Public Employees Benefits Board
Meeting Minutes

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

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

PEB Board Counsel:
Katy Hatfield, Assistant Attorney General

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

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

Approval of July 2017 PEB Board Meeting Minutes
Greg Devereux: On one of these three sets of minutes, I have a question. I can't find it at the moment, so I'm fine in approving them if I can't find it before we approve them but I'd love to be able to ask the question at some point. I can always call Dave.

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

Approval of July 19, 2017 PEB Board Meeting Minutes

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

Approval of July 27, 2017 PEB Board Meeting Minutes

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

Legislative Update

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2018 Open Enrollment Update

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

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

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

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

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

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

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

Harry Bossi: Yes, I understand.

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

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

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

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

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

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

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

Renee Bourbeau: We had nine.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Renee Bourbeau: Yes.

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

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

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

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

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

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

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

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

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

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

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

Dave Iseminger: No.

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

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

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

Renee Bourbeau: That's correct.

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

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

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

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

Sue Birch: Absolutely.

Renee Bourbeau: Yes.

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

NW Prescription Drug Consortium

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

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

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

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

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

Greg Devereux: Thank you.

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

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

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

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

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

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

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

Sue Birch: Ray, can I clarify? Is it $800 million worth of drugs or $800,000? The document says $800 million.
Ray Hanley: It’s $800 million. It's a million people and $800 million.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Carol Dotlich: Thank you very much.

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

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

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

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

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

Slide 13 – Savings: Savings is critical to any group. The question is why would you choose us? The answer is because we follow the money and try to ensure financial performance. We have very aggressive price guarantees and discount guarantees. We do that by utilizing the services of the Burchfield auditing firm, a very Cadillac auditing firm. They work for Centers for Medicare and Medicaid Services (CMS) and large employers. Once a year they bring in all of our data, look at our claims and benefits, and give us a market assessment. We have about half a million or so lives in a group benefit program, of which UMP is a part. I want compared to employers that have roughly half a million people on the West Coast and I want those bids to be current. The contract stipulates that we do not pay for our market assessment, which is done by an independent third party, but we do have control over it. It's something that Moda had to accept. If our contract is a point and a half off the market assessment, we automatically go into negotiations, and that did happen last year.
We have a fixed administrative fee so we know exactly how much Moda Health and their subcontractors are making. They pay an administrative cost per claim which is currently $2.95. I'm 20,000 lives away from bringing it down to $2.58 per claim because we built incentives into the contract. The administrative cost per claim idea is complicated but the pharmacy business is largely opaque, it's not as transparent. We are very transparent, so much so that we get 100% of your

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

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

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

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

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

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

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

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

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

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

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

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

Tim Barclay: It does. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

Dave Iseminger: The prescription drug card program?

Greg Devereux: Yes

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

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

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

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

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

Ray Hanley: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Report on Benefits Ideas

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

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

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

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

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

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

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

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

Marty Thies: That's correct.

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

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

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

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

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

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

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

PEBB Dental Plan Comparison

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

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

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

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

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

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

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

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

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

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

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

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

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

Public Comment

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

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

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

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

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

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

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

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

Barb Scott: That is true.

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

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

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

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

Irene Svete: July 6.

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

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

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

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

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

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

Dave Iseminger: Correct.

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

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

Tim Barclay: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Greg Devereux: Thank you very much.

Preview of Next Meeting's Topics

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

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

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

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

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

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

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

Carol Dotlich: Yes, I am.

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

Lou McDermott, meeting adjourned**.**

Meeting adjourned at 4:15 p.m.