisions. There's no reason why we couldn't do that, but my response was I don't think of bifurcating risk pools because of the ownership of the plan as really being that important, or that critical, or that foundational of a principle. It isn't something I would advocate or recommend, but again, it's an illustration of something we could do if we wanted to. There are operational costs to manage the different risk pools. I think you need to think about, as you're grouping the segments of our population in risk pools, we generally think about, and the public generally thinks about if you're in a risk pool, you're getting rated together, you're accessing the same rates. There's a reason why we're putting people together or separating people out into risk pools.

I don't know, Tim, if that gets to any of the things you were thinking about.

**Tim Barclay:** I think it does. I would add one more thing to that, and I think the risk pools in many ways define how the Legislature funds the program. When we start thinking about moving the populations around, it impacts how the Legislature is going to view the world and how they fund it. Which is one of the reasons that I would say it would make no sense, for example, to push the Medicare and the non-Medicare populations together because their funding sources and costs are so different. I think that's one of the things to consider, too, when we talk about how we split this up and where we move people, is from the Legislature's perspective. How they fund the program is tied to those risk pools.

**Megan Atkinson:** That's a very valid point. I appreciate you making that. When we think about the different risk pools, and think about the different ways to either put population together or separate the population out, we want to think about, does it make sense to have populations rated together, funded together, or populations distinct from one another.

**Kayla Birch:** Slide 3 – Other State Examples. Another question that came up last week was what are other states doing? I did a little research over the last few days. As of 2017, I found 19 states that allow pooling of public employees and school employees. Of course, practices within those programs vary, but most of them appear to offer continued coverage to early retirees with no employer premium contribution much like what we do in PEBB currently. The Medicare risk pools are managed separately.

I provided a couple examples. In Oregon, there is the Oregon Educators Benefits Board (OEBB) and the Oregon Public Employee Benefits Board (OPEBB), much like the separation in Washington State. The state purchases the health benefits for those programs and then the non-Medicare retirees, both in OEBB and OPEBB have the option to continue their current coverage with no employer contribution, or they can purchase benefits through the PERS Health Insurance Program (PHIP). When they become Medicare eligible, they are removed from the OEBB Program or the OPEBB Program and the Medicare risk pool is managed by the PHIP.

New Jersey is similar to Oregon and Washington in the sense that they have a health benefits program for state employees and a school employee health benefits program, SHBP and SEHBP. The state offers all self-insured benefits and they have two separate pools of the State Health Benefits Program and the School Employee Benefits Program. The early retirees are able to continue the same benefits without the employer premium contribution. When they retire, they're able to purchase the Medicaid Advantage Plans offered through their state benefits program.

Also in my research, I found a couple financial analyses on alternative risk pool options. They did not find significant financial impacts by either separating or further combining risk pools. It seemed like most states are starting to embrace value-based purchasing strategies, or moving from fully insured to self-insured programs as a way to save money and help with the growing health care costs versus shifting risk pools around.

**Harry Bossi:** My understanding at this point is that SEBB could align the benefits differently with regard to what type of plan might be available or what the individual benefits within the plan might be. They may have more therapy visits or less therapy visits. They could have different copays, coinsurances, all deductibles. All those kinds of things. It seems to me that affects claims history and risk at some point. I don't know unless the SEBB and the PEBB were clearly pretty similar, very similar, they would want to combine the two employees, the actives. I don't know if that's even part of this discussion, but until you really had claims history determined, is there a significant difference? If there is no difference, then by all means, it makes sense to combine. But if the risk factors, the risk history, if you will, claims history, whatever goes into the risk pool analysis, is similar or nearly identical, then it seems to me fewer pools would make sense. I hope that comment made some sense.

**Dave Iseminger:** Harry, I want to reconfirm that this analysis and this discussion does not include any discussion about combining the active employee risk pools of PEBB and SEBB. The Legislature clearly made a third separate risk pool and it would require a legislative act. The agency has not been tasked with another report about a consolidation of SEBB employees and state employees. That sort of consolidation isn't part of this analysis at this time.

I also want to highlight, what Harry's alluded to, that the SEB Board is currently and on Monday, receiving more information per their request about different treatment limitations for their self-insured plans. Although they have established self-insured plans that build off of the Uniform Medical Plans that this Board has authorized for this program, they have some interest in, and want to evaluate, some differences.

I want to assure this Board that as each Board makes its own decisions with regards to benefit information and changes, as an agency we will evaluate that change for the other program and bring that information to the other program. If they go forward with making a change on a treatment limitation, for example, we will then evaluate that for the PEBB Program and bring this Board information about what the cost or impacts would be in making a similar change. If you made an action and change in your benefit design, we would similarly present that to the SEB Board so we can try to maintain a similar alignment of benefits where it makes sense and the Boards both feel that it makes sense just to help with the administrative processes of educating both of these populations.

They're all coming to the same Health Care Authority website. We've been thinking very deliberately about branding for the self-insured plans for the SEBB Program. They need to use the Uniform Medical Plan name, but there are other words in those names. There is Classic, CDHP, Plus, but we are trying to make sure the populations are of enough size that at some point, whether you have 100,000 or 130,000 people, you know, at a certain point the population is large enough that they all start to look the same. We want to make sure we're analyzing benefit design for both Boards where one takes action that the other may be interested in taking action.

**Carol Dotlich:** Do you know if there is a significant difference in the claims history of the two groups? The retired public employees and the retired school employees? Is there a significant claims history difference?

**Kayla Hammer:** We are in the early phases of collecting data so I can't speak to that yet, but I do believe that will be part of the conversation when we meet again in September.

**Tom MacRobert:** I've already expressed to Dave that I had lots of things I was going to say and lots of questions I was going to ask, but my big concern with this is when we were asking for input, we didn't have enough information. We were going to be referring to your slides where you had the color charts. I like this one, I don't like that one, but the resolution of having another meeting in September really takes care of my major concerns because Dave said they would have the information necessary to share with us so we could make informed decisions about what we want to do moving forward. Thank you for that and I won't make any motions.

**Dave Iseminger:** We'll be able to describe order of magnitude and relative impacts for different scenarios. We're going to be very careful about getting too granular. We don't want to talk about pennies, we want to talk about the macro order of magnitude of these types of shifts. We will be able to provide that relative impact analysis or insight so that you can draw your own conclusions and provide your own insight on the scenarios being evaluated.

**Tom MacRobert:** Keeping with the topic of motions, would it be necessary to make a motion to have that date set for September 17?

**Dave Iseminger:** No, the agency has the authority under the Open Public Meetings Act to call a special meeting. There is not action needed from the Board. I set a date so you can get it on your calendars. At the last meeting I asked the Board Members to provide Connie and me any comments you had at this point by August 10. I still want you to think about it. We'll get your next round of feedback at the next Board Meeting.

**Carol Dotlich:** I'm very interested in any analysis of the differences between the two retiree pools. In other words, is there a difference in the expense in the extent of the medications they're on, the number of hospital visits, the number of doctor visits. I want to know if there are significant patterns of difference between the two groups.

**Kayla Hammer:** I can't say for sure the analysis will get that granular as far as the number of hospital visits and things like that, but we will be looking at relative cost differences between groups.

### **Centers of Excellence Update – Spinal Bundle**

**Marcia Peterson,** Manager, Benefit, Strategy, and Design Section, ERB Division. I have no handouts. I think it was the April 25 meeting where we gave you a report on the Centers of Excellence Program for total joint replacement. We mentioned at that time we were in the process of doing a procurement for another bundle. The new bundle is for spinal fusion, or lumbar fusion more technically. We have identified two Centers of Excellence that we will be working with going forward. They are Capital Medical Center in Olympia and Virginia Mason Medical Center.

Provided we complete and sign the contracts with them, starting on January 1, 2019, UMP Classic and CDHP members will be able to go to either of these Centers. If going to either of these Centers of Excellence, Capital Medical Center or Virginia Mason, and undergo an evaluation for appropriateness and fitness for surgery following the Bree Criteria, the member will have little to no out-of-pocket costs. In Classic, they don't have to meet their deductible or copays. For the CDHP, because of IRS regulations, you are required to meet your deductible. But in general, we try to ensure that finances are not a barrier to anyone using this program as long as it takes place at one of those Centers of Excellence.

Just like the total joint replacement benefit, the Centers of Excellence Program is administered by Premera. They work with the member to gather their medical records and create a welcome packet. They basically hold the member's hand through the process even to the degree of helping with their travel itinerary, the hotel they'll stay at, and so forth, if travel is involved.

This is a voluntary benefit for folks. We hope we've created enough of an incentive and eliminated the barriers so members will use these Centers of Excellence. We've done the work and they do meet the quality criteria. A member can still go to any provider within the Regence network who can provide this service, but they won't have the financial incentive, no out-of-pocket costs.

As a reminder, our goal with the Centers of Excellence Program is to encourage our members to use appropriate care, to use the best possible quality of care, and to design and create a program that is seamless and provides the best possible quality for the member.

**Sue Birch:** Marcia, I want to make a comment. I'm new to this state, the Centers of Excellence, and the bundles. Again, I commend you because we've now moved from one Centers of Excellence to the second with other possible services in this process. There's a movement that's happening with transformation and I think the fact that you all are building entities and partnerships around low cost and high quality is really where we're able to save as we bring all of health care into this venue of low cost, high quality, and we even things out. It's going to keep paying dividends for us and we'll be able to have those great flat premiums we're liking, or reduced premiums. I want to thank you all. It's fabulous to hear that we've now got another bundle.

**Marcia Peterson:** And great member experience, as well. I could go on and on about this, Dave knows, because I think this is such a great program for our members. It's exciting to see, you know with the first bundle, we had Virginia Mason, which is a great place. They provide great care, great quality. This time around we were pleased to see a community hospital like Capital come forward. So many of our members live in this area and go there anyway. Capital really stepped up. They worked hard to meet our criteria and the Bree criteria. That's exciting because our members may not want to travel to Seattle if they live here or in Thurston County. Lots of kudos to Capital and Orthopaedic Associates for stepping up.

**Sue Birch:** I want to remind Board Members that these procedures come with warranties. They guarantee their work. It's a fabulous concept in health care.

### **Medicare Retiree Health Benefits**

**Molly Christie,** Strategic Plan Project Manager, Benefit, Strategy, and Design Section, ERB. In this presentation, I will discuss current enrollment in the PEBB Medicare plans, why we're evaluating the Medicare portfolio, why UMP Medicare rates have been increasing, how PEBB has tried to mitigate these growing costs, the declining value of the Retiree Drug Subsidy, Medicare retiree benefit options that other states have pursued, and our project timeline.

Slide 2 – PEBB Program Retiree Health Benefits. An evaluation of the PEBB Program retiree health benefits has been a work in progress since the beginning of this year. In January, staff presented to the Board, background information on retiree health benefits. In the 2018 legislative session, the Governor set aside funding for HCA to evaluate PEBB retiree coverage options. I'll share our goal for this evaluation, as well as our progress thus far.

Our goal is to better understand sustainable and supportive plan offerings, specifically for our Medicare retirees who make up approximately 90% of the PEBB Program retiree population. This includes understanding reliable strategies for maximizing federal resources and stabilizing member premiums.

Slide 3 – PEBB Program Medicare Retiree Plan Offerings and Enrollment. As of June 2018, PEBB had approximately 93,000 members in its five retiree plans. There are four

rows on the table, two of the plans are under Kaiser WA, the classic Medicare plan and the Medicare Advantage plan. The majority of members are in UMP Classic Medicare, more than half. All members in a PEBB Medicare plan must be enrolled in original Medicare to be eligible for our plans. This covers Medicare Part A, or inpatient and hospital services, and Medicare Part B, outpatient or physician services. The UMP Classic Medicare and the Kaiser Washington Plans are coordination of benefit plans, which means they're charged as a secondary insurer after Medicare.

In contrast, we have two Medicare Advantage plans, one under Kaiser WA and the other in Kaiser NW, which replaces original Medicare. They cover Medicare Part A and Part B and receive funding from the Centers for Medicare and Medicaid Services (CMA) to cover Medicare eligible costs for those plans.

We also have a Premera Supplement Plan F that helps offset out-of-pocket expenses for original Medicare, including deductibles and coinsurances. We have just over 14,000 members in Plan F. As a note, changes in federal law effective January 1, 2020 will prohibit new enrollees in Plan F for purchasing any national Medicare supplement plan off policy, so the OIC has recently released information that Washington can offer a new Plan G. Plan G is essentially identical to Plan F, but it doesn't cover Medicare Part B deductible. The average Medicare Part B deductible is about \$183. So that is a consideration.

I will discuss Medicare Part D Plans later in the presentation, but I will note that all four of our plans under Kaiser WA, UMP, and Kaiser NW offer creditable coverage, so they offer prescription benefits. They are not Part D benefits. They're not Medicare products. They have been deemed by CMS to be equivalent to, or as generous as, the standard Part D benefit, but they do not receive Part D subsidies.

Slide 4 – Why Evaluate PEBB Program? There are a number of compelling reasons. First, it's time. Medicare has changed a lot in the past decade or more, and so have this population of PEBB Medicare retirees. For instance, in 2006, CMS implemented Medicare Part D, the Medicare prescription drug benefit. It's available to all Medicare retirees. Prior to 2006, most Medicare retirees were receiving prescription drug coverage through an employer-sponsored retiree plan. Those that did not have access to an employer-sponsored plan did not have access to prescription drug coverage. So, Medicare Part D was introduced to fill that gap.

The Medicare retiree population, both within PEBB and nationally, has been changing since the introduction of Part D. The size of the population continues to grow. This is particularly as baby boomers reach 65. The retiree population is also aging, people today are living longer, they're living healthier, and that adds to the size of the population as well.

The second reason we're evaluating the PEBB Medicare Program has to do with the Retiree Drug Subsidy (RDS). The RDS Program was introduced alongside Medicare Part D with the intent to incentivize employers that offered prescription drug coverage to their Medicare retirees to continue doing so. In order to incent these employers to continue offering prescription drug coverage, CMS would essentially refund 28% of allowable drug costs. Many employers took advantage of that at the time. There are fewer and fewer offering prescription benefits to retirees through an RDS plan.

**Carol Dotlich:** Could I stop you for a moment? You said 28%? What was that figure again?

**Molly Christie:** Up to 28% of allowable drug costs.

The point of all this is as prescription spending increased, the value of the Retiree Drug Subsidy has declined. What we get back from the subsidy and how we can pass it on to members in terms of the cost of their plan, the out-of-pocket they're spending, is declining. There may be other options such as Medicare Part D subsidies that would provide greater value. We will explore those.

As we've discussed throughout the Board season, volatility in the prescription drug market is resulting in instability in member premiums. We understand this is a particular challenge for PEBB Medicare retirees on fixed incomes.

To illustrate this last point, the chart on Slide 5 – UMP Classic Medicare Rates reflects UMP Classic Medicare rates since 2012. It's broken down by pharmacy and medical costs. The pharmacy costs are in dark blue, the medical costs are in light blue, and these are total rates excluding the \$5 HCA admin fee, and not including the explicit subsidy. In other words, these are not broken down by employer versus retiree paid. I'd like to note a large portion, which is more than half for most of these years, of the bid rate is attributed to prescription spending. This portion has been steadily growing. There has been an increase of almost \$100 since 2012, whereas at the same time when you look at the medical costs, the portion of the bid rate attributed to medical has been relatively stable. It was around \$180 in plan year 2013 and it's within \$10 of that (\$189) for 2019.

What this shows us is that with prescription drug volatility, where we're going to see the increase in premiums, is primarily due to prescription spending. There is the market factor. We're seeing the prices for prescription drugs go up, the utilization of specialty drugs increase, new specialty drugs entering the market, but also the PEBB UMP Classic Plan is the only source of prescription coverage for Medicare retirees enrolled in that plan. They don't get prescription coverage through Medicare. Essentially, we're seeing Medicare helping cushion the costs of our medical services of that part of the premium because we're secondary payer. That's not the case for prescriptions. That's where a lot of this growth is occurring.

And another point is that volatility, when I use this term, I don't necessarily mean a straight upward trend. You might see some dips, you might see some unexpected numbers, and I think that is a large part of it, it's unpredictable. This upward trend has been relatively sharp in the past few years. Luckily, in plan year 2019, we're going to see it level off. I will temper that by saying that downward trend may not continue because there is so much uncertainty with prescription drugs right now.

**Tom MacRobert:** I'm looking at this chart and I'm curious if you can explain. If you look at the prescription drug amounts, they are actually fairly stable – slight increases, but then, between 2017 and 2018, you had a \$51 increase. It's a big jump. Other years not so much. What caused a significant jump in that particular year?

**Molly Christie:** That's a great question. I don't have the answer.

**Sue Birch:** I believe it's specialty drugs. I wish Ryan or Donna were, but I believe it's the specialty drug advances. We can get back to you with more information in that because Ryan or Donna will have some information.

**Dave Iseminger:** I do think it's specialty drug, but we'll get clarity back to the Board.

**Sue Birch:** I do want to comment. There was information out this morning about Medicare releasing a new study on driving towards value-based formularies and trying to contain pharmacy pricing with moving toward generics and a few other things on the Medicare side. I will ask staff to come back to us with actions we can take to try to reign in our pharmacy spend so we get the best value for our members. I will ask you all to pull that together. I can't find it right now, but information released this morning. Medicare has definitely started to talk about moving towards generics and moving towards value-based formularies. I'm sure that issue will be coming back to the full Board.

