

Public Employees Benefits Board
Meeting Minutes

June 20, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 4:00 p.m.

Members Present:

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

Members Absent:

Harry Bossi

PEB Board Counsel:

Katy Hatfield

Call to Order

Sue Birch, Chair, called the meeting to order at 1:32 p.m. Sufficient members were present to allow a quorum. Audience and board self-introductions followed.

Meeting Overview

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

UMP Value Formulary Follow-up and Policy Resolution

Ryan Pistori, Assistant Chief Pharmacy Officer, Health Care Authority. I will respond to questions from the June 7 meeting and then ask you to take action on the policy resolution before you today.

Slide 2 – Questions. The first question was on the current structure of the UMP formulary. I have listed the five tiers for the UMP formulary. There is Preventive Tier, Value Tier, Tier 1, Tier 2, and Tier 3. The Preventive Tier are drugs required under the Affordable Care Act, or recommended by the United States Preventive Services Task Force (USPSTF). The Value Tier are the specific high-value medications to certain chronic conditions, like hypertension, cholesterol, diabetes, depression. Tier 1 are primarily the low-cost generic drugs. Tier 2 are the preferred brand name drugs, as well as any high-cost generics. We do have some staggering of the generics between Tier 1

and Tier 2. Like the generics where we have the staggering, the same applies for the brands where the preferred brands are in Tier 2 and then any non-preferred drugs, primarily the non-preferred brands are in Tier 3.

Dave Iseminger: We wanted to make sure we brought what the current formulary is because there were some questions about the use of the phrase "Value Tier". The Value Tier Ryan just described was put in place by Board action in 2012. That unfortunately has the same word "value" in it, but that's not to be confused with the value-based formulary principles we've been presenting to the Board.

Ryan Pistorosi: Slide 3 - What would happen to some of the drug classes? How would they be impacted? We brought two different drug classes today that we previously proposed as part of the value formulary, which are the androgens and the insulins. Slide 4 is a table showing the current structure of the androgen drug class. You'll notice we have a few different drugs listed. Most of the different drugs are listed under the testosterone. Across the columns are the different tiers. This slide shows how the drugs are placed within the androgen drug class. With the value formulary, we would be affecting the drugs that are currently in Tier 3 and requiring members to use Tier 1 or Tier 2 alternatives prior to allowing the Tier 3 drugs to be covered.

Dave Iseminger: Ryan, to be clear, that would be new diagnoses being treated.

Ryan Pistorosi: Correct. You'll see a little later we do have the edited clause in the policy resolution that will grandfather members on the current cost-share based on suggestions from the June 7 Board Meeting. Newly diagnosed members would be directed to the Tier 1 and Tier 2 alternatives prior to Tier 3.

Dave Iseminger: Ryan, let's plain talk this. If you are currently taking a Tier 3 testosterone drug listed, and if the Board passes this resolution, what would happen to you?

Ryan Pistorosi: I would continue to take it at the current cost-share.

Greg Devereux: If a generic came on the market, do you get switched to that?

Ryan Pistorosi: Yes. The policy resolution states that when a drug becomes a multi-source brand, members switch to the generic alternative. It's the same drug, same strength, same dose, same route and it's approved by the FDA to be interchangeable. At the pharmacy, it's the same drug. State law requires that there is generic substitution for drugs.

Dave Iseminger: Ryan, will you clarify for the Board, if they don't take action today, my understanding is what you just said applies in today's current formulary. Regardless of their action today, it is exactly what would happen. If you were on the testosterone drug that went generic and there was a generic version with the same exact mechanism, the same exact strength, you would be switched to generic. That's already the current policy of how the UMP formulary works.

Ryan Pistorosi: Correct. Drugs that go from single-source to multi-source are automatically moved to Tier 3. In this, the drugs are already Tier 3 so they would stay Tier 3.

Dave Iseminger: Another example: I go to my doctor in February 2019, the Board has passed the resolution, and I have a need for one of these testosterone drugs. My doctor wants me to have AndroGel. What would happen?

Ryan Pistorosi: In that example, you are a member newly diagnosed and being treated. At the pharmacy they would say, "This medication is not covered but there are alternatives for you to use first." The Tier 1 drugs are injectable testosterone and Tier 2 has a few different topical testosterone. You would be directed to these different testosterone products.

Dave Iseminger: If I go through those and they don't work for me, then my doctor can request AndroGel?

