

Public Employees Benefits Board
Meeting Minutes

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

Members Present:

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

Members on the Phone:

Myra Johnson

PEB Board Counsel:

Katy Hatfield

Call to Order

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

Agenda Overview

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

Follow-Up Responses to March 21, 2018 Meeting Questions

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

Greg Devereux: Do we have that written here?

Dave Iseminger: No.

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

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

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

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

ChampVA Follow-Up

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

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

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

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

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

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

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

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

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

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

retirement, or for Plan 3 employees upon separation as long as they enroll in the coverage at that point.

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

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

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

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

that if somebody was dually eligible for Medicaid and Medicare, they would be auto enrolled in a Part D plan at the federal level.

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

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

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

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

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

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

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

Harry Bossi: Barb, for clarification, let's use employer-based group, can someone defer a second time, a third time, or a fourth time? Or is it one time? If somebody retires, goes to work for Boeing and opts out because they have great coverage there but that situation changes, so they opt in to the retiree, but then they get a job offer to go back to work, can they defer back out?

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

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

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

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

Greg Devereux: So that's one time?

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

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

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

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

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

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

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

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

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

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

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

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

Barb Scott: It is complicated.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Tim Barclay: Understood.

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

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

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

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

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

Barb Scott: I like to be technically accurate.

Sue Birch: Thanks for that distinction.

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

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

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

Greg Devereux: Thank you.

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

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

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

SEBB Procurement Update

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PEBB Procurement Update

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

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

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

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

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

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

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

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

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

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

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

Centers of Excellence Program Update

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Slide 11 shows some of the comments we received.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Marty Thies: Total spend for all joint replacements?

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

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

Centers of Excellence Program – Spinal Fusion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SmartHealth

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Slide 14 is a list of 2018 SmartHealth Events.

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

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

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

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

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

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

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

UMP Value Formulary Options

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

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

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

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

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

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

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

Sue Birch: Several millions?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Donna Sullivan: That is correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Public Comment

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

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

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

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

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

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

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

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

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

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

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

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

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

Preview of May 21, 2018 PEB Board Meeting

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

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

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