**Molly Christie:** Slide 6 – Cost Mitigation Strategies. There are two major strategies PEBB has been using to mitigate increasing Medicare costs. On the state side, there is the Retiree Drug Subsidy, which we discussed earlier. PEBB Medicare health plans with creditable drug coverage participate in the RDS and the state receives approximately \$21M each year deposited into the state general fund. The explicit subsidy is another strategy that helps reduce member out-of-pocket spending on Medicare plan premiums. In 2018, the Legislature increased the explicit subsidy from \$150 to \$168 effective 2019. However, the cost of this increase alone was nearly equal to the money the state received in RDS revenue in a single calendar year. There is some canceling out of the revenue that the state received through RDS and the expenditure on the increase in the explicit subsidy.

**Tom MacRobert:** You keep referring to this as a one-time increase, but I'm assuming it's going to remain \$168 going forward. It's not going to drop back to \$150. A one-time increase would be just for this coming year and it would change again.

**Dave Iseminger:** We talked about that exact wording of the slide. The Legislature hasn't taken an action to change it for several years and then this was the change, and just because they made this change doesn't mean that they wouldn't necessarily make another change up or down. The outlook shows they moved it from \$150 to \$168, but as we know, in any specific budget cycle, anything can change. It was trying to convey that there's not an assumption that there would be another increase just because there was an increase this last legislative cycle.

**Molly Christie:** Slide 7 – Explicit Subsidy Impact on UMP Medicare Premium. This slide illustrates why the state is at risk of not qualifying for the Retiree Drug Subsidy in future years. The retiree-paid portion of the Medicare premium is represented in dark blue and the state-paid portion, also known as the explicit subsidy, is represented in light blue. UMP Medicare premiums have been increasing sharply in recent years. They leveled off in 2019, primarily driven by increasing prescription spending. As the retiree-paid portion, the dark blue bar, increases and the light blue bar does not increase at the same pace, UMP Medicare is at risk of no longer qualifying for the RDS.

I will provide a caveat to this and this is specifically for the UMP Medicare plan. It's more dire for UMP Medicare, less so for the Kaiser plans that also participate in the RDS program. The \$18 increase in the explicit subsidy helped offset premium costs and it will help offset the premium costs in plan year 2019. Additional increases to the explicit subsidy will likely be required to maintain eligibility for RDS past 2019.

**Carol Dotlich:** Can you tell me why the difference between the Kaiser plans and the UMP? Why one will qualify and the other will not?

**Molly Christie:** They are better able to contain costs for prescription spending. Their premiums haven't risen at the same pace as the UMP premiums.

**Carol Dotlich:** But I thought they had a jump in their premium price a year ago.

**Molly Christie:** Yes. It has to do with measuring against the standard Part D benefit as the benchmark. Our plans have become very expensive compared to the Standard Part D benefit and the Kaiser plans. Their prescription coverage is not quite as expensive compared to that Part D benefit.

**Dave Iseminger:** Carol, the other piece is that Kaiser plans replace A and B. Rather than being a coordination of benefit secondary, they actually qualify for multiple federal streams of funding. It's not just the RDS subsidy. They have multiple ways and multiple funding sources to help offset premium increases that members may experience that are not funding streams available under the current structure of the UMP Classic Medicare plan. That helps absorb the shock that members may experience from a premium increase. There are more financial funding streams that the A / B replacement plans have that a creditable coverage plan does not.

**Carol Dotlich:** Does that make Kaiser a Medicare Advantage Plan?

**Molly Christie:** We have two Kaiser Medicare Advantage Plans. They have prescription drug coverage, but it's not Part D drug coverage. You can have a Medicare Advantage Plan with or without drug coverage. The prescription drug coverage can either be Part D coverage or it can be creditable drug coverage. The subsidies for each of those are different. If it's a Part D plan, there's specific Part D subsidies. If it's creditable drug coverage, there's the RDS.

What Dave is saying is, for Advantage plans, they get subsidies for Medicare A and B because they cover those as well. The way the bidding process works for those, if there's additional money left over, they split that with CMS and then they need to use that money to either make their plan more generous or reduce the cost of their plan. Medicare Advantage plans tend to have more generous Part D coverage when they offer Part D, than, for instance, a standalone Part D plan because they have a little bit more wiggle room.

Slide 8 – State Spending on Explicit Subsidy vs. RDS Revenue. This graph shows the state expenditure on the explicit subsidy, represented by the green trend line. It has been increasing. RDS revenue, in blue, has remained flat. The assumed upward trend in the state expenditure, is based on potentially necessary increases to the explicit subsidy to maintain RDS revenue eligibility, as well as 4% retiree population growth.

As the former slide showed, increases in the explicit subsidy would likely be required to maintain eligibility for the RDS after 2019. However, the revenue from the RDS is unlikely to increase and that causes a gap between state expenditure and state revenue for Medicare plans. Recent years have seen a steep decline in the number of states and large employers that participate in RDS. Between 2010 and 2017, the number of Medicare beneficiaries whose employers received RDS fell from 6.8 million to 1.6 million. And in 2017, approximately 2.7% of all Medicare beneficiaries were enrolled in plans receiving the RDS, whereas 72.5% were receiving their prescription benefits through Part D plans.

Twelve states offer prescription drug coverage to Medicare retirees through an RDS plan. Eight of those states have an RDS plan only. That's the only way they offer prescription benefits. The remaining states have a combination of an employer group waiver plan and an RDS plan.

**Carol Dotlich:** With the prescription drug costs going up, there have been a lot of advances in prescription treatments for people, drugs that have actually cured diseases that people suffered with long term. Do you see an opportunity for the prescription drug cost trend to go down as a result of some curative ability of the newer drugs?

**Molly Christie:** I don't know if the prescription drug costs would go down. I think medical costs will go down if you're having drugs that are curing, for instance Hepatitis C. Associated costs for treating Hepatitis C throughout a patient's life are extremely high. The cost of medication to cure it is also extremely high, but it may be offset by no longer having to treat the disease. I see it as a possibility. I don't know if it means that the price of the prescriptions themselves would go down.

**Dave Iseminger:** I think that's a good attempt at that one. I think this is another example of there is no real general answer to that question. It's going to be very case specific because it's going to be what is the price of that drug versus the overall plan cost. If you're trying to parse out overall plan costs going down because it goes up in one area or down in another area, and just because it does that on one drug doesn't mean it will do it on the next drug or the next disease state. That's an interesting piece for us to consider, Carol. That's a really tough one to predict on even a general basis because it will vary from drug to drug and disease state to disease state.

**Carol Dotlich:** I'm not seeing huge increases in the medical costs on your chart. I see the increase in the pharmacy. Am I wrong about that?

**Molly Christie:** No, you're not. That's absolutely what it's showing and I think a big part of that is because we're secondary. We're paying secondary to Medicare. They're insulating us from a lot of the medical costs. Medical costs may still be going up and are likely still going up, but Medicare A & B, original Medicare is covering most of that before the UMP Medicare plan has to pay out.

**Sue Birch:** I would ask staff to confer with our pharmacy specialists because of the nationally acclaimed DUR Program, which is a Drug Utilization Review group that we participate in. There'll be some information that can come back to the Board. Carol, especially on this kind of harbinger of what's to come around prescription costs. I

believe we can get better information from Ryan and/or Donna or our physician team because I've seen information out there and I bet we could make an article or two available because I think the future looks very bleak around pharmaceutical pricing without explicit federal activity. I don't see that coming either.

**Molly Christie:** Slide 9 – What Other States Are Doing. How are other states providing retiree benefits to their Medicare retirees. One option is the Employer Group Waiver Plan, commonly referred to as the egg whip (EGWP). EGWPs are self-insured or fully insured Part D products and authorized by CMS. They're available only to an employer's retirees. There is a provision for Part D plans that on the individual market, the Part D plan has to be available to all Medicare beneficiaries within the service area. For UMP, that would be an issue because we have UMP members across the country and internationally. With an EGWP, the plan only has to offer that coverage to the retirees. It doesn't have to offer to everybody nationally who is a Medicare beneficiary. EGWPs also have an optional wraparound provision, the EGWP Plus Wrap, which allows for benefits similar to an employer's current prescription coverage, so there is a bit of customization that is possible with an EGWP.

Between 2010 and 2017, Medicare retiree enrollment in EGWPs grew from 2.4 million to 6.8 million. They are becoming more popular. There's also the Medicare Advantage Plus Part D (MA-PD) plan which I mentioned earlier. An MA-PD is a one-stop shop for all of your Medicare benefits. You have your original Medicare Part A and B, as well as prescription drugs. The prescription drug benefit is the standard defined Part D benefit. Many Medicare Advantage plans offer enhanced benefits for the standard Part D benefit and beyond those that are offered by standalone Part D plans. 35 states have implemented either an EGWP or an MA-PD for retired Medicare eligible public employees.

Part D plans have become more attractive to employers partly because CMS offers a direct subsidy. It's a prospective risk adjusted direct subsidy and a reinsurance subsidy to Part D plans that aims to cover 74.5% of the cost of basic benefits. There's also manufacturer discounts available to Part D plans under the Affordable Care Act. This is the coverage gap discount program, the 50% manufactured discounts for brand name drugs that's in the donut hole. And these help reduce or offset plan and member costs in that donut hole period of the standard Part D benefit. To reiterate, PEBB doesn't offer any Part D prescription drug coverage. We have creditable drug coverage so we do not currently have access to these Part D subsidies or the coverage gap discount program. Finally, there's the private exchange option.

These are common options although the private exchange has only been implemented in one state. This is a portfolio of group coverage Medicare plans, so including supplemental plans, Part D plans, Advantage plans managed by insurance carriers or consultants and these do allow for greater plan choice compared to a typical employer offering for retirees. For instance, at the beginning of this meeting I went on one of the exchanges and said I was a 65-year old man looking for benefits, I live in Olympia, I have no disability, and the results were nine Medigap plans, the supplement plans; 16 standalone Part D plans; and 20 Medicare Advantage plans.

**Sue Birch:** Can you share what particular state you were referring to?

**Molly Christie:** Nevada.

**Sue Birch:** Nevada has this. Thank you.

**Molly Christie:** Slide 10 – Timeline. We're in the evaluation stage, the bright blue on the left-hand side. Through the end of the year, we'll be evaluating options. We will present options, one or more to the Board in January. 2019 activities listed on this timeline are subject to legislative action and Board approval. 2020 is implementation and hopefully launch of a new portfolio, or change the portfolio in 2021.

**Dave Iseminger:** Chair Birch, can I ask that we take a five-minute recess? We have one more item we need to bring to the Board. We're finalizing it now.

### **Break**

**Sue Birch:** Dave, we have something to add in. Take it away.

**Dave Iseminger:** We don't have the Board vote on benefit changes typically because they are wrapped into the inherent endorsement of the rates. However, the change to the dental benefit doesn't have a corresponding rate resolution. In order for the Class 3 benefit to change in the Uniform Dental Plan, the Board has to take action to change the benefit. I apologize for bringing this without giving you a week to review. I think it's a very straight forward concept, but we can answer any questions you have. This resolution is to ask the Board to adopt the change in Class 3 restoration limits. Change it to five years from seven years. The change would be effective the first of the coming plan year.

This is a Uniform Dental Plan only change because the five-year limitation on Class 3 already exists within the two managed care plans. This is aligning this change to the other parts of the portfolio. We've described it but not in resolution format at the prior meetings and past presentations.

**Sue Birch:** Dave, could you remind the Board what dental plan Class 3 includes?

**Dave Iseminger:** Crowns are an example.

**Sue Birch: Resolution** PEBB 2018-14 – Uniform Dental Plan. **Resolved that,** beginning January 1, 2019, the Uniform Dental Plan Class 3 Restoration Limit will be five years.

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

Voting to Approve: 7

Voting No: 0

Resolution PEBB 2018-14 passes.

### **Public Comment**

**Maria Britton**, Executive Director, Retired Public Employees Council of Washington. I had a question regarding the Medicare Retiree Health Care Benefit. On Slide 8 of that presentation, am I correct in thinking that most likely we will not get the RDS because the state subsidy will be \$168, but the amount required is \$192?

**Sue Birch**: No, I don't think that is correct. This information is informational only and staff is preparing the Board for further information. I think they were just trying to show the spend on the subsidy versus the RDS revenue. I think it's dangerous to infer any conclusions at this point. Is that correct, Molly?

**Molly Christie**: Yes.

**Maria Britton**: Okay. I'm also wondering is there a reason that the Kaiser and Medicare Advantage plans don't use Part D? Is it a rule or is there a reason why they don't?

**Beth Heston**: As the Kaiser contract manager, I can tell you that their benefit is actually richer than Part D's requirement.

**Maria Britton Sipe**: Okay, so they wouldn't get more of a benefit if they went through that? It wouldn't be cheaper for the plan? The insurance? Okay. And then I wanted to clarify on the EGWP, Slide 9. Did you say that retirees who, if they were under that, would have to stay local to get the coverage?

**Molly Christie**: No, they don't have to stay local which is one of the nice things about it. They can still live wherever they want in the country. Internationally could potentially be a problem. It is complicated now. But what's nice about the EGWP is the plan itself wouldn't have to be offered to all Medicare retirees where one of our Medicare retirees lives. It would only be for PEBB Medicare retirees.

**Maria Britton Sipe**: Okay. And finally, I just wanted to share that in terms of the Exchange, that would not be something that many of our members would find attractive. That's one of the reasons so many of them go to UMP because their cognitive level is declining. Having that much choice and being that overwhelmed is extremely scary for a lot of them. I just wanted to share that. Thank you very much for your time.

**Sue Birch**: Thank you for those comments. I want to remind the Board Members that the next meeting is September 17 in the afternoon. Thank you, Dave for all your leadership and to your team for doing such a great job. We are thrilled to be saving the state about \$20M and to be doing good work for all of our members. Thank you very much.

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

**Combined Public Employees Benefits Board and  
School Employees Benefits Board  
Meeting Minutes**

**DRAFT**

September 17, 2018  
Health Care Authority  
Sue Crystal Rooms A & B  
Olympia, Washington  
2:45 p.m. – 4:45 p.m.

**PEB Board Members Present:**

Sue Birch  
Tim Barclay  
Carol Dotlich  
Myra Johnson  
Tom MacRobert

**PEB Board Members Present by Phone:**

Yvonne Tate  
Harry Bossi  
Greg Devereux

**SEB Board Members Present:**

Lou McDermott  
Pete Cutler  
Sean Corry  
Patty Estes  
Katy Henry  
Dan Gossett  
Terri House  
Wayne Leonard

**SEB Board Member Present by Phone:**

Alison Poulsen

**PEB Board and SEB Board Counsel:**

Katy Hatfield

**Call to Order**

**Sue Birch, Chair**, called the meeting to order at 2:47 p.m. Sufficient members were present of both the PEB Board and SEB Board to allow a quorum. Board introductions followed.

## **Agenda Overview**

**Dave Iseminger**, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda. Today's meeting is a special joint meeting of both Boards to discuss one topic, the Retired and Disabled School Employees Risk Pool Analysis. Under legislation, this agency is to consult with both Boards. The ultimate decision that the Legislature may or may not make based on the report that the Health Care Authority produces could impact either or both programs. This is not the first step on a journey of consolidating the programs. This is a discussion because of a specific legislative report about where K-12 retirees should be housed within the various programs and risk pools created under current state law. This is a special meeting under the Open Public Meetings Act. I make this point because we need to stick to the topic on the agenda.

## **Retired and Disabled School Employees Risk Pool Analysis**

**Kayla Hammer**, Fiscal Information and Data Analyst, Financial Services Division, HCA. Today we'll talk about the legislative reports. We'll discuss background, what is the report and its purpose, the anticipated 2020 risk pools, 2018 PEBB Program enrollment, PEBB Program non-Medicare risk pool data and information, PEBB Program Medicare risk pool data and information, and the retired and disabled school employees risk pool scenarios and their implications.

Slide 3 - What is the Report? RCW 41.05.022(4) requires the Healthcare Authority, in consultation with the PEB and SEB Boards, to complete and submit an analysis of the most appropriate risk pool for the retired and disabled school employees. This is our second round of consultation with both Boards. This report is due to the Legislature on December 15, 2018. Comments and feedback from this Board consultation and the previous consultation will be documented. It's my intent to share it as an appendix to the report in regards to the most appropriate risk pool, cost impacts, member experience, state and federal laws and regulations, implementation, and administrative complexity.

**Dave Iseminger:** The legislation did not outline the criteria. What Kayla just described is what we see as high-level categories for potential impacts. It is not described in statute.

**Tom MacRobert:** I'm curious. Could you give me a little more explanation on what you mean by member experience? I'm assuming you're referring to people who have gone through some type of situation comparable to this.

**Kayla Hammer:** What I mean by member experience is if we were to make changes to the current risk pools that exist, how would they be affected? Would that result in having to choose new plans? Would it impact their cost personally or as a group? Those are examples of what I mean by member impact.

**Tom MacRobert:** Then also, implementation and administrative complexity. Are you anticipating that if you make changes, there will be overarching concerns in making those changes?

**Kayla Hammer:** Yes, that's correct. We will go into more detail in this presentation. But, yes, there are some overarching things that would change should risk pool changes be suggested.