Ryan Pistorosi: Yes. If you try the lower-cost alternatives and you don't get the right therapeutic effect or you have adverse events related to them, your doctor can submit a request saying, "My patient has tried these and is requesting this non-preferred product." You would be granted an approval after a review.

Dave Iseminger: The only reason what you just described applies to me is because I'm a new diagnosis. I would have been grandfathered if I already had been taking a Tier 3 drug.

Ryan Pistorosi: Correct. We don't want to interrupt members who are currently stable on their drugs.

Sue Birch: Can you clarify the copays in this scenario?

Ryan Pistorosi: As a member that was currently using the drug, I was paying Tier 3 or 50%. After January 1, 2019, I would continue to pay 50%. I could still qualify for a Tier 3 exception. I could go through the process and try to qualify for a Tier 2 copay in that example. For Dave's example, he would be directed to either the Tier 1 or Tier 2 drugs first, which would be about \$25 per month copay, or for the Tier 2 drugs, \$75 per month copay.

Tom MacRobert: Using Dave's example, he was just diagnosed. His doctor says that he should take AndroGel. Does he have to test all five of drugs before getting AndroGel?

Ryan Pistorosi: In this example, it may depend on Dave's situation. In Tier 2, we have the gel and the gel pump. They are the same drug. If Dave tries the gel, we wouldn't force him to take the gel pump. If he had a reaction or it wasn't working for him, he may not necessarily need to try the gel pump. He would need to try the topical solution because it may work differently. There may be something in the gel that reacts with his skin. It doesn't necessarily mean the testosterone's not working for him. We would direct him to the topical solution as another alternative for a transdermal testosterone product.

Sue Birch: I want to clarify. Being a nurse, I believe the physician would be working with those routes of the medication anyhow. It's not, in this particular case, because one being topical and the gel pump being a different -- or is that topical too?

Ryan Pistorresi: Both of those products are topical. The gel and the topical solution are both placed on the skin. The pump is like a moisturizer pump.

Slide 5 has a different drug class. The insulin drug class has different types of insulins. There are short acting insulins, when administered, provide insulin that works immediately. There is also intermediate insulin, when administered, has a longer duration of action. There are long-acting insulins, typically administered once a day and mimic a basal insulin, that baseline insulin you have running throughout your body throughout a normal day.

Within this drug class, there are many different products spread between the Value Tier, Tier 2, and Tier 3. In this example, Tier 3 products are considered long-acting insulins. The long-acting insulin in the Value Tier is Basaglar. In the case of the value formulary, the only insulins impacted are the long-acting insulins. Members taking short-acting insulins, intermediate insulins, and mixed insulins, which are a mix between intermediate and short, would not see a change. Members currently using Tier 3 long-acting insulins would not see a change. Those impacted are newly diagnosed members that need to be on a long-acting insulin. In this example, there is a Value Tier option available to them, which is Basaglar. There are a few other insulin glargines, but in case it's not effective, or there are adverse events - injection site reactions or other issues - they would be able to step to Tier 3 products.

Greg Devereux: How many total drug classes are there? A dozen?

Ryan Pistorresi: At the last meeting, we showed eight drug classes from the twelve presented.

Greg Devereux: So is that a dozen or eight? My question is how many drug classes and how many total drugs within those classes?

Ryan Pistorresi: We are proposing eight drug classes now.

Greg Devereux: In Tier 3?

Ryan Pistorresi: In all of Tier 3, I believe there are 350 drugs.

Carol Dotlich: When you say there are 350 drugs, is that the number of drugs impacted by this proposal?

Ryan Pistorresi: No. That is what I believe are the number of Tier 3 drugs in the UMP value formulary. I would need to get back to you on that number.

Dave Iseminger: Ryan, for clarity, are you saying there are 350 drugs total in Tier 3 across all drug classes? Is that your estimate?

Ryan Pistorosi: That is my estimate but I would need to get back to you to confirm. There is a number from the model that lists Tier 3 drugs as 350. I don't know if that's the drug classes we were looking at or across all drug classes because we were not evaluating all drug classes in the last iteration of the value formulary model.

Carol Dotlich: Can you give us an assessment of how many drugs would be impacted by this current proposal?

Dave Iseminger: Perhaps we take all the questions and have Ryan check the formulary as we move on to another presentation and come back with accurate answers for your decision today.

Greg Devereux: To follow-up on Carol's question, what I was asking earlier, are we trying to avoid people using Tier 3? How many? I think it's the same question -- how many are in that category of the classes that we're going to impact -- so 350 sounded like everything in Tier 3.

Dave Iseminger: Ryan's going to confirm: a) if 350 is the right number, b) if it's the entirety of the Tier 3 formulary, or c) if that's just the subset for the eight drug classes; and if it's not the subset for the eight drug classes, the number of drugs related to the subset of eight.

Tom MacRobert: So that 350, I thought you said 353, actually, not 350. Did I hear that wrong? Anyway, are the drugs in that category for the eight ones that we're looking at, not any of the four that we're not looking at? So that 350 represents the eight classes that we're considering?

Ryan Pistorosi: I'll check. I will be able to confirm that later in this meeting.

Carol Dotlich: For clarity's sake, the 47,000 people already on Tier 3 drugs would experience no impact from this proposal. Is that correct?

Ryan Pistorosi: Yes. The 47,000 people currently using Tier 3 drugs would not see a change with the value formulary because they would continue to receive the medications they've been prescribed at the same cost-share.

Dave Iseminger: To dovetail onto that, there is that piece, when a drug goes from single-source to multi-source and members moved to a generic. That's happening already under the current formulary and isn't something that would change on the policy proposal that's before you. I just do want to be clear, Carol, that if one of the drugs that those 47,000 members are taking, there is suddenly a generic that comes out, those people would experience a change. They would experience that today regardless of what the Board does on the resolution today.

Sue Birch: And that's because we're a generic-mandated state. When something goes generic, we are already mandated to move them into that provision of generic drugs.

Dave Iseminger: Ryan's going to go confirm numbers and we'll keep going through the presentation. Slide 6 you have seen many times. It's a quick overview of the general

principles the agency used and discussed with the Board as the basis for bringing forward a value formulary design for the Board's consideration.

Slides 7 and 8 have a refined version of the resolution we've been working on with the Board. Slide 7 doesn't have changes so I'll focus on Slide 8 where there were modifications to both bullets based on the discussion the Board had on June 7. If we focus on the third bullet - members who have been taking a non-preferred drug will be grandfathered at the Tier 3 cost-share unless they receive, or have already received, a cost-share exception. The refinement is based on concerns Board Members had about grandfathering being a permanent state. That last clause ensures individuals who have already gone through the Tier 3 exception process and paying a Tier 2 cost-share are not inadvertently moved back to their Tier 3 copayment rate. This modification essentially leaves individuals in a grandfathered status who are already taking a Tier 3 drug, those 47,000 members that Carol was referring to a few minutes ago.

The fourth bullet is reinforcing the policy that already exists when a drug goes from a single-source brand to a multi-source brand where individuals move to the generic alternative. We want to be clear and transparent about how those 47,000 members, if something goes generic, they transition to the generic at that point. Both provisions have had slight modifications to account for that. This makes it a prospective application policy for individuals newly diagnosed, directing them to preferred drugs at that point.

Carol Dotlich: Is bullet 4 already in place?

Dave Iseminger: Yes. That concept already exists within the UMP formulary. We actually struggled with whether we should reinforce it and leave it on the page, but we thought it was important for the context of the discussion to be very clear that if an individual is already on a Tier 3 drug, any time a generic comes out, they move to the generic setting.

Tim Barclay: Can we add language on the first bullet on Slide 7? Correct me if I'm misunderstanding something, but I believe this is the definition of what someone needs to do to qualify for a Tier 2 cost-share instead of Tier 3. Can we make a point here of when a person has met this criteria and eligible for the Tier 3 drug, they would pay the Tier 2 cost-share? There's some value to the member for having followed this process of trying the non-Tier 3 drugs before moving to that point. Can we make that point in this resolution that it actually has a positive impact on the member from a cost-share perspective?

Sue Birch: Tim, so could you clarify for me? You're suggesting we insert a second bullet point or a third?

Tim Barclay: No, I think this bullet point just needs enhanced.

Sue Birch: Please read what you're proposing.

Dave Iseminger: We're creating a record now that stands the ravages of time. If the Board is clear, I understand the point that you're making, and it provides that additional context to individuals who are reading the slide, so to speak. If the Board understands

the intent of it and that is really the underlying inference of the impact to the member who might go back and read this, I would suggest that you could also develop that understanding in the record, as well as an alternative to modifying the words on the page.