**Dave Iseminger:** Tom, an example would be if the K-12 retirees were moved into the SEBB risk pools, there are currently no procurements or Medicare products that have been procured. There would need to be additional procurements. The SEB Board would have before it the task of authorizing similar or different product offerings. That would be an example of administrative complexity. We might have Medicare plans for PEBS and different Medicare plans for SEBB, as an example.

**Kayla Hammer:** Slide 5 – Insurance Risk is the likelihood that an insured event will occur requiring the insurer to pay a claim. In health insurance risk, it's viewed on more of an aggregate level instead of the singular example seen on this slide. The amount of risk would be measured by the likelihood that the total claims cost would exceed what was expected.

Slide 6 – What is a Risk Pool? A risk pool is a group of individuals whose medical costs are combined and evaluated to calculate premiums. It's also a means to organize legislative funding for the different pools. Regardless of personal circumstances, if you are part of a risk pool, you will 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 has impact on the premiums.

Slide 7 – Risk Pool Dynamics. Although the risk within a pool impacts the rates, risk pool changes would not result in aggregate cost savings as the risk pools are not the primary driver for rate setting. There will be individual impacts that can vary dependent upon the changes proposed because when you are moving risk around, you would be reducing or increasing subsidization between individuals. Combining people with different levels of health risk into a single pool increases the level of subsidization from the relatively healthy to the relatively unhealthy. Currently, in the PEBS non-Medicare risk pool, the employee population is subsidizing the non-Medicare retirees, as an example. If you were to combine people with a similar health risk, there would be the opposite effect. There would be little to no subsidization.

**Dave Iseminger:** The Board will see examples of what Kayla just described in later slides with numbers. We'll be coming back to this concept with tangible examples. I think the first bullet on Slide 7 is a profound piece that changing risk pools doesn't change the aggregate cost to the system. Let's say a billion dollars is being spent right now. If you mix up the population into different pools, you're still spending a billion dollars. It's what individual people are paying. I think some people believe that changing around the risk pools could create money in the system, but the reality is that it's still the same total amount of money. It's how different people are pooled. The system isn't creating, losing, saving, or generating money with the idea of changing risk pool arrangements.

**Kayla Hammer:** Correct. Slide 8 – Anticipated 2020 Medical Risk Pools, is an example of anticipated risk pools for 2020. Each one of these pools is legislatively mandated and the way the Legislature funds each pool is different. There is the non-Medicare community-rated risk pool under PEBB. It consists of state and other employees, non-Medicare state retirees, and non-Medicare school retirees. The PEBB Program Medicare risk pool consists of Medicare-enrolled state and school retirees. The SEBB risk pool is solely a school employee pool under the SEBB Program, which is separate from the PEBB Program.

Slide 9 – Anticipated 2020 Risk Pool Considerations. Assuming no changes in 2020, this slide lists considerations about the scenario that currently exists. In the PEBB non-Medicare risk pool, it combines the employees with the retirees. 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. The non-Medicare retirees pay the community rate. In the PEBB Medicare risk pool, it combines the state and school retirees that are eligible and enrolled in Medicare. The plans offered to that pool are not the same as the non-Medicare pool. The plans are rated separately based on member experience, and the state premium contributions are a portion of the plan rate up to a monthly limit.

**Lou McDermott:** I noticed you said member experience. I want to make sure what you're referring to is claims experience. Two different ways to interpret member experience.

**Kayla Hammer:** Yes, that's correct. Now we'll look at and discuss data. The next few slides show PEBB Program enrollment data. Slide 11 – PEBB Program Member Enrollment. This data is enrollment by group as of August 2018. The member count is accountable subscribers and dependents. There's an asterisk next to state employees and state retirees with notes below. On this table, state employees also includes others. It includes political subdivision or employer groups. There's also the K-12 current people that are in the PEBB Program in this count, COBRA, and others. The state retiree asterisks includes state retirees and those employer group or political subdivision members.

**Dave Iseminger:** When a political subdivision joins and contracts with the Health Care Authority for PEBB benefits, not all of them bring retirees with them. It's a subset of political subdivisions. I want to be clear that not everyone who joins the PEBB Program includes retirees. As a reminder, there are about 72 K-12 school districts with some or all of their bargaining units in PEBB benefits. But, come 2020, they get moved out of PEBB risk pools and put into the SEBB risk pool.

**Kayla Hammer:** There is a significant difference between these populations. If you look at the state employee count, for example, that's a lot of employees versus the non-Medicare retirees that are within that pool.

**Dave Iseminger:** Employees and dependents.

**Kayla Hammer:** Yes. Slide 12 – Subscriber Enrollment is member count. The dependents accounted for on the last slide are not on this slide.

Slide 13 – 2017 PEBB Program Non-Medicare Risk Pool Data. Now we will discuss data specific to the PEBB Program Non-Medicare risk pool. This is 2017 claims data. We'll talk about relative risk scores, average monthly paid claims, and total annual paid claims separated by group.

**Dave Iseminger:** This discussion is about the first box on the left side of Slide 8.

**Kayla Hammer:** Yes. Slide 14 – What is a Risk Score? A risk score is a calculated number reflective of the risk within a population or morbidity. Morbidity is the rate of disease in a population, or how unhealthy is that population, and a measure of that. Risk is calculated based on demographic information, diagnosis codes, drug codes, and utilization. Population groupings with higher average risk as expected to have higher claims cost due to that high morbidity.

Slide 15 – Non-Medicare Relative Risk Scores. This data is based on 2017 claims data.

**Pete Cutler:** On the risk score, is this used for risk adjustment within the PEBB Program or is this risk analysis being used just for purely analytical reasons? I'm curious how it connects to the rate setting process.

**Kayla Hammer:** The risk scores that I'm sharing today were a separate analysis and not necessarily what we use for rate adjustment. I would have to double-check that to be completely sure.

**Pete Cutler:** But the PEBB Program still does use some type of risk adjustment process for the populations?

**Kayla Hammer:** Yes. That is correct.

**Carol Dotlich:** You're talking very quickly for me to keep up. My question is back on the other two slides where you had program member enrollment and subscriber enrollment. The totals are quite different. Can you define what the difference is between the two total numbers?

**Kayla Hammer:** Yes, I can. Slide 11 is member enrollment. It has the subscribers and any dependents on their account. It's a significantly higher number. Slide 12 is looking at subscribers, which is just the employee or retiree, who are eligible and able to enroll in the medical benefits. No dependents.

Slide 15 shows risk scores relative to the statewide PEBB non-Medicare average of 1.0. Any amount above or below 1.0 is the percent of utilization expected compared to the average. An example would be, if you look at the table and see the school retiree non-

Medicare at 1.682, their expected utilization is 68% higher than the statewide average of 1.0.

**Sue Birch:** Average in this pool?

**Kayla Hammer:** Yes, average to this pool. Slide 16 – Average Monthly Non-Medicare Paid Claims per group. This is also 2017 PEBB Program claims data. The dollar amount shown is per adult unit per month (PAUPM) and is relative to the statewide average of \$535. The monthly average paid claims is based on utilization and is impacted on plan selection. If a specific group was prone to selecting a specific plan that paid at a higher level than other plans, that can have an impact on what is shown here in the average paid claims. If you think about the last slide with the risk scores and connect those to what you're seeing here in average monthly paid claims, the groups that had the higher relative risk score tend to have, on average, a higher paid claims amount per month. The enrollment slide you saw earlier had over 100,000 subscribers in the state employee group. The numbers are much smaller, only a couple thousand, in the high utilizing groups. That helps create balance across the pool as far as overall cost.

**Pete Cutler:** On the paid claims, is that affected by whether somebody's seeing a consumer directed or a high deductible plan versus one of the other plans?

**Kayla Hammer:** Yes, the plan selection does impact that. Without having it in front of me, I couldn't say which group chooses certain plans more often than others. But that definitely does impact the cost of what's paid.

**Pete Cutler:** Am I right that the risk adjustment would not be impacted by that because it would look at how many tendency of what drugs you use, what kind of diseases you had, whatever factors that are not keyed by what your point of service cost share is?

**Kim Wallace:** Correct. The risk adjustment that we do as a regular matter of course in the PEBB Program to establish the ultimate premiums and rates does not adjust for differences in plan design.

**Pete Cutler:** Okay. That would make sense because the factors mentioned on Slide 14 were diagnosis codes, demographic information, drug codes, those kind of things, which really are not tied to what kind of out of pocket cost you have in your plan. Thank you.

**Kayla Hammer:** Slide 17 – Annual Non-Medicare Risk Pool Paid Claims. This slide also based on 2017 claims data. This is looking at all members. You may notice the percent of enrollment does not equal 100% because there are other groups in the non-Medicare pool, the employer groups. They are not part of this state employee line in this particular table, which is strictly state employees. There are other people within this particular risk pool and they account for about 12% of the enrollment.

Now we will talk about the middle column on Slide 8, the PEBB Program Medicare Risk Pool. Slide 19 – Medicare Risk Pool. Medicare data is shared separately from the non-Medicare data because the risk pools are separated in statute and funded differently by the Legislature. The insurance plans offered to the different groups are different. The Centers for Medicare and Medicaid Services (CMS) regulates the kind of insurance plans that can be purchased by people enrolled in Medicare. And then because of the differences in the insurance types, the reimbursement is different between the two populations.

**Dave Iseminger:** As an example, on the Medicare pool for pharmacy benefits, the UMP benefit in the PEBB Medicare pool pays primary for pharmacy but it pays secondary for medical. In the non-Medicare risk pool, the UMP pays primary for everything. That's an example of the reimbursement model being different.

**Kayla Hammer:** The PEBB Medicare plans are either secondary to Medicare or they are Medicare advantage plans. This results in the two populations cost data not being comparable since Medicare is picking up the bulk of the allowed costs for the Medicare pool on medical.

Slide 20 – Medicare Risk Scores. Based on our research, the K-12 retirees currently enrolled in the PEBB Program are slightly more healthy compared to the PEBB Medicare risk pool as a whole. However, K-12 retirees have significantly higher morbidity than active employees and early retirees. There are challenges and complexities with comparing the risk scores and associated costs of the Medicare and non-Medicare risk pools due to some of those things I mentioned on the previous slide, primarily, the way in which the plans reimburse based on the different types of plans offered to those two populations.

**Lou McDermott:** On your second bullet, could you say the PEBB Medicare retirees also?

**Kayla Hammer:** That's correct. Both or all the populations in the Medicare pool have higher morbidity than the active.

**Lou McDermott:** I just wanted to make sure we weren't calling it out because it wasn't similar in the other pool.

**Dave Iseminger:** As a reminder, the context of this report is what to do with K-12 retirees. The information, if it's silent for other parts of the retiree population, it's because the question being answered is what to do with K-12 retirees. The absence of information about other parts of the pools doesn't mean that it's similar, different. It's because we're trying to focus on the simple and straightforward K-12 retiree piece. We're trying not to introduce even more complexity within the description.

**Kayla Hammer:** Slide 21 – Annual Medicare Risk Pool Medical Benefit Costs by group. It's important to point out that the benefit cost amount is a combination of things. It is

self-insured claims cost, administrative fees, and fully insured medical premiums. This is not strictly claims costs as it was on the previous slide when we were talking about the other risk pool within PEBB. The total medical benefit costs between the groups is similar. There is some increased cost in the school retiree group within that risk pool, but they also have a higher percentage of member enrollment.

**Dave Iseminger:** Again, we tried to spend a lot of time with the titles of these slides because I know as you flip back and forth between medical benefits cost and claims cost, you'll start to think that they're the same thing but they really aren't. Claims cost is just claims cost. This is titled medical benefit cost and that description at the bottom indicates it's more than just claims. I just want to remind you about that difference.

**Sue Birch:** Could you share a little more information about administrative fees, if that is a blended rate? And could you give us a little more context about administrative fees?

**Kayla Hammer:** We pay a fee to Regence for managing this for us. It's related to having a self-insured program.

**Sue Birch:** Thank you.

**Kayla Hammer:** Slide 22 – Scenarios: Implications and Considerations. I want to discuss the scenarios that we presented previously and talk about implications and considerations. Slide 23 – Create SEBB Program Non-Medicare Risk Pool, is a slide you've seen before. This is a scenario that would create a non-Medicare risk pool under the SEBB Program and we would remove the non-Medicare school retirees currently in the PEBB Program and move them into a community pool with the school employees under the SEBB Program. The school Medicare retirees would remain in the PEBB Program Medicare risk pool.

**Kim Wallace:** Kayla, I think what this is showing is that on the left-hand side in the green is the current PEBB Program non-Medicare risk pool without the non-Medicare school retirees. We move them over to the far right and essentially create the same type of non-Medicare risk pool for SEBB as there would be for PEBB.

**Kayla Hammer:** That is correct, Kim. Slide 24 - Considerations. Any risk pool changes that we discussed today will require changes to state legislation and likely changes in the way the Legislature funds each of those risk pools. The non-Medicare school retirees could have the same plan options they use prior to retirement in this particular scenario, which would result in a positive member experience for many. This could also lead to a negative member experience for the PEBB participating school non-Medicare retirees currently in the PEBB Program having to move over and to potentially having to switch insurance again. There are impacts on the employee populations as well. By removing some of the higher utilizing population currently in the PEBB non-Medicare community-rated pool, there could be a slight reduction in premiums for employees, assuming they were having a high impact on the current pool. By adding higher utilizing

population to the SEBB employee pool, there could also be an increase to premiums for school employees. These are potential impacts.

**Dave Iseminger:** Just a couple of additional examples of what this would really feel like to a member. The second bullet, for example, non-Medicare school retirees could have the same plan options they used prior to retirement. Let's go forward in our time machines, and it's now April of 2020. The plans that the SEB Board is currently talking about creating and are now in place in January 2020, at the end of that school year, Katy Henry retires from her teaching job. Now she can continue to have the same plans versus right now what would happen is she would come over and be in the PEBB plans. She would pick up on PEBB plans that are similar to those that state employees have. The example we're trying here is Katy gets to have the same plans she had as a school employee. She would have to probably pick up more of the premium, but the plans that she's already begun experiencing as a K-12 employee in SEBB, she would be able to maintain that experience and wouldn't switch plans until the point she reached Medicare age.

The third bullet is really describing, on Slide 11, the number of people that are non-Medicare school retirees currently in PEBB, about 4,000 members. Those are the members that, if the pool switched and you move that purple box to the far right, if this were the scenario the Legislature picked, those 4,000 people would have an affirmative plan switch that would have to happen.

**Wayne Leonard:** The K-12 remittance that we currently pay, does that subsidize both the non-Medicare retirees and the Medicare retirees? Or is it primarily one group?

**Kayla Hammer:** It's both.

**Tom MacRobert:** I want to make sure I understand this. So on the one hand, non-Medicare school retirees could have the same plan options, meaning if you have Kaiser Permanente, Uniform Medical, those remain the same, correct?

**Kayla Hammer:** What I meant by having the same is actually speaking as of 2020. Let's say you are in SEBB in 2020. You enrolled, you're working. You sign up for X plan. Then next year, 2021, you retiree. You would potentially be able to keep whatever you signed up for in 2020. In 2021, you could have that same plan. But for people that are already retired and under the PEBB Program right now, they may not have access to the plans that they've become accustomed to over the last two years of their retirement.

**Tom MacRobert:** So, that's the third bullet then that you were referring to. They might have to switch in that scenario.

**Kayla Hammer:** Yes.

**Tom MacRobert:** Okay, thank you.

**Kayla Hammer:** Slide 25 – Create SEBB Program Non-Medicare and Medicare Retirees Risk Pools. In this scenario, there would be the non-Medicare risk pool created under SEBB, like on the previous scenario. But in this, we would also create a Medicare pool under the SEBB Program. That would remove the Medicare school retirees from the PEBB Program into their own pool that would be managed by SEBB. The same considerations would exist as on the previous scenarios slide, as for the non-Medicare risk pool under SEBB. In this scenario, though, the HCA may need to procure a Medicare portfolio for the SEBB Program. Current PEBB Medicare school retirees would then maybe have to select new plans. This could impact up to 34,000 subscribers. It also could lead to a divergence of rates, plan offerings, member costs, and subsidy amounts.

If the pools were separate, there's no guarantee the Legislature would award the same Medicare explicit subsidy for both populations. We talked before that the K-12s currently in PEBB Medicare were slightly healthier than the Medicare pool as a whole. There would be assumed savings if you were to move them into their own pool. But it's not guaranteed that they would receive the same subsidy amount they were awarded previously under PEBB. There could be savings, there could not be. It depends on what the Legislature would decide to do. There's also additional administrative and program costs associated with this scenario. The implications for the Medicare retirees is that reducing the population can impact the risk of the pool, which would then impact the rates. The school Medicare retirees could end up with some savings, potentially. And then there is also the potential for the state Medicare retirees who were slightly less healthy to have an increase in their premiums.