Tim Barclay: And that's fine. I think it is important, though, that when we communicate this, at some point, the communications team is going to have to present this to members.

Dave Iseminger: We have three communication team members in the audience taking diligent notes.

Tim Barclay: To them I would say please make sure we emphasize the point that there is a cost-share value to members for having followed this process. Then that's good enough. Thank you.

Yvonne Tate: I see that as more of a procedural issue than a policy issue. I agree. If you do it, you suggest, that'd be fine.

Carol Dotlich: I would like to state for the record that it's always better for the consumer, the member to know exactly what the resolution says. I think it's important to have that language and I don't think it's very troublesome to just put a sentence in place. I would like to see that change.

Sue Birch: I would like to hear the specific language change you're both suggesting because if we were going to put it anywhere, to me, it would be in the beginning portion. But I believe that it's already inherent in this notion of moving forward with value-based formulary. For example, Tim, are you suggesting, in the opening preamble, Resolved that, beginning January 1, all UMP plans require the use of value-based formulary so as to increase member's value orientation? Are you suggesting we put it there? Or how exactly are the two of you suggesting it be reworded?

Tim Barclay: It almost needs to be a subordinated comment underneath the first bullet that says, "After following this procedure, the member would pay the Tier 2 cost-share instead of the" -- that's not the right language but, "instead of the Tier 3. Grandfathered members taking that drug will continue to pay the Tier 3 cost-share. People who follow this process and end up in the Tier 3 drug will pay the Tier 2 cost-share." And the reason I think it's important is because as we've talked before, we're not really clear about this exception process in our communications to members now. It's not clear on the website that this exception process exists. I fear this is going to be perceived as a take-away and it's not, right? It's a procedure. We're not impacting existing members. People who follow this process actually get an advantage at the end of the day. I'd like to make it clear so we're not sending an incorrect message that somehow this is a big restriction, a big take-away of benefits.

Sue Birch: I hear the intent of what we're proposing. I'm just struggling with how you want to word it and I'm trying to see a third bullet point, if there's a way we could modify that.

Yvonne Tate: Again, I think these are procedural issues more than policy. Generally speaking, your policy statement is very broad based and your details around that policy are included in procedures and communication documents. I'm just afraid we're crossing the line between procedure and policy. That's my two cents.

Myra Johnson: Would something like a footnote at the very bottom of it, saying something about grandfathering? I'm not sure about language, but something about Tier 2 or Tier 3 or even grandfathering maybe, just a small footnote so it's not a loss for members. Would something like that work, Tim? I don't know. Instead of placing it actually in a bullet, maybe a footnote at the end of all the bullets?

Tim Barclay: It would work for me.

Myra Johnson: Would that still make it more of a policy, because it would be more like informing?

Yvonne Tate: Well, the agency puts together a whole packet of open enrollment information for employees that clarify not only this proposed policy but other policies by which the agency operates under. I just think it's more procedural and fits better in any open enrollment communication you're going to give the staff.

Dave Iseminger: I would say we've received quite a lot of suggestions about how we can beef up the description of the exception process and our communications teams will be working on that as well. I want to reassure the Board that is also in the works. We've had quite a lot of feedback about ways to improve that communication and that's in our pipeline as well.

Sue Birch: I see heads and staff members over here, I think, wanting to help assure the Board about the member orientation process. Is there something staff want to add to clarify that this is taken care of in the procedures?

Barbara Scott, Policy, Rules, and Compliance Section Manager, ERB Division. I think what Renee Bourbeau's staff are saying is that as we roll these things out into open enrollment communications, there is a good amount of plain talking done to help this type of detail make sense to members. They are in the back thinking how best to write this which will look plain talked from what the resolution will look like today. In some instances, we pick your resolutions up and drop them in, especially when it comes to rule. But when it comes to our communications, Renee's team is very used to plain talking things so it makes sense to the members.

Scott Palafox, Deputy Director, ERB Division. The other piece I want to add to hone in on Tim's and Carol's concern, as well as add strength to what Yvonne is saying, is that when we communicate this type of information in our newsletters and open enrollment material, and often plain talk it, we also use those communications as a means of substantiating the policy side of it. If anybody has a question of whether or not that was in or out, they can refer back to that newsletter or communications that holds value to not having it in a policy. But at the same time, making sure we shed light on it.

Tim Barclay: Scott, could you talk about the timing of the release of that information relative to the public availability to this Board resolution? How much of a gap in time is there between the two?

Scott Palafox: By the time decisions are made in July, we start to formulate the communications for open enrollment. We'll have a September newsletter and, in October, information goes out to all members explaining the changes made as a result of the decisions approved by the Board.

Dave Iseminger: Tim, those are direct member communications that occur for open enrollment. But we've been working very hard this past year as your sister Board takes actions, of having news releases on the website that plain talk versions within a couple days. This is really the first action the PEBB Board will take this year so I can imagine as we develop a newsfeed within the next two to three business days, we would have a preliminary plain talk version that goes along with it rather than leaving just the resolution out there. Now, anyone in the public could see this resolution and the words, which is where I think your concern is coming from with the delay from member communications that hit people's mailboxes in October versus an action taken today. We do work on plain talking our language and talking about actions the Boards are taking in part of our newsfeed. I can see a more direct upfront plain talking that comes out in the next couple of business days, to give context to the Board's action today.

Sue Birch: Dave, has staff or you received any concern to this point of confusion? Has anything come in as we've posted publically and people know that we're working on the construct of the value-based formulary? We receive input at Board Meetings, but has anything further come in to your knowledge?

Dave Iseminger: None that I'm aware of.

Carol Dotlich: I've received responses to the survey that we did. Are you interested in hearing those or not?

Sue Birch: I think it would be important to share that.

Carol Dotlich: Okay. We put the original proposal out to the membership and asked for feedback. I have a couple of examples of what I'm hearing back. "I'm unable to travel to Olympia for the hearing on this proposed change to our medical benefits. As a retiree with health problems, I'm concerned about what this proposal will do. It looks like it puts a decision on our medication in the hands of the insurance company instead of my doctor. It's my opinion that my doctor knows more about my needs than an unknown medical insurance provider. 'Medically necessary and clinically appropriate' puts an unreasonable burden on the physician to justify every medical drug decision they make on my behalf. Many generic drugs have caused undue stomach and bowel disruptions that required a change to either brand name drug or in some cases, no drug at all. My doctor is already too busy to see me without a month or two month wait for any appointment. The required documentation that these changes require will make further demands on his time that will prevent timely appointments. I hope this makes my position clear." It's signed by the retiree.

Dave Iseminger: Carol, the way the Board's conversation went on June 7 and how this resolution changed I would think addresses many of the concerns. This individual would not have to go to their doctor to maintain the current drug they're under. They could continue on their Tier 3 drug. The resolution as it's written now is prospective only and affects me when I get my new testosterone diagnosis and asking me to try the earlier tiers before the Tier 3 drugs. Hopefully, there are assurances to the concerns raised in that particular --

Carol Dotlich: I'd like to read a second one, if I might.

Sue Birch: Go ahead and proceed. I do think it's important to understand the timing. I'm unclear of the timing of when this survey went out, but go ahead.

Carol Dotlich: "I have a major concern with the new proposal in the email that was sent out yesterday." This one came in June 19, to give you sense of date. "At one point, somebody at a desk in the insurance office decided that there was another similar medication that I should use instead of the one my doctor prescribed. Insurance would not pay for my medication, which already had a very high copay unless I followed their mandate to try something else. I became very ill and still had to argue with them to go back to what my doctor and I knew was working for me. It scares me that someone who's never met me has so much power over deciding what medication I'm allowed to take. That decision should be between me and my doctor. Currently, I'm trying a new drug that is beginning to show results and I'm fearful that someone in an office will decide it's not medically necessary. What works for one person may not work for someone else. Medicine is both art and science. And treating patients as numbers in a formula is damaging and degrading. I pay nearly \$700 a month out of my own pocket for medical and I expect to get my care based on what my doctor feels is best for me, not what a bureaucratic desk thinks is medically necessary for the average person. Please do whatever you can to protect those of us who have medical issues that are not average and need medications that may not be the same as everybody else."

I just want to reiterate, on behalf of the retired people I'm here to represent, 60% or so are already using the generic medications available in place of the preferred drugs. That's over half. I think that tells you pretty well that people are trying to save money where they can on their medications. I understand the problems we're facing with the pharmaceutical companies and the costs. I just wanted to share some perspectives of some of the people that have contacted me.

Dave Iseminger: I appreciate that you've gone to the efforts to bring more perspective of the individuals you're representing, the members and those situations. I do want to reiterate the