**Dave Iseminger:** There's a lot to unpack on this slide. I'll share a couple of examples. I want to level set for each of the Boards. I want to make sure the SEB Board realizes when the agency goes to the PEB Board, we present both non-Medicare plans and Medicare plans. We talk about both risk pools and both plan options and premium setting at the same time for both of those risk pools. In this scenario, that would be done at the SEB Board, as well. Because right now, the agency is presenting the SEB Board with plans on, if I were wearing my PEBB hat, we'd be talking about the non-Medicare risk pool. We would have to very likely go forward and do procurements and bring other plan designs forward to the SEB Board for this second risk pool the Board would manage, the fourth risk pool for the agency, but the second risk pool for the SEB Board. It's not a given that we'd be able to procure the same carriers, the same plan design we've seen as we've presented different benefit options to the SEB Board that your demographics are different. There could be a different rating if the pool is split apart. That would be a whole other function and work stream that would be generated under this scenario to the SEB Board is procurements for Medicare plans, authorizing of Medicare plans, rate setting for Medicare plans. We would be doing everything just like we do for the PEB Board twice. HCA would be doing it twice for the SEB Board.

The third bullet means that if you have separate Boards, separate plans, and separate risk pools, things could diverge in a variety of different ways. It's no guarantee that any of those divergences would happen, but it's certainly possible, given that the

populations would be rated and assessed differently by the carriers. You very well may get somebody who says they used to pay less with them, or, now they are paying more. There's going to be that comparison between two separate Medicare risk pools that are described here in a way that doesn't exist today.

Kayla highlighted the subsidy amount and how the Legislature could handle that differently. I'm not as confident that the SEB Board understands the funding mechanism that happens for retirees and how it differs from employees. For employees, there's a state contribution where the employee pays the difference between what is the total cost from the carrier minus the state contribution. There's an amount the carrier agreed to that is the total plan payment rate to carriers. You subtract the state contribution and the difference is what the employee pays.

On the retiree side, there's the payment rate for the carrier and then the state Legislature has set for next year, the state will contribute \$168. There's a flat amount put in the state budget that is paid. The difference is then paid by the employee. Of course, I'm oversimplifying because it's not really \$168. It's \$168 or 50% of the premium, whichever is less. But in effect, there's a flat dollar amount put directly into the budget. On the employee side, it is negotiated. There's Collective Bargaining Agreements. On the retiree side, it's a flat amount the Legislature puts in the budget.

**Kayla Hammer:** That's specifically for Medicare retirees.

**Pete Cutler:** My understanding is in the HCA statutes, there's a provision that, in essence, requires the premiums for non-Medicare retirees to be based on the average claims experience of those non-Medicare retirees plus active employees. Is there a similar type provision in the language dealing with setting premiums in the SEBB Program?

**Kayla Hammer:** There's no language now because at this time, the SEBB Program is strictly an active pool of school employees.

**Pete Cutler:** Okay, that would make sense now that you mention it. And there's nothing about that in the future if there is a change, it's just silent?

**Kayla Hammer:** This report is the next step for the Legislature to evaluate if they were going to make any changes.

**Pete Cutler:** Great, thank you.

**Carol Dotlich:** I would like to explore a little bit the impact of the Medicare explicit subsidy if the two groups, the Medicare eligible were separated.

**Kayla Hammer:** As of right now, for the PEBB Medicare risk pool, which has the school retirees in it now, there is a set amount for the explicit subsidy. I believe it's going to be \$168 in 2019 or 50% of the premium, whichever is less. If they were to separate, there

is nothing in statute about what the subsidy amount would be for the SEBB Medicare risk pool. That would be up to the Legislature to decide and reevaluate. I can't speak for what they would do or if they would make any changes to the PEBB pool with it being sliced pretty much in half. We do know that there is nothing written for the SEBB, if there was a SEBB Medicare pool.

**Patty Estes:** When we talk about procurements, I know we've talked a lot about our timeline for SEBB and launch. What's the timeline if we were to try to procure Medicare plans?

**Dave Iseminger:** I'll answer this two different ways. This is all hypothetical as to when any changes would go into effect. If scenario two were selected by the Legislature, the earliest they could make any changes would be during the 2019 Legislative session. It would be very challenging and I'm pretty sure the agency would explain why implementing for plan year 2020 would be particularly challenging. It would be on a 2021 timeframe or later. It would depend on what the Legislature set as the timeline.

For doing the actual procurement process, we actually haven't done a full evaluation as to the Medicare procurement options. I'll give an example. When we did our life insurance procurement on the PEBB side and rebooted that product from beginning to end, procurement all the way through implementation was just under a year. When we are working on the SEBB procurement currently, the SEB Board in the March meeting authorized and directed the agency to go forward with a disability procurement, as an example. We've gone through that procurement and today brought you some preliminary benefit design pieces, asking you to take action soon. We're in contract negotiations and then the plan would go into effect in 2020. It really depends. I would say anywhere from a year and a half to two years is average. The more complicated the procurement, like our third party administrator for Regence, that took three and a half years plus two years of implementation. The less complex procurements can be under a year from beginning to end. But it's typical that it's somewhere between a year to two years.

**Sue Birch:** I think it's important to note, you referred to it as scenario number two. I believe you're referring to Slide 25 and now you're referring to scenario one on Slide 23. Is that correct?

**Dave Iseminger:** I was trying not to number them. And now you're saying I'm numbering them in voice.

**Sue Birch:** You numbered them. I just wanted to clarify for everybody.

**Dave Iseminger:** Yes.

**Kim Wallace:** I wanted to add also that when we're thinking about a procurement related to Medicare plans, that also introduces CMS and Medicare. The overarching

environment in regulations, etc. One of the things that HCA is researching and is aware of is that there's an added set of deadlines and considerations when entertaining the idea of offering new or different Medicare plan options. That would be another factor that comes into play as we would be planning a Medicare related procurement.

**Wayne Leonard:** A quick question to clarify my understanding. I think you just said when the Legislature makes this decision. Is this just informational for us or are we going to make a recommendation to the Legislature?

**Dave Iseminger:** You could use "when" or "if." There were 20 years of legislative reports about K-12 benefits consolidation and then the official recommendation wasn't what was passed in the House Bill 2242. When and if, let me correct that part on the record. The second piece is, we're here consulting with you, describing the scenarios and what pieces we're seeing as considerations. The agency is charged with making a recommendation on the most appropriate risk pool. The Boards separately or together are not dictated to take a vote. We're asking for your insight so that we can add it into the report. The agency will make a recommendation. Whether the Legislature puts this on a shelf and it collects dust; or they, for ten years, two years, one year, or they act on it in 2019, there are a lot of different factors in the legislative arena as to whether something will be specifically acted on or not. It's the agency making a recommendation and the Legislature taking action one way or the other, or leaving things how they are.

**Tom MacRobert:** Kim, if I'm understanding what you just said correctly, though, if you were to transfer a large pool like the Medicare retirees from one group to the other group, you could have the potentiality of having to go out and do a whole new procurement of benefits for that group because you've made such a substantial change?

**Kim Wallace:** I was commenting on the plan offerings that the HCA would be entertaining and wanting to offer across all retirees, both the K-12 and the state retirees. The act of separating them into two different pools suggests that there is a reason to do that. It's part of the analysis that we're doing, looking at that question. Are there compelling reasons to do that? It may be that there are not. HCA is interested in your feedback and views on the desirability of actually splitting the Medicare retirees to separate pools. From our vantage point, we want to highlight that is serious work and it comes at a cost. What we're thinking hard about and inviting you to comment on, is the benefits, what's really achieved by such a separation? What goal would be achieved by separating the Medicare retirees because of the administrative complexity, cost, and timing? We would want to be really clear as to what is being achieved.

**Kayla Hammer:** Slide 27 – Create Two Additional SEBB Program Risk Pools. In this scenario, the non-Medicare school retirees would be removed from the PEBB Program under the non-Medicare risk pool into their own pool under the SEBB Program. The Medicare school retirees would be removed from the PEBB Program and in their own risk pool under the SEBB Program.

Slide 28 – Consideration. There are similar considerations as previous slides for the non-Medicare and Medicare pools, particularly the PEBB non-Medicare pool. There's likely a small impact to employees in the PEBB Program and SEBB Program based on the risk pool in which the non-Medicare or school retirees are assigned. PEBB Program employees may save by removing the higher utilizing, the small utilizing population, as mentioned previously.

There is the possibility that SEBB Program employees, if Slide 23 scenario was enacted, could have slightly higher rates. But in this scenario, school non-Medicare retirees would be in their own pool. There would be no subsidization situation happening in the SEBB employee pool. However, the small risk pool for non-Medicare retirees would result in increased cost for those early retirees because we would be removing that subsidization talked about previously, the value of a community-rated pool. It's estimated that the premium increase could be as much as 58% to 60% for that small pool of people. That's assuming no legislative subsidy was in place for the non-Medicare retirees.

**Dave Iseminger:** A big piece of this Kayla is trying to highlight is a lot of these implications and considerations are rooted in the fact that it's such a small number relative to the big picture. Again, if you go back to the earlier slides, we're talking about 2,600 subscribers or 4,000 members compared to hundreds of thousands of individuals in a risk pool. When you get to that small of a pool, it has a lot more volatility.

**Sue Birch:** Dave, are we worried with these smaller entities, of the plan design and/or the offerings that would be available?

**Dave Iseminger:** Sue, I do think that's another implication of the scenario on Slide 27. The SEB Board would have to decide, are you going to rate the pools separately for employees and non-Medicare retirees but give them the same plan offerings, or do we do another set of procurements with a different set of plans and have something that's a middle ground between employee plans and full Medicare retiree plans. It would open up the door to that further question in a way that is not present in either of the prior two scenarios, where the non-Medicare school retirees are with the school employees. It doesn't necessarily inherently introduce that. It just means that they would be community-rated separately. The SEB Board could decide to offer the same plans from the employee risk pool or a different set of plans. It would at least create that option.

**Kayla Hammer:** Slide 29 – One SEBB Program Risk Pool. This scenario illustrates one risk pool under the SEBB Program that contains employees, non-Medicare and Medicare retirees, removing both groups of retirees, the non-Medicare and Medicare from the PEBB Program, all under SEBB.

Slide 30 – Considerations. Further verification is needed on the legality of this scenario. We know it requires changes to Washington State legislation, as this is fundamentally different from the way risk pools are currently funded and managed under statute. Federal law needs further review. The illustration does look like a community-rated pool

but it would not function that way because one thing we do know is that under federal law, no issuer can sell a major medical policy to a Medicare enrollee. That means, regardless of the risk pool, the Medicare retirees will still be purchasing specific plans, which is not the same as people that are not enrolled in Medicare.

**Dave Iseminger:** If you stay on Slide 29, it looks like everybody's together and being treated the same exact way. But it functionally would not be that way because the bottom purple box would have completely separate plan offerings than either or both of the prior two boxes. The reality is if you were trying to community rate them in a single pool as shown on Slide 29, you would end up immediately having some sort of adjustment factor based on the different plan designs. You would immediately see a different rating structure within what looks like one pool. It would create this plan adjustment factor for lack of a better description that is inherent to the fact that Medicare retirees will have fundamentally different options than non-Medicare retirees. It may look like one pool but it wouldn't function like one pool, which would beg the question, why make it look like one pool.

**Kim Wallace:** I want to circle back to the comment I made a few minutes ago. We're looking at these different options. I think it's important to consider what would be achieved by moving away from what is currently anticipated so that we can be really clear. That's what HCA is seeking in our report. HCA wants to be really clear on the rationale and underpinnings of our analysis of the most appropriate risk pool for the K-12 retirees. We're keeping in mind what would be accomplished. Why? What would be the better outcome from a recommended change? We invite you to share your views on the opportunities to change and why. What are you envisioning accomplishing?

**Tom MacRobert:** I'll jump in. After you have gone through and given us a really good descriptor of all of these different plans, I can see no benefit to switching. Maybe you could enlighten me as to why that perception is incorrect. I would love to hear it. But as it stands right now, I can't see any benefit.

**Dave Iseminger:** Several of us around this table went to law school so we can always play devil's advocate. I don't want anyone to think that me saying one way or the other is supporting an option. It's just me being a lawyer. One of the examples would be the member experience of being able to maintain the same plans, especially that non-Medicare retiree. If you were to move them in the way that's described on Slide 23, where you move non-Medicare retirees, school retirees into the school employee risk pool, then those recently retired young retirees or not Medicare eligible retirees, they get to maintain that plan relationship that they've experienced. At least the future new retirees, not the current ones that are in the PEBB pool. That would have a disruption. But future new retirees would be able to have similar plans they experienced as school employees. They only have one switch to the Medicare retirees plans in the PEBB Medicare risk pool when they enroll in Medicare. If you kept the exact system that was in place today that's envisioned for 2020, you'd have a K-12 employee who has SEBB plans, they're an early retiree, they move to the PEBB non-Medicare risk pool plans,

then they become Medicare eligible and have another shift into a completely different Medicare plan. You could eliminate one of those shifts by a future state where the K-12 non-Medicare retirees are able to maintain the same plans they enjoyed as active school employees. That's one advantage to one of the scenarios.

**Tom MacRobert:** But that would be the smallest group we're talking about, the least number of people that would be impacted.

**Dave Iseminger:** Correct. That is a small group. It's about 4,000 members and I think it was 2,600 subscribers.

**Tom MacRobert:** Okay, thank you.

**Katy Henry:** But it would affect all future SEBB retirees.

**Dave Iseminger:** Correct.

**Dave Iseminger:** Katy, another point, for the record, to keep in mind is that with the consolidation of SEBB, as I always say, the bridge to PEBB will become more apparent. There are many school teachers who learn about PEBB very close to retirement and that's the first time they ever hear of the PEBB Program. With one agency administering both programs, that bridge will be clear and that number may get higher as time goes by.

**Patty Estes:** I just want to make sure I'm understanding the cost to a school employee if we put the non-Medicare retirees into the same risk pool with the school employees, that would increase their cost.

**Kayla Hammer:** It could impact the cost because you are moving a small group of people that are typically utilizing into --

**Patty Estes:** With a smaller funding mechanism with a subsidy. Am I understanding that correctly?

**Kayla Hammer:** With the non-Medicare risk pool scenario, it is assumed there would be no legislatively mandated subsidy for the non-Medicare retirees. They benefit from a blended premium rate by being in a pool with active employees. Does that make sense?

**Patty Estes:** No, it's okay, though.

**Kayla Hammer:** It's a lot to take in on one day.

**Pete Cutler:** Following up on that, in fact on Wayne's questions, the payment that school districts who don't have employees in PEBB currently, which is a great majority of districts, there is a monthly payment, which I think is referred to as a carve out. It

represents the Health Care Authority's estimate of the cost that the PEBB Program plans incur for all the school retirees that's calculated and updated every year. In theory, on Slide 24 where it talks about the impact of moving the non-Medicare school retirees into a single pool with actives, there could be an increased premium for school employees. My understanding and theory, if you're calculating that carve out accurately, it would not have a premium impact because the dollars would now be pulled out and no longer available to school districts - because they're going to HCA to pay for those costs and would no longer be transferred to HCA and they would remain with the school district.

**Kayla Hammer:** Let me clarify. You're saying that in that scenario, there would essentially be a wash?

**Pete Cutler:** Right. I think on making a decision on what to recommend here, for me, it's influenced by trying to understand how that carve out funding mechanism would offset premium impacts that would otherwise be expected to occur. I don't need a discussion right now. But it would be useful before we go too much farther.

**Kim Wallace:** What some people refer to as the carve out, others refer to as the K-12 remittance. One thing I wanted to clarify for the group is the amount of money you're referring to that the school districts pay in the K-12 remittance covers the value of the retiree costs and comes in two flavors: the implicit subsidy and the explicit subsidy for retirees. That amount is financially modeled and calculated by HCA. They are suggested values. I want to make the point that the Legislature does pick a number and they don't have to pick the suggested value.

**Pete Cutler:** Thank you for that clarification. In my prior role, often reviewing those numbers, that's an important part for the record. It's actually a legislative decision based on analysis provided by the Health Care Authority.

**Kim Wallace:** Right. The reason that's important is how much of a wash would occur. It's a funding decision about that retiree subsidy amount. I think none of us know what exactly would come of that calculation of that implicit subsidy.

**Dave Iseminger:** As we're moving on, I want to say even though this presentation didn't really get into the inner workings of the K-12 remittance or carve out, they'll certainly be described in the report about the implications. There were too many variables, especially with how Kim just described it for it to be as fruitful of an add-on to this presentation. It certainly will be discussed in the final report.

**Pete Cutler:** Dave, I think it would be useful to have something written up available to Board Members. Maybe just post it on the web. I think providing feedback on different options for pooling, unless you understand the mechanism for the remittance, it really is hard to make an informed point of view. I hope we can get something in writing before December. Thank you.

**Carol Dotlich:** I wanted to clarify, under this scenario on Slide 23, can you foresee the impact on the PEBB non-Medicare risk pool costs?

**Kayla Hammer:** Potentially. We talked about relative risk scores previously. And we talked about how in the Medicare pool under PEBB, currently, the K-12 retirees are healthier than the pool as a total. So there is the potential that by removing a, maybe slightly healthier -- they are mostly comparable. But there could be a negative impact, I suppose, on the PEBB Medicare pool. It would depend on the number of people removed and the overall effect on the rating of the plans that happened after the fact. I could say yes, there could be. But it's hard to say.

**Kim Wallace:** I think your comments just now seem to be focused on a change in Medicare retirees and splitting them up. I think Carol's asking about on Slide 23, the movement that's happening is the non-Medicare school retirees leaving PEBB and coming over and joining --

**Kayla Hammer:** I was looking at the wrong scenario. You were curious about the impact on the PEBB Program non-Medicare risk pool by removing. The non-Medicare school retirees who were slightly healthier, had a slightly better risk score than the non-Medicare state retirees. So you're removing a small amount of people that are still high utilizing but less high utilizing than the other non-Medicare retirees. There is a possibility that the ratio of healthy to less healthy could be disrupted. So potentially, that could result in some increase to that PEBB non-Medicare pool.

**Dave Iseminger:** Carol, in the non-Medicare risk pool, there's 275,000 state employees. There are 5,300 non-Medicare state retirees and 4,000 school non-Medicare retirees. So a very small portion of when you compare on Slide 15 the relative risk score that's in the middle of those three populations. It's probably going to be fairly small but it could happen. And that would be a slight increase overall because you're taking out some subset of the piece that is on the healthier side of the equation but not the healthiest or largest.

**Carol Dotlich:** Do you have any sense of percentage or dollar amount that change could be?

**Kayla Hammer:** I do not have that information. And it wouldn't be something that could easily be measured until you went through the procurement process and looked at the new pool and had conversations with carriers to get a real idea about what that would be.

**Patty Estes:** Am I correct in remembering that the current K-12 employee population enrolled in PEBB is around 30-35,000?

**Dave Iseminger:** No, it's 3,500.

**Patty Estes:** Okay. Taking that into effect, too, there could potentially be about 7,000 that move out.

**Tim Barclay:** I think you asked for our thoughts and comments on these various options. I'll give that to you. Remember, you asked for it. So just quickly on the four different options, my thought is the fourth one makes no sense. You're bundling people together to bundle them together only to do all the work to separate them to make it sort of functional for others. I don't think the fourth option is really worth a whole lot of conversation.

**Sue Birch:** Tim, to clarify, you're referring to the one on Slide 29?

**Tim Barclay:** Yes. The single risk pool of all the different people. I won't spend a lot of time on that.

I think the interesting question is if we start with the first scenario on Slide 23, which I think makes a lot of sense. I agree with Pete's comments earlier that throwing the non-Medicare school retirees in with the school employees doesn't have to have a big impact depending on how the K-12 remittance funding is transferred with it, and how it's administered in the calculation of the premiums. It's a small number of people. You've got some sense of potential for offset, in terms of how they decide to do the K-12 remittance. The administrative simplifications of not making people switch into the PEBB Program, I think this scenario makes a lot of sense.

The second one on Slide 25, I'm struggling to see the value. We're going through some work now in PEBB to restructure the Medicare benefit portfolio. To ask the Health Care Authority to do that twice, present it, and potentially deviate between different boards doesn't make a lot of sense to me. People, no matter what pool they come from, when they become Medicare eligible have to make a choice, have to make a change of plans. It's not going to make life easier for them to go to one versus the other. Furthermore, I think it's a little inconsistent with the whole context of how SEBB was created in the first place, which was to create more consistency between how folks are funded and managed. I think it would be a little bit counter to where the Legislature's trying to go to then take a population that has already combined into a single Medicare benefit package and split it into two and create more administration and more differences. I don't think it makes a lot of sense to split that pool out.

The third one I already commented on. I just don't think those people are big enough or different enough with the K-12 [indecipherable] to justify splitting them into a separate pool. That's my take on it, when it's all said and done, the only scenario that really makes any sense to pursue is the first one.

**Wayne Leonard:** I would concur with Tim's summary. If there are going to be any changes, it appears that the pooling on Slide 23 would probably be the only one that makes sense. And even with that, I would hope that we would look at minimizing the

administrative costs of administering all these different pools or plans. If it was going to result in higher administrative costs, I'd probably rather just keep it the same.

**Tom MacRobert:** You have to submit this to the Office of Financial Management in November? Is that correct?

**Dave Iseminger:** Yes. All the legislative reports this agency does, this is one of 41 that we're doing this calendar year, or between last session to this session. All of our reports, we do a review through OFM. It's a standard part of the legislative report-making process for this agency.

**Tom MacRobert:** It's my understanding, unless there's something that comes completely out of whack, that's something they just say it looks good. The numbers look good. The numbers match. It's not an analysis of what you're trying to do but rather it's an analysis of the numbers you're using, right?

**Dave Iseminger:** I think it varies based on the reports. I've seen reports that the agency's worked on that's had a lot of substantive feedback that has said this needs further clarification. You need more data to represent this piece. Or there's this other part of the equation. That's why it is a multi-week process to really give the best report possible to the Legislature with a critical eye from OFM, outside of the agency to inform that process. I would definitely not describe it as a rubber stamp. It is a substantive process.

**Tom MacRobert:** At the time you send the report, you're going to have to make a recommendation. You're going to have gone through these different scenarios and come to a conclusion as to which one you think represents the interests of everybody and make that recommendation. Hopefully OFM says yes and it goes to the Legislature.

**Sue Birch:** Tom, I don't think it's fair to represent that HCA would make the recommendation that represents everyone's opinion. I don't believe HCA would suggest we represent either the PEB or SEB Board in that recommendation.

**Tom MacRobert:** No, I wasn't asking that. What I was saying is that you are going to have to come to a recommendation.

**Sue Birch:** That is correct.

**Myra Johnson:** First, I want to say thank you. You've clarified the mud just perfectly. Thank you and I appreciate that. I, too, am liking the scenario on Slide 23 with the explanation on Slide 24. My one concern, and I know the answer's probably going to be, "We're trying, we're trying." That last line, "Possible increase premium for school employees." I would like that to be miniscule if even non-existent, which I understand with all the scenarios in play and I understand it is a possibility. If this is the one that you move forward, reiterate that any increase is not a positive.

**Yvonne Tate:** What I was thinking about is between the option on Slide 25 or Slide 23, I guess the question really is, if you have a [indecipherable] . . .

**Sue Birch:** Thank you for that, Yvonne. Anybody else on the line? Harry, Allison, or Greg, if you've gotten off your flight?

**Harry Bossi:** I'm okay, thank you.

**Alison Poulsen:** I don't have any further questions. I really appreciate the thoughtful discussion. This is a complicated and important decision.

**Sue Birch:** Thank you, Alison. I have a question I'd like to ask for a little clarification. On scenario one, Slide 23. Is the thought process that by moving the non-Medicare school retirees, even though we might have more uniformity with the types of plans that they're moving onto when they're not an active employee, it's likely that the plans are going to be more similar and so that's the dominant health care motive. Is the thought that the Medicare plans offered to both are state employees PEBB and SEBB members are going to be more uniform throughout the state? Was that some of the thought process you had about the Medicare plan designs that would be available in that middle column?

**Dave Iseminger:** In this scenario on Slide 23, essentially nothing would change but this wouldn't be something that prompts a specific change in the Medicare risk pool. There are plenty of other pieces the PEB Board's been evaluating as to implications for the Medicare risk pool. But right now, state and school retirees have the same option to the same plans in that Medicare risk pool. If there were any changes to the plan offerings, they would remain equally accessible by both parts of the risk pool because they are in a single risk pool. I think that's what you might be asking.

**Sue Birch:** It seems to me that the carriers would be able to offer more uniformity based off Medicare.

**Dave Iseminger:** That's what they do now. There is no distinguishing in the Medicare risk pool based on what kind of retiree you are. You're a Medicare retiree in the Medicare risk pool. The only reason they're different is we were just highlighting K-12 versus state. But from a carrier standpoint, that Medicare risk pool in the middle column, there's no differentiation based on who your employer was when you were an active employee.

**Kim Wallace:** I want to ask a follow-up question to Sue. I think you're asking a question about the kind of continuity or alignment that people experience when they become a retiree. I think it's a matter of Health Care Authority making a policy decision that gets implemented in terms of managing the Medicare portfolio. There has been historically, care taken to create a logical path for employees covered under the PEBB Program to have benefits or at least carriers that they are comfortable with, familiar with,

etc. when they retire. Currently, in the PEBB Program, the carriers offering Medicare plans to retirees are carriers that are familiar to our offering plans to employees. I think one of the questions with the new SEBB employee program, the question would be then, how is it that there is this logical, reasonable flow and path for them to go from being a K-12 employee with SEBB coverage to being a K-12 retiree with Medicare coverage in PEBB. I think it's a good point. I think it's part of designing and maintaining the full Medicare portfolio that we now, the HCA has an evolving responsibility to consider designing a Medicare portfolio of offerings that makes sense for all the folks that are retiring into Medicare in a new way. We've cared about that for a long time but I think it's part of the review and the new look at the full Medicare portfolio being offered is taking into consideration what do all of the people experience as they come in to Medicare coverage as a retiree. Is that what you were asking about?

**Sue Birch:** Thank you. That's exactly what I was looking at here. I'm trying to understand how we're stair stepping folks.

**Carol Dotlich:** I agree with Tim. I think this plan makes the most sense of all the scenarios provided.

### **Public Comment**

**Fred Yancey**, on behalf of the School Retirees Association. Thank you very much for your attention to this issue. The life of a retiree living on a fixed income, as you know, is a challenge. And our concern really is your perspective of what scenario you pick. Our concern is what we have to pay for insurance. It's a very simple sort of concern. So we want the best scenario that gives a retiree the best insurance at the lowest cost. It was suggested, and I think Ms. Wallace suggested it as well, but I won't put words in her mouth and I may have misunderstood her. But if you look at the number of subscribers and we talk to our seniors that have retired, you only have a fraction of retirees that elect to go into the PEBB Program to begin with. I think it's because there aren't enough offerings to attract enough retirees. I mean, the real question is, you know, should you be out there getting some more options for retirees. The ones I talk to, our own membership, probably, we're guessing only about 40%, you know, belong to the PEBB Program. When I looked at the Medicare offerings because I'm Medicare eligible, you know, I was kind of dismayed at the few choices I had. I'm happy with the choice I made but I talk to my friends that are not even school related and they tell me their Medicare plans. And I'm going, "Boy, there's a wide variety of choices that I didn't see reflected in the PEBB." So again, thank you very much. Our concern and I didn't hear anything about that today other than general comments and it's too bad. I really would like to know what sort of rates we're looking at for retirees. I don't know how -- I understand how hard that can be to find out. Thank you.

**Julie Salvi**, with the Washington Education Association. Sorry I didn't sign up earlier. So our interest is ensuring that the retirees stay in a robust enough pool, to have the best deal available for them. And I look at the current state of affairs and the first options where a number of your Board Members were also recommending as really being kind of the two options before you that would check off a number of those boxes

for us. The other -- I didn't hear a lot of interest in the other plans and I just wanted to offer an idea, which is I would like to see some entertainment of how a transition plan could be made because I think what we're going to run into is current non-Medicare retirees who are in PEBB who are not going to be interested in moving to SEBB only to move back to PEBB in a few years when they're Medicare eligible. And then once K-12 employees are in SEBB, many of those people who are early retirees, non-Medicare retirees would like to stay in SEBB. And that may be an option. There could be a way to transition between the two and not have current non-Medicare retirees bouncing between PEBB and SEBB. And that may be a more interesting option to consider if you're ruling out some of these other options going forward. So kind of an option of how you might transition with the carve out or remittance that is out there. I think there's a mechanism, financially, to make that work. And that would be a new scenario that would keep the employees in mind for how many changes they're having to go through.

**Doug Nelson:** Yes. Doug Nelson from Public School Employees of Washington. So on the record, we support Slide 23. I think we're talking about the non-Medicare retirees. And you have to realize, in the K-12 system, we have developed an organically developed insurance industry over 30, 40 years. I think what this whole SEBB Program is about is providing something similar for everybody across the state. And so I recognize that the PEBB or the SEBB non-Medicare retirees will have to change. Join the club. There's about 160,000 K-12 employees who are going to be changing too. So I agree with Julie. If we can figure out an easy transition way, that would be great. But if not, it might be just a bullet that has to be bitten on like everybody else is. Thank you.

**Dave Iseminger:** I do appreciate the historic nature of bringing both Boards together for a conversation that could impact both. I just appreciate everybody coming together for a special meeting. I appreciate the comments from both Boards in July and particularly today as we were able to get more information to you for your consideration. We'll wrap up all of your comments and insight as an appendix, or as some part of the report, and appreciate your willingness to engage on such an important topic. I was glad we were able to give you about 45 days' notice for this meeting and that everybody could come here to the Health Care Authority. So thank you all.

**Sue Birch:** Dave, thank you, as usual to you and your team for preparing all of this and getting us all together.

Meeting adjourned at 4:25.

**Public Employees Benefits Board**  
**Meeting Minutes**

**DRAFT**

September 17, 2018  
Health Care Authority  
Sue Crystal Rooms A & B  
Olympia, Washington  
4:50 p.m. – 5:00 p.m.

**Members Present:**

Sue Birch  
Tom MacRobert  
Tim Barclay  
Myra Johnson (joined late)  
Carol Dotlich

**Members via Phone:**

Greg Devereux  
Harry Bossi  
Yvonne Tate

**PEB Board Counsel:**

Katy Hatfifeld, Assistant Attorney General

**Call to Order**

**Sue Birch, Chair**, called the meeting to order at 4:50 p.m. Sufficient members were present to allow a quorum. Board self-introductions followed.

**Approval of March 21, 2018 PEB Board Meeting Minutes**

**Sue Birch:** Tim Barclay moved and Greg Devereux seconded a motion to adopt. Minutes approved by unanimous vote as written.

**Approval of April 25, 2018 PEB Board Meeting Minutes**

**Sue Birch:** Tim Barclay moved and Yvonne Tate seconded a motion to adopt. Minutes approved by unanimous vote as written.

**Approval of May 21, 2018 PEB Board Meeting Minutes**

**Sue Birch:** Tim Barclay moved and Harry Bossi seconded a motion to adopt. Minutes approved by unanimous vote as written.

### **Approval of June 7, 2018 PEB Board Meeting Minutes**

**Sue Birch:** Harry Bossi moved and Yvonne Tate seconded a motion to approve. Minutes approved by unanimous vote as written.

### **Approval of June 20, 2018 PEB Board Meeting Minutes**

**Sue Birch:** Tom MacRobert moved and Carol Dotlich seconded a motion to adopt. Minutes approved by unanimous vote as written.

### **Approval of July 17, 2018 PEB Board Meeting Minutes**

**Sue Birch:** Greg Devereux moved and Tom MacRobert seconded a motion adopt. Minutes approved by unanimous vote as written.

**Tim Barclay:** I would like to take a moment and make one comment on the record. I would like to ask the Health Care Authority, Dave, in particular, since the next time we meet is our January retreat, to make sure one of the agenda items for that day is the long-term disability basic benefit. As much as we can, have a conversation about how best to go about advocating for an enhancement in that benefit for our members.

**Dave Iseminger:** One of the few people in the audience is Marcia Peterson, who has just started working on the retreat agenda. So noted.

I just want to say the Board approved 170 pages of minutes in about five minutes. And, it took a lot longer to get to that five minutes. I want to thank Connie and Jesica who spent a lot of time getting them ready when they saw the opportunity to have a 15-minute special meeting to get minutes approved instead of waiting until next year. I appreciated their effort to get them here and the Board for being willing to tack on at the end of the meeting.

**Carol Dotlich:** I want to again express my concern about the customer service at the time of open enrollment. I was hopeful that there would be a phone option where people could leave their name and number for a call back when lines were busy. It's my understanding that what's going to happen now is, when the lines are tied up and staff are busy with keying in, and the phones are less busy, they're simply going to turn the phones off with a message saying that you'll have to call back. The message would say "we'll be shut down from one to three – you may call back after that," or, "you have to call back tomorrow." I understand how busy the staff is and I appreciate that there have been staff hired and there's a real effort to improve customer service during open enrollment, but I'm disappointed that we weren't able to put something else into place, something a little more customer friendly than just turning off the phones.

**Sue Birch:** Carol, thank you for that feedback, but I would just ask Dave to clarify.

**Dave Iseminger:** I will clarify. During open enrollment, we don't turn the phones off. In anticipation of open enrollment, for example, this week or next week, we catch up on forms received that need to be processed. One of the vicious cycles we end up in is people call to find out where their form is in the queue, and we can't queue the form because we're on the phone telling them where it is in the queue. As we get closer to open enrollment, but not during open enrollment, we'll find the lowest call volume from

historical times, and say, "this two-hour period on a Friday shows that it's the lowest call volume and it has the lowest impact." During that period, we would turn off the phones and say, "For business reasons we are working on X, Y, Z, the phones will be back on at blank time." But, they are not turned off during open enrollment. During the month of November, there is no turn off.

If it is down in November, it's because there's a system failure. It's not because of keying forms in the month of November. The phones stay on that entire time. As we get closer to open enrollment, but not before open enrollment materials go out in October, we catch up and help get out of that vicious cycle of people asking questions we can't answer because we're working on the forms. It's trying to get ahead of that.

**Sue Birch:** Dave, thank you for that clarification. I do want to comment, Carol, that there are ways to access us. I don't think we'll have system disruptions like you're suggesting during the open enrollment period.

**Carol Dotlich:** So, my question to you, is this phone system incapable of accepting a message from me, I need to talk to you, that you could call me back? The system that you have in place won't do that. It won't say, "please leave your name and number, and we will call you back within the next 24 hours, or 48 hours." Or whatever it is. Your phone system here won't do that. Is that my understanding?

**Sue Birch:** Carol, I don't know that we have programmed the system that way. I think we need to explore your very explicit question. But, we are currently not programmed that way because staff have made the recommendation to configure it the way Dave has just explained. But, let us take that forward, and we can talk offline to get back to you about the specifications of our current system.

**Tom MacRobert:** I think I know what Carol's talking about where there are certain places where you can call in and it will say, "we will take your number and you will be placed in the queue, and we will be able to get back to you within the next number of minutes."

**Dave Iseminger:** We do that. It was a limited roll out feature last year and it didn't have as robust a queue as individuals would like, but that's called a callback feature where you're left in the queue but you don't have to sit and listen to elevator music. It calls you back in real time and then you're put on a brief hold. But, Carol's also describing leaving a voice message. At the end of the day, or at some point if there's down time, and I'll tell you right now there is never down time during open enrollment, so it would be at the end of the day, collecting voice messages and calling people back the next day.

**Sue Birch:** Dave, thank you again for that clarification. I'll ask staff to prepare a summary and email that response out for further clarification. Because I think we've configured it a certain way, Carol, I don't think we have necessarily a system dysfunction like you're suggesting. Or lack of function. I don't think we've configured it that way. But we'll clarify. Thank you for that comment.

**Sue Birch:** Our next meeting is the Board Retreat on January 31, 2019.

**Sue Birch:** Meeting adjourned at 5:00 p.m.

**Public Employees Benefits Board Retreat**  
**Meeting Minutes**

**DRAFT**

January 31, 2019  
Health Care Authority  
Sue Crystal Rooms A & B  
Olympia, Washington  
9:00 a.m. – 5:00 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:**

Michael Tunick, Assistant Attorney General  
Katy Hatfield, Assistant Attorney General

**Call to Order**

**Sue Birch, Chair**, called the annual retreat to order at 9:04 a.m. Board and invited guests introductions followed.

**Meeting Overview**

**Marcia Peterson**, Manager, Benefits Strategy and Design Section, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda. The theme of the Retreat was Ensuring Affordability and Value for Members.

**Addressing Health Care Affordability: Identifying and Addressing Waste**

**Mich'I Needham**, Chief Policy Officer, Clinical Quality & Care Transformation Division, Health Care Authority and **Nancy Giunto**, Executive Director, Washington Health Alliance discussed affordability and waste in health care.

## **Panel Discussion: Pharmacy Challenges from the Physician Perspective**

**Panel Moderator – Emily Transue, MD**, Assistant Medical Director HCA

**Panel Members: Norris Kamo, MD**, Virginia Mason Medical Center; **Matthew Mulder, MD**, Valley Medical Center; **Gurpreet Rawat, MD**, Kaiser Permanente of Washington; **Keith Bachman, MD**, Kaiser Permanente Northwest

**Emily Transue, MD**, led a panel discussion on pharmacy challenges from the physician perspective. There was a question and answer period.

There are a lot of generic/substitutable medications available. There was a discussion on a “step process” for dispensing drugs - you start with a generic and move to others if medically necessary. It can be difficult for a physician to keep up with all the steps and different formularies. The panel indicated they did not have issues with members insisting on using brand-name drugs and being willing to try generic drugs. There was a robust discussion on pharmacy.

## **UMP Pharmacy Update**

**Marcia Peterson** provided an update on the Uniform Medical Plan pharmacy. Communication and client engagement is important in taking charge of your health care.

## **2019 Open Enrollment Summary**

**Renee Bourbeau**, Manager, Benefits Accounts Section, shared the results of the 2019 open enrollment. Renee shared the engagement process for getting information to the subscribers, PEBB Program enrollment changes for 2019, and customer service strategies.

## **Disability Benefits**

**Cade Walker**, Executive Special Assistant ERB Division, Health Care Authority Representative from the Department of Employment Security

**Kisha Turner**, National Senior Accounts Underwriter, The Standard

**Jared Benedetti**, Consulting Actuary, The Standard

**Dave Tappan**, Employee Benefits Manager, The Standard

**Cade Walker** led a panel discussion on disability benefits. Cade provided an overview of disability insurance. The new state Paid Family and Medical Leave Program was described. The Standard talked about trends in employer-sponsored disability benefits.

## **The Empowered Consumer & Personal Health Technology**

**Molly Christie**, Strategic Planning Project Manager, ERB Division

**Matthew Toney**, Strategic Planning Project manager, ERB

**Molly** and **Matthew** gave a robust presentation on consumerism in health care, the personal health tech market of health, and wellness applications providing many examples. They shared trends in the personal health tech market and future considerations, and what the PEBB Program is currently doing.

### **Emerging Medications Update**

**Ryan Pistorosi**, Assistant Chief Pharmacy Officer, Clinical Quality & Care Transformation Division presented an overview of new drugs that recently came onto coming on the market and the potential cost impact to the PEBB Program.

### **Medicare Retiree Health Benefits**

**Kim Wallace**, SEBB Finance Manager provided an update on the report the agency submitted to the Legislature. The Health Care Authority is evaluating the PEBB Program Medicare retiree health benefits. Kim provided a progress report and identified next steps.

### **Medicare Supplement Plans**

**Betsy Cottle**, Contract Manager, discussed the closing of Medicare Supplement Plan F, what that means for our subscribers, and details for the new Plan G.

### **Retired and Disabled School Employees Risk Pool Analysis Report to the Legislature**

**Kim Wallace**, SEBB Finance Manager. The Legislature charged the Health Care Authority with analyzing the appropriate risk pool for the retired and disabled school employees. The report was submitted to the Legislature on January 17, 2019. Kim gave an update on the submitted report.

### **2019-2021 Governor's Budget Update**

**Tanya Deuel**, PEBB Finance Manager shared an update on the Governor's 2019-2021 budget. Tanya discussed funding rates; the Medicare explicit subsidy; decision packets, both funded and partially funded; and other funding.

### **2021 Benefits Priorities**

**Marcia Peterson**, led a Board discussion on their ideas on benefit priorities for 2021. **Greg Devereux**, is interested in disability, orthodontia, and vision. When were they changed last? **Harry Bossi**, is interested in the vision benefit. **Sue Birch** would like to see enhanced behavioral health and wellness. **Tom MacRobert's** number one concern is the rising cost of medical care, specifically prescription drugs.

### **Public Comment**

**Fred Yancey**, would like the retreat to use microphones. Technology discussed was not a comfortable discussion. Interested in premiums and benefit design for retirees. Who makes those decisions? What is the timeline? Stakeholders should be involved. The value of the retiree drug subsidy has declined.

### **Legislative Update**

**Dave Iseminger**, talked about the bills currently in the Legislature. There are three main bills that may impact the PEBB Program.

- HB 1085 – Medicare Retiree Subsidy
- HB 1220 / SB5275 – Add the Insurance Commissioner to the PEB Board as a non-voting member
- SB 5335 – LEOFF 2 Board – Ensure retiree pension payment made for the entire month in which the retiree dies

Bills that may impact both Boards.

- HB 1065 / SB 5031 / HB 1215 – Surprise Billing (balance billing)
- Tobacco / Vapor Products – Raising the age of access
- HB 1099 – Network Adequacy
- HB 1523 / SB 5526 - Public Option Bill
- HB 1145 – Dependent Care Assistance Program (DCAP) Employer Contribution Match Pilot Program

**Sue Birch:** The next PEB Board Meeting is March 20, 2019, starting at 1:30 p.m.

Meeting adjourned at 4:10 p.m.

Note: The PEBB January 2019 Briefing Book can be found on the PEB Board webpage: <https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials>

**TAB 4**



# Legislative Update

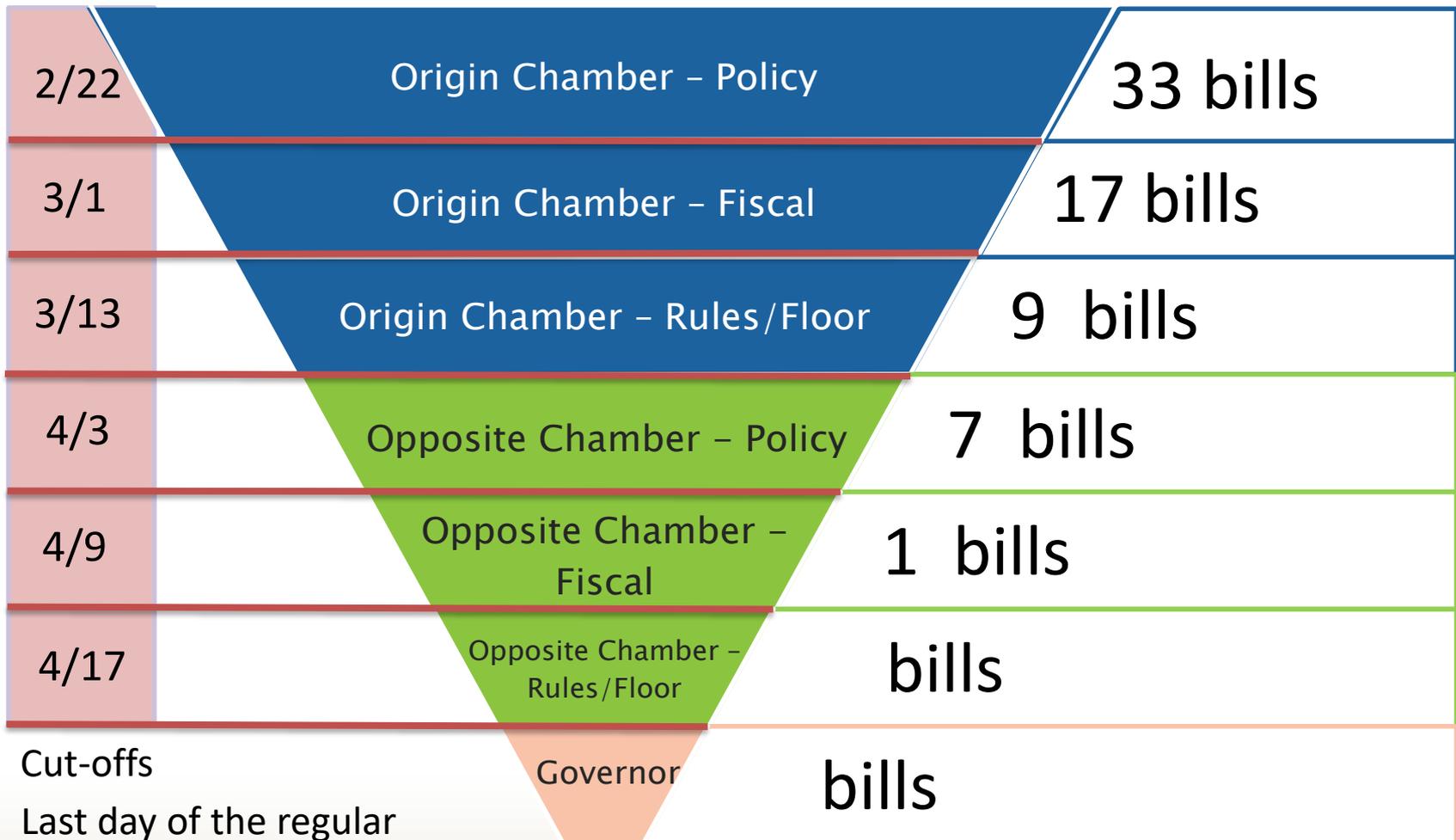
Cade Walker, Executive Special Assistant  
Employees & Retirees Benefits (ERB) Division  
March 20, 2019

# Number\* of Bills Analyzed by ERB Division

	ERB Lead	ERB Support	
High Impact	33	26	59
Low Impact	69	113	182
	102	139	241

\*As of 3/12/19

# Legislative Update – ERB high lead bills



Cut-offs  
 Last day of the regular  
 session: **4/28**

# PEBB Program Impact Bills

- HB 1085 - Concerning premium reduction for medicare-eligible retiree participants in the public employees' benefits board program
- HB 1414/SB 5335 - Paying state retirement benefits until the end of the month in which the retiree or beneficiary dies
- *HB 1220/SB 5275* - Adding a non-voting representative from the Office of the Insurance Commissioner to the PEB Board

## SEBB Program Impact Bills

- HB 1547 - Concerning basic education funding (levy lid)
- HB 2096 - Concerning educational service district health benefits

# ERB Impact Bills

- *HB 1065/SB 5031* - Protecting consumers from charges for out-of-network health care services
- *HB 1074/SB 5057* - Protecting youth from tobacco products and vapor products by increasing the minimum legal age of sale of tobacco and vapor products
- *HB 1523/SB 5526* - Increasing the availability of quality, affordable health coverage in the individual market
- *SB 5889* - Concerning insurance communications confidentiality

# ERB Topical Bills

- Reproductive health:
  - *SB 5602* - Eliminating barriers to reproductive health for all
- Pharmacy:
  - *HB 1224* - Concerning prescription drug transparency
  - *HB 1879* - Regulating and reporting of utilization management in prescription drug benefits
  - *SSB 5184* - Concerning prescription coverage and the use of mail order services
  - *2SSB 5292* - Concerning prescription drug cost transparency

# Questions?

Cade Walker, Executive Special Assistant  
Employees and Retirees Benefits Division  
[cade.walker@hca.wa.gov](mailto:cade.walker@hca.wa.gov)

**TAB 5**



# UMP Pharmacy Update

Marcia Peterson, Manager  
Benefit, Strategy, and Design Section  
Employees and Retirees Benefits Division  
March 20, 2019

# Themes from the Retreat

- Waste
  - Between medical and pharmacy benefits, there is estimated to be \$236 million in waste (non-evidence based practices) in commercial plans in Washington State – tip of the iceberg
- Use of generics
  - Situations where the patient feels like they need to be on the non-formulary drug are very rare
  - If there's a generic drug the provider will normally prescribe it – they're interested in helping their patients save money
  - Patients are almost always willing to try shifting to generics

# Themes from the Retreat (*cont.*)

- Formulary Transparency
  - It would be helpful if patients and doctors had easy access to the formulary – like a tool to view the Preferred Drug List

<https://www.hca.wa.gov/ump/ump-classic/search-ump-preferred-drug-list>

- Navigating formularies was considerably less complicated for the physicians in the Kaiser plans (staff model)

# Uniform Medical Plan (UMP)



Information for... ▾

Forms & publications News Compare plans Find drugs Glossary Accounts Contact

## Prescription drugs

Find a network pharmacy

What you pay for drugs

**Search the UMP Preferred Drug List**

Filling your prescriptions

Limits on drug coverage

## Search the UMP Preferred Drug List

Use the [UMP Preferred Drug List](#) to find:

- If a drug is covered by the plan.
- How much you will pay for a drug based on the [drug's tier](#).
- If the drug [must be preauthorized](#).
- If the drug must be purchased from the plan's specialty pharmacy, Ardon Health.
- If there are any [limits on a drug's coverage](#).
- If there are less expensive alternatives.

[Changes to the UMP Preferred Drug list are posted online](#) at least once a month. However, not all drugs are listed on the UMP Preferred Drug List. Also, a drug may change tiers at any time, particularly when a generic equivalent becomes available. New brand-name drugs may not be covered during the first 180 days they are available.

For questions about your prescription drugs, or to check if a new drug is covered, call Washington State Rx Services at 1-888-361-1611 (TRS: 711).

## Other prescription drug tools

Use the [prescription price check](#) if you want to know how much your drug will cost.

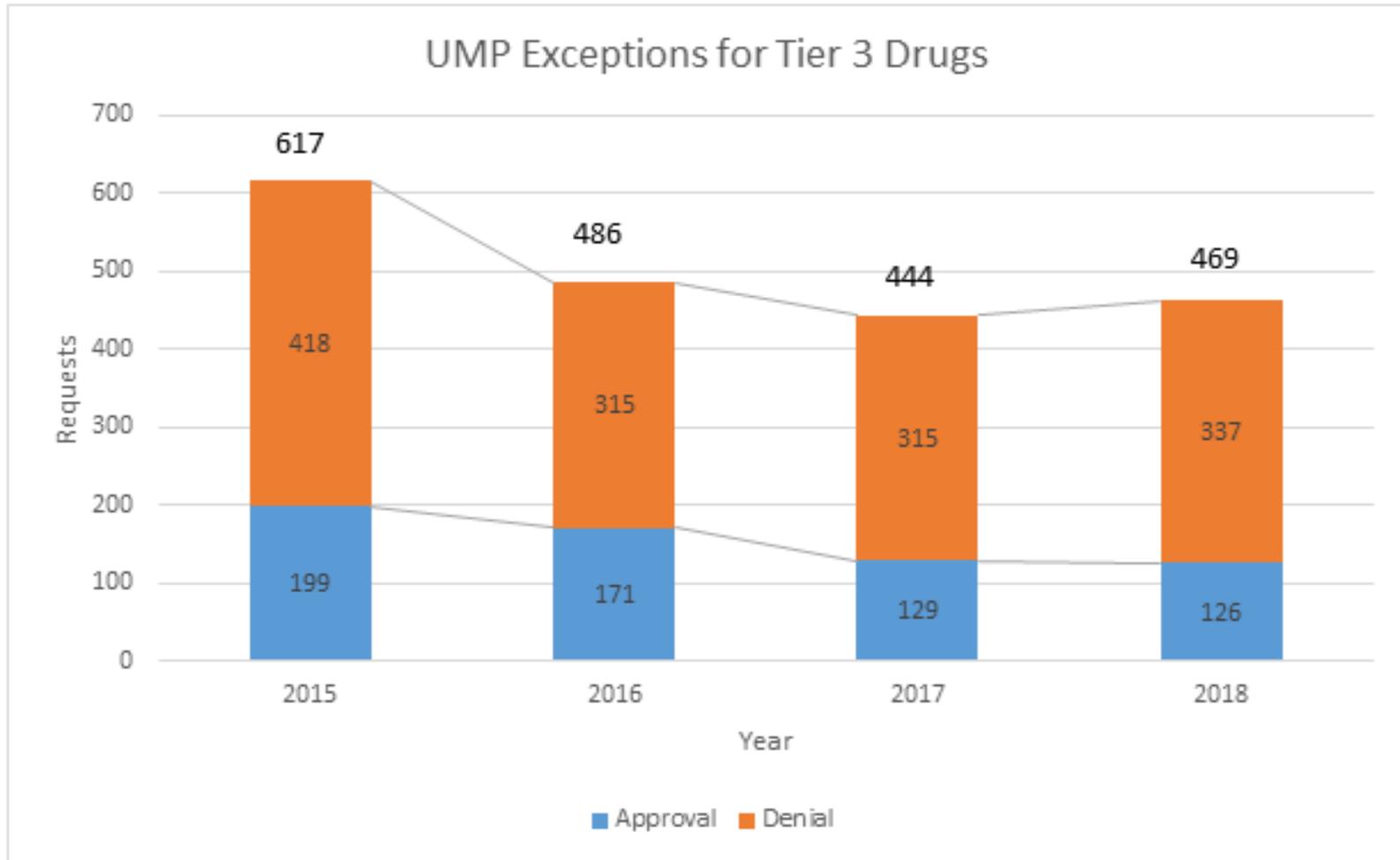
Get information about your drug

UMP Preferred Drug List



# UMP Exceptions for Tier 3 Drugs

- Members request an exception so they can pay Tier 2 for a Tier 3 drug
  - 70% of requests were denied
  - Includes people who haven't tried the lower cost alternatives



# Uniform Medical Plan Proposed Value Formulary

## *Where does the “value” come from?*

- Access to medicines that are equally effective, but more costly than therapeutic alternatives, are not covered

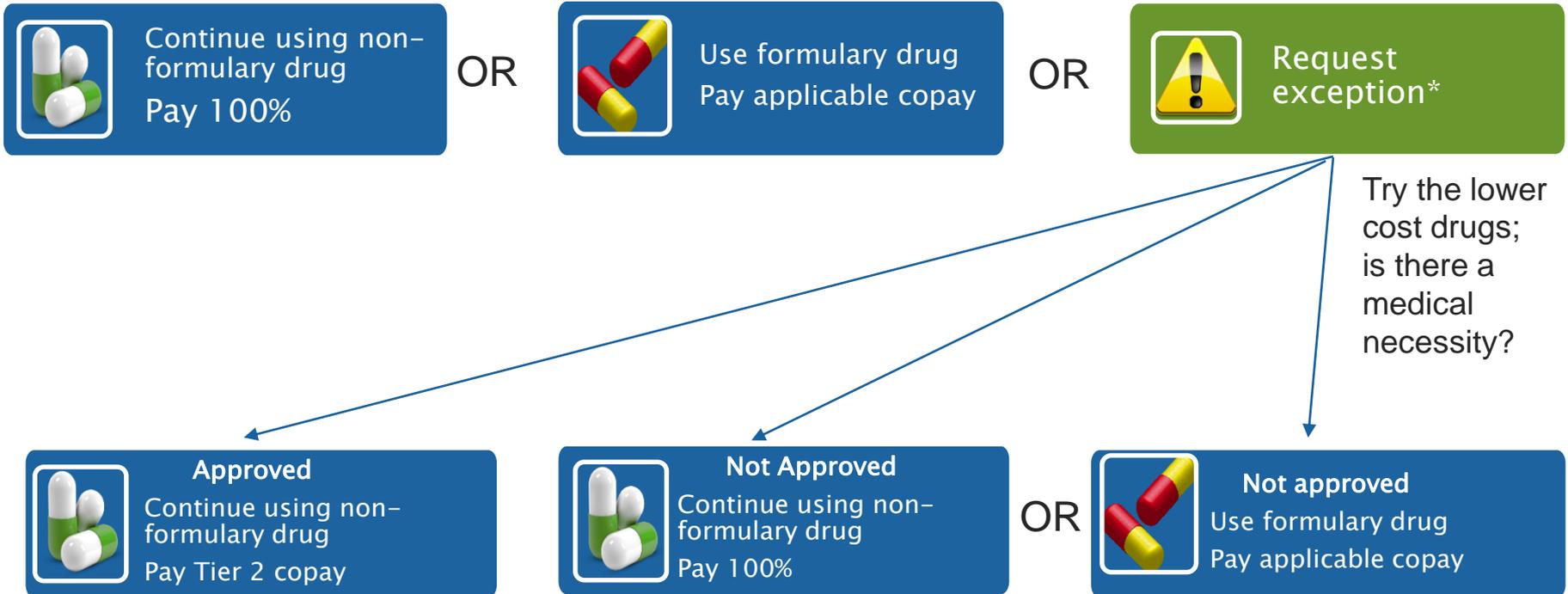
## *What does this mean for members?*

- Access to medicines in every covered therapeutic class
- Possibility for lower out-of-pocket costs at the pharmacy
- An exception process for non-formulary (non-covered) drugs if determined to be medically necessary by the member’s physician and the plan

\*Antipsychotics, antidepressants, antiepileptics, chemotherapy, antiretrovirals, immunosuppressives, immunomodulatory/antiviral treatment for Hepatitis C



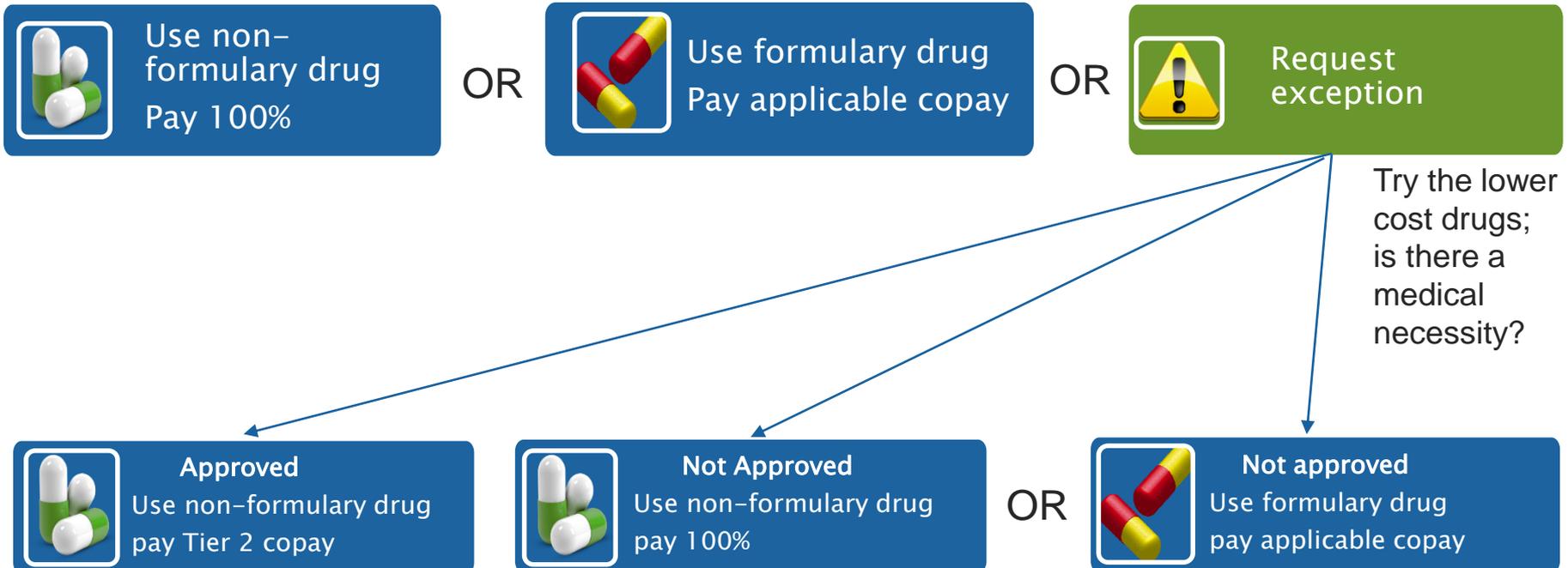
## Member is notified their previously covered drug is now non-formulary



\* Members who have previously gone through an exception process for the non-covered drug will not need to repeat it. Also exempt: refill protected drug classes.



## Member is newly prescribed non-formulary drug



# Refill Protected Drug Classes

Antipsychotics

Antidepressants

Antiepileptics

Chemotherapy

Antiretrovirals

Immunosuppressives

Immunomodulatory/antiviral  
treatment for Hepatitis C

**Generic drugs** are copies of brand-name drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety, and strength as the original drug.

**Therapeutic alternative drugs** are drugs that may have chemically different contents but are purported to have the same effect as other drugs for treating a condition

# Proposed Policy Resolution PEBB 2019-01 Value Formulary

Beginning January 1, 2020, contingent upon approval of a value formulary resolution by both the PEB Board and SEB Board, all UMP plans require the use of a value-based formulary and:

- Nonformulary drugs are covered only when medically necessary and all formulary drugs were ineffective or are not clinically appropriate for that member, and
- Multi-source brand-name drugs, including those in refill protected classes, are covered only when medically necessary and all formulary drugs have been ineffective or are clinically inappropriate for that member, and

# Proposed Policy Resolution PEBB 2019-01

## Value Formulary (*cont.*)

- Members who have been taking a non-formulary drug are required to switch to the formulary drug, unless:
  - they receive or have already gone through the exception process and been approved, or
  - their drug is within one of the refill protected drug classes which include: antipsychotics, antidepressants, antiepileptics, chemotherapy, antiretrovirals, immunosuppressives, and immunomodulatory/antiviral treatment for Hepatitis C.

If the UMP Value Formulary is  
going to go into effect on  
**January 1, 2020**

PEB Board will need to  
approve no later than  
**June 5, 2019**

## Discussion

- Are there additional changes to the Resolution that you feel should be made?
- Is there additional information that the Board needs?

# Questions?

Marcia Peterson, Manager  
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Employees & Retirees Benefits Division

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# Appendix

# Terms

- ▶ **Drug class:** A group of drugs that have similar properties or work in similar ways.
- ▶ **Formulary:** List of covered drugs selected according to their safety, efficacy, effectiveness, and cost.
  - ▶ Open formularies include all medications, including brand-name drugs and generics (usually at different cost-shares).
  - ▶ Closed formularies include a limited list of drugs, usually excluding brand-name drugs with generics and/or therapeutic alternatives.
- ▶ **Generic drug:** A medication created to be the same as an existing approved brand-name drug in dosage, form, safety, strength, route of administration, quality, and performance characteristics. Generic medicines work the same as their brand-name counterparts.
- ▶ **Multi-source brand:** A brand-name drug that is no longer under patent protection and has one or more generics available.
- ▶ **Preferred drugs:** Drugs that have been selected for inclusion on the Washington Preferred Drug List (PDL) according to safety, efficacy, effectiveness and cost. These drugs have a lower member cost-share than non-preferred drugs. The Washington PDL is used by UMP and the Department of Labor & Industries.

# Terms

- ▶ **Substitution:** Replacing a brand drug or biologic with a generic or interchangeable biosimilar. Required under Washington State law.
- ▶ **Therapeutic alternative:** A drug that is not chemically identical to another drug in the same therapeutic class, but has similar effects when given in therapeutically equivalent doses.
- ▶ **Therapeutic drug class:** A group of drugs that can be used to treat a certain medical condition or conditions.
- ▶ **Therapeutic Interchange Program (TIP):** Allows a pharmacist to substitute a therapeutic alternative drug for a nonpreferred brand-name drug in certain cases.
  - ▶ **Refill Protection:** Refills for drugs in the following classes are protected from therapeutic interchange: antipsychotic, antidepressant, antiepileptic, chemotherapy, antiretroviral, immunosuppressive, and immunomodulator/antiviral treatment for hepatitis C (for which an established, fixed duration of therapy is prescribed for at least 24 weeks but no more than 48 weeks). Drugs in these classes are subject to automatic substitution when a generic equivalent is available (see Substitution, above).

# June 2018: Prior Value Formulary Proposed Resolution

## Policy Resolution PEBB 2018 – 01 Value Formulary

Resolved, that 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

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## Policy Resolution PEBB 2018 – 01 Value Formulary (*cont.*)

- 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).

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### Tim's amendment:

- “non-grandfathered members who have qualified for Tier 3 drug coverage will receive reduced Tier 2 cost-sharing, and”

**TAB 6**



# Emerging Medications Update

Ryan Pistoresi, PharmD, MS  
Assistant Chief Pharmacy Officer  
Clinical Quality and Care Transformation  
March 20, 2019

# Presentation Overview

- **Tibsovo**
  - Relapsed/refractory acute myeloid leukemia (AML) with IDH1 mutation
- **Azedra**
  - Pheochromocytoma or paraganglioma
- **Galafold**
  - Fabry disease and an amenable galactosidase alpha gene (GLA) variant
- **Libtayo**
  - Metastatic or locally advanced cutaneous squamous cell carcinoma (CSCC)
- **Oxervate**
  - Neurotrophic keratitis
- **Vitrakvi**
  - CNS or solid tumors with a neurotrophic receptor tyrosine kinase gene fusion
- **Gamifant**
  - Primary hemophagocytic lymphohistiocytosis (HLH)
- **Lumoxiti**
  - Relapsed/refractory hairy cell leukemia (HCL)
- **Firdapse**
  - Lambert-Eaton myasthenic syndrome (LEMS)
- **Elzonris**
  - Blastic plasmacytoid dendritic cell neoplasm (BPDCN)
- **Cablivi**
  - Acquired thrombotic thrombocytopenic purpura (aTTP)

# Tibsovo (ivosidenib)

- Tibsovo is approved for treatment of relapsed or refractory acute myeloid leukemia (R/R AML) with IDH-1 mutation
  - First medication targeting IDH-1 mutation in R/R AML
- First-line treatment for AML is chemotherapy
  - Tibsovo considered as early as second-line treatment for patients with IDH-1 mutations who are not candidates for intensive therapy
- IDH-1 mutations are found in approximately 6% - 10% of all patients with AML
  - About 700 to 1,100 patients living with AML with IDH-1 in the US each year
  - Anticipated to see 1 patient every 2-3 years in UMP

# Azedra (iobenguane I-131)

- Azedra is approved for treatment of unresectable, locally advanced, or metastatic pheochromocytoma or paraganglioma who require systemic anticancer therapy
  - First FDA-approved drug for these specific conditions
  - Azedra is absorbed in cancer cells and radioactive decay causes cell death
- Other treatment are limited
- Annual incidence of pheochromocytomas is 50 cases per year in the US  
Annual incidence of paragangliomas is 1,600 cases per year in the US
  - A fraction of these patients may develop to metastatic disease
  - Anticipated to be very rare for UMP

# Galafold (migalastat)

- Galafold is approved for the treatment of Fabry disease in patients with an amenable galactosidase alpha (GLA) gene variant
  - This causes a buildup of globotriaosylceramide (GL-3) in cells, causing inflammation, fibrosis, and cell death
- Galafold stabilizes and enhances the activity of defective alpha-galactosidase A (alpha-Gal A) proteins
  - The only other drug approved for Fabry disease is Fabrazyme (agalsidase beta injection), an enzyme replacement therapy of alpha-Gal A
- There are about 3,000 patients living with Fabry disease in the US
  - UMP Members have used Fabrazyme in the past, but there have been no requests for Galafold

# Libtayo (cemiplimab-rwic)

- Libtayo is approved for treatment of metastatic or locally advanced cutaneous squamous cell carcinoma (CSCC)
  - First FDA-approved treatment for advanced CSCC
- Current treatment options for advanced CSCC include chemotherapy, cetuximab (Erbix), or pantumumab (Vectibix)
- Although rare, CSCC is the second most common type of skin cancer
  - Approximately 700,000 cases are diagnosed each year in the US
  - Approximately 7,000 people die each year from CSCC
  - Most cases are cured with surgical removal
  - Very few patients have metastatic or locally advanced CSCC, so requests for Libtayo are expected to be low

# Oxervate (cenegermin-bkbj)

- Oxervate is approved for the treatment of neurotrophic keratitis
  - Oxervate is the first medication approved for neurotrophic keratitis
  - Oxervate is the first biologic ophthalmic agent
- Neurotrophic keratitis is a degenerative disease in which nerves leading to the cornea are damaged leading to impaired healing, development of ulcers, and eventually blindness.
- Current treatment options are supportive therapies, such as artificial tears, antibiotics, and other eye care
- Neurotrophic keratitis is rare, with only 65,000 people in the US

# Vitrakvi (larotrectinib)

- Vitrakvi is approved for the treatment of advanced central nervous system (CNS) or solid tumors exhibiting a neurotrophic receptor tyrosine kinase (NTRK) fusion
- Vitrakvi is recommended for patients who have NTRK fusion and who have progressed beyond all standard therapies for their respective cancers
- There are an estimated 2,500 to 3,000 individuals living with cancer with NTRK fusion each year in the US
  - Anticipated to be very rare for UMP

# Gamifant (emapalumab-lzsg)

- Gamifant is approved for treatment of primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease or intolerance with conventional HLH therapy
- Primary HLH is very rare, with less than 100 cases diagnosed each year in the US
  - Challenging to diagnose (and potentially underdiagnosed) due to variable clinical presentation and variability of genes that are associated with this disease
  - Anticipated to be very rare for UMP

# Lumoxiti (moxetumomab pasudotox-tdfk)

- Lumoxiti is approved for treatment of relapsed or refractory hairy cell leukemia (HCL)
  - First FDA-approved drug targeting CD22
  - To be used following two prior systemic therapies
- Treatment options include cladribine or pentostatin as first-line therapies, or rituximab for resistant or relapsed disease
- HCL is rare, with an approximate incidence of 3 cases per 1,000,000 people
  - Anticipated to be very rare for UMP

# Firdapse (amifampridine)

- Firdapse is approved for treatment of Lambert-Eaton myasthenic syndrome (LEMS), a progressive degenerative neuromuscular disease
- LEMS is a rare autoimmune neuromuscular disorder characterized by muscle weakness due to reduced acetylcholine (ACh) release
- Approximately 1,000 patients each year in the US are diagnosed with LEMS
  - Anticipated to be 1 patient in UMP with LEMS

# Elzonris (tagraxofusp-erzs)

- Elzonris is approved for treatment of blastic plasmacytoid dendritic cell neoplasms (BPDCN)
  - BPDCN is a rare, aggressive cancer characterized by skin lesions
- Other treatment options are chemotherapy regimens for acute lymphoblastic leukemia (ALL) or lymphoblastic lymphoma (LBL).
- Estimates of incidence and prevalence are challenging, due to changing nomenclature and lack of a precise clinical definition prior to 2008
  - 2018 paper suggests about 4 cases per 10,000,000 diagnosed each year in the US
  - Rates appear to be higher in males age 60 and older
  - Anticipated to be very rare for UMP

# Cablivi (caplacizumab-yhdp)

- Cablivi is approved for treatment of acquired thrombotic thrombocytopenic purpura (aTTP)
- aTTP manifests as blood clots in small blood vessels, blocking blood flow to brain, heart, kidneys, and leading to internal bleeding, low platelet count, and hemolytic anemia
  - Each episode is considered a medical emergency
- aTTP is considered to be extremely rare, with about 3 cases per 1,000,000 adults and 1 case per 10,000,000 children.
  - Anticipated to be very rare for UMP

## UMP Budget Impact

- The anticipated combined budget impact of these 11 new drugs for UMP is approximately \$800,000 per year
  - Some drugs could cost upward of \$300,000 per treatment-episode or \$600,000 per year
  - Estimated UMP budget impact is based off plan size and estimated per-member-per-month estimates from third-party analyses
- Last PEB Board meeting, anticipated impact of 8 new drugs was \$877,000 per year
- Total of 19 new drugs reviewed in 2019 is anticipated to be \$1.68 million

## Recent Generic Entries

- Authorized generics (AG) are approved brand name drugs that are marketed as a generic drug
  - Often are sold with lower prices than brand products
- **Hepatitis C:** Harvoni AG and Epclusa AG (Jan 2019)
- **Asthma Rescue Inhalers:** ProAir AG and Ventolin AG (Jan 2019)
- **Asthma/COPD:** generic Advair Diskus and Advair Diskus AG (Feb 2019)

# Questions?

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**TAB 7**



Washington State  
Health Care Authority

Smart [heart] Health

Marcia Peterson, Manager  
Benefits, Strategy, and Design  
Employees and Retirees Benefits Division  
March 20, 2019



# Objectives

1. Provide 2019 SmartHealth updates
2. Describe SmartHealth participation
3. Introduce a resolution regarding the SmartHealth incentive deadline

# 2019 SmartHealth Portal

**FEATURED ACTIVITY**

## Take Your Well-Being With You

Download the Limeade App and track your well-being goals anywhere, anytime.

VIEW ACTIVITY >

JAN 2, 2019 - DEC 28, 2019 212 3,557 100 pts

SmartHealth [Learn more](#)  
Supporting you on your journey toward living well.

### My Plan



Steps Challenge: Track



Share Your Happy Place



Track Your Spending Habits

CURRENT HISTORY

2 Level 2  
**Keep Going**

- Earn 2,000 points and complete your WBA
- PEBB subscribers will qualify for the \$125 Wellness Incentive

Complete this level by Sep 30, 2019 to earn this level's reward.

Reach 2,000 pts

# 2019 SmartHealth Updates

## Marquee events

- **SmartHealth WBA Week:** February 25-March 3, 2019
- **SmartHealth Week:** June 3-9, 2019
- **Governor Walks for SmartHealth:** July 2019
- **Leader Walks for SmartHealth:** August-September 2019

## PEBB Program Incentive deadlines:

- \$25 Amazon.com gift card = December 31, 2019 (all eligible)
- \$125 wellness incentive = September 30, 2019 (for most eligible)

# 2019 SmartHealth Levels

## Level 1

Complete WBA worth  
800 total points

**\$25 Amazon.com gift  
card** (earn and claim by  
12/31/2019)

## Level 2

Complete level one  
and 2,000 total points

**\$125 wellness incentive**  
applied to next year's  
medical deductible or  
CDHP/HSA (earn by end  
of incentive period)

## Level 3

Complete levels one  
and two and 4,000  
total points

**Wellness champion badge**

# 2019 Incentive Flyer



Smart  Health

Have fun. Earn rewards.  
**BE YOUR BEST!**



**\$125**  
Wellness  
Incentive

+



**\$25**  
Amazon.com  
gift card

Learn more at [www.hca.wa.gov/pebb-smarthealth](http://www.hca.wa.gov/pebb-smarthealth)

# SmartHealth Participation

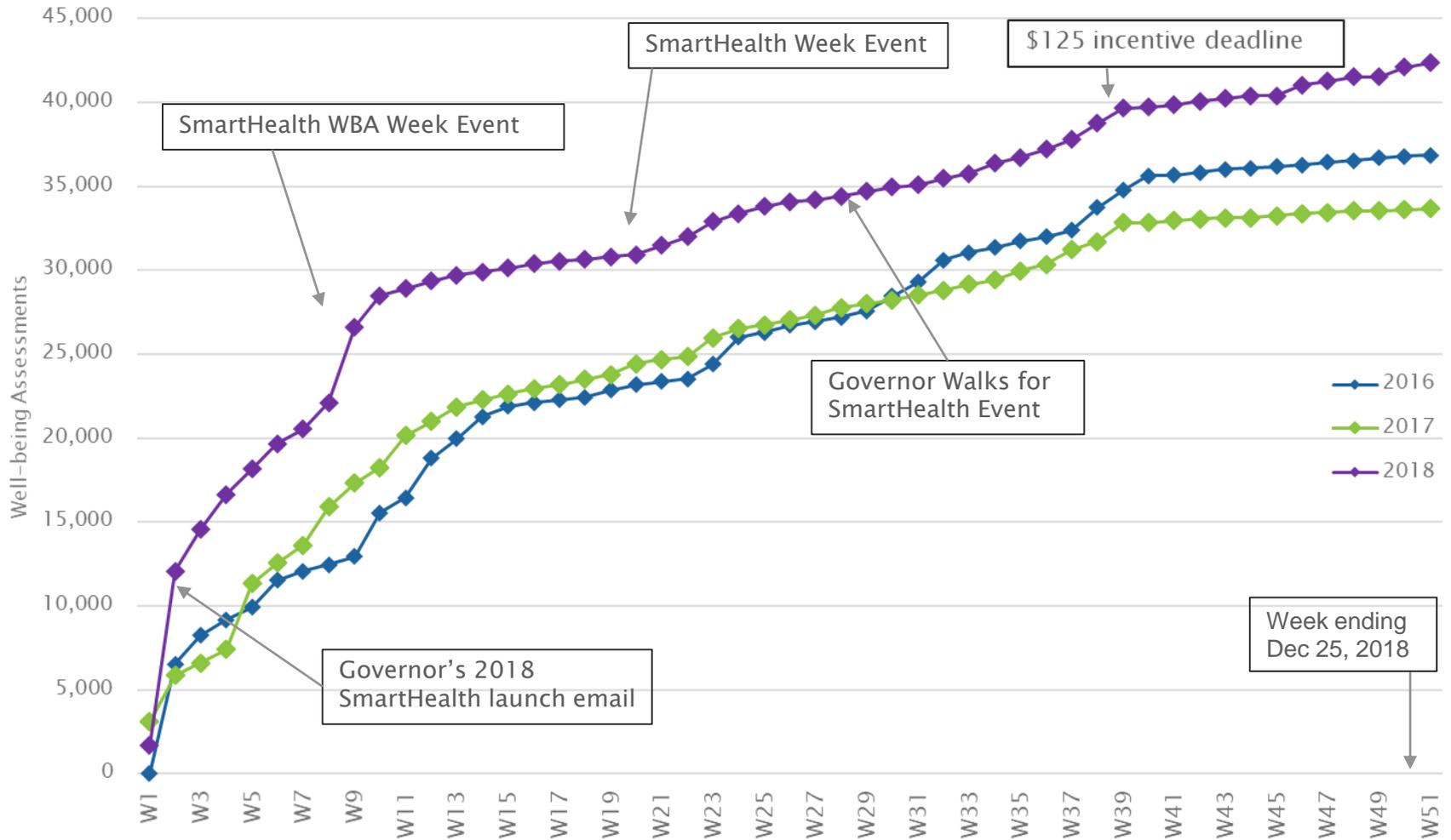
# New SmartHealth Registrations

As of December 31, 2018

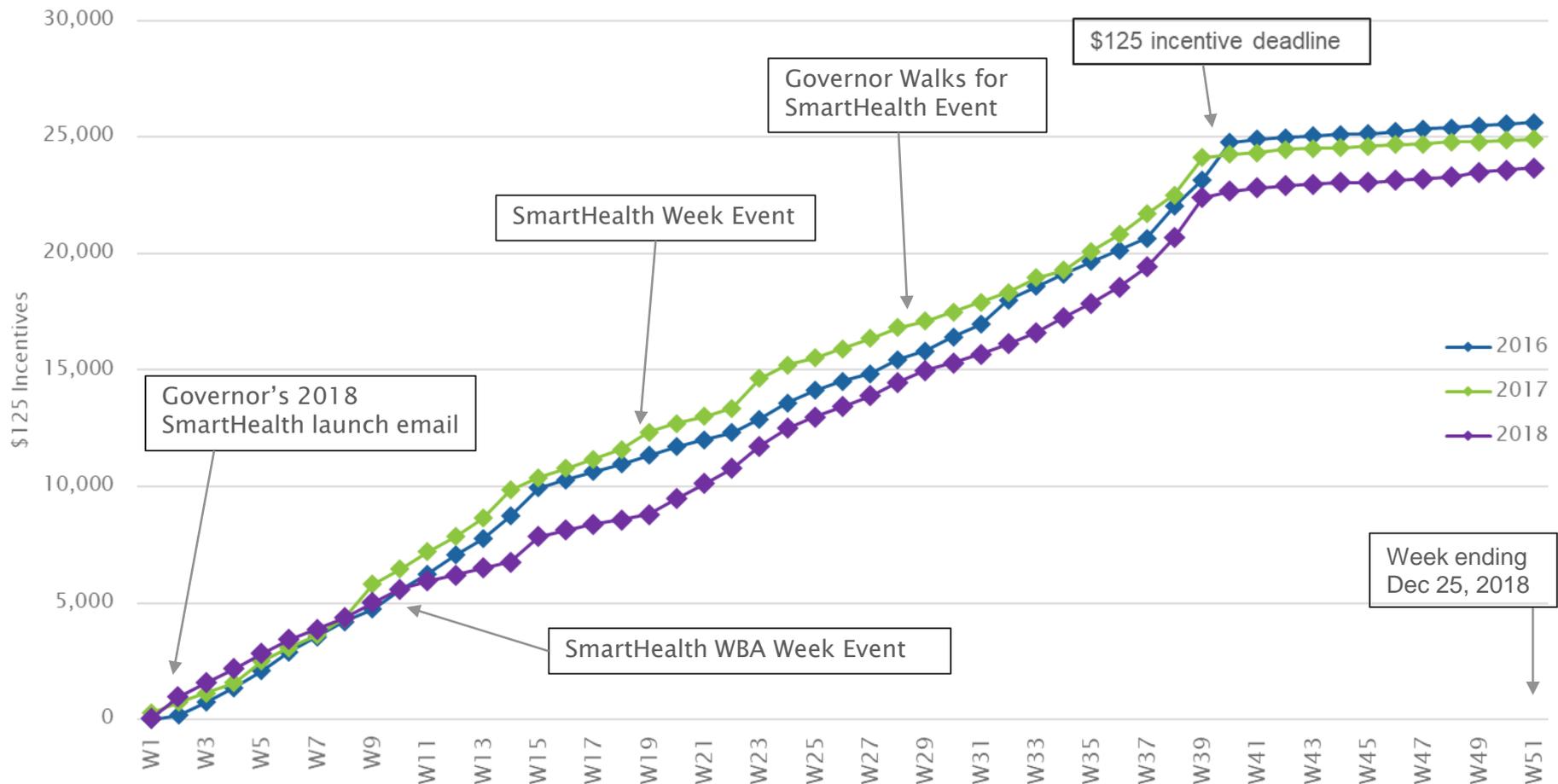
- 2017 new registrations totaled **6,746** for the entire year
- 2018 new registrations totaled **12,082** through Dec. 31, 2018
  - 2018 SmartHealth level breakdown (12,082):
    - No Level: 1,069
    - Level 1: 7,000
    - Level 2: 2,990
    - Level 3: 1,023
- Total current SmartHealth registrations 2015-2018: **67,137**
- Total SmartHealth registrations ever: **81,453\***

\*Includes employees who have left PEBB benefits

# Well-being Assessment Completions: 2016, 2017, and 2018



# \$125 Incentive Qualifications: 2016, 2017, and 2018

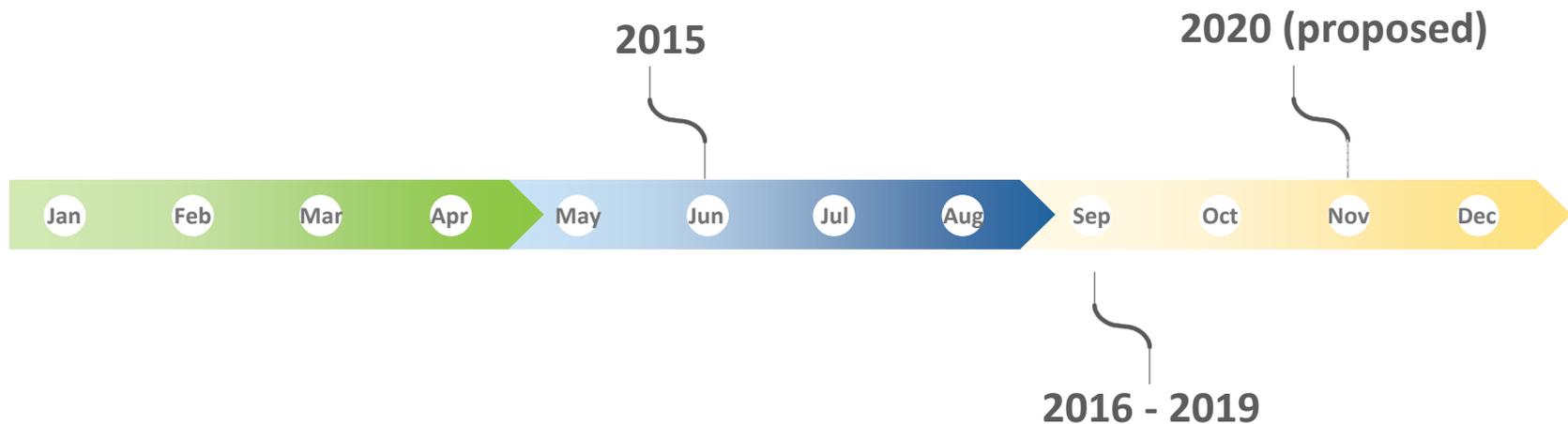


# SmartHealth Cohort Analysis

- Includes SmartHealth users who completed the Well-being Assessment in 2015, 2016, 2017, and through June 2018
- Compares aggregate self-reported scores on the Well-being Assessment year over year
- SmartHealth users who originally rated themselves “at-risk” (scoring 3.5 or lower on the 5-point scale) increased their scores across all 34 SmartHealth dimensions across well-being, productivity, and health

# Proposed SmartHealth Resolution

# SmartHealth Incentive Deadline



# Proposed Policy Resolution PEBB 2019-02

## Deadline for completing wellness activities

Effective January 1, 2020, to receive a Public Employees Benefits Board (PEBB) Wellness Incentive in the following plan year, eligible subscribers must complete PEBB Wellness Incentive Program requirements by the following deadline:

- For subscribers enrolling in PEBB medical with an effective date in January through September, the deadline is November 30.
- For subscribers enrolling in PEBB medical with an effective date in October through December, the deadline is December 31.

# Questions?

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Employees and Retirees Benefits Division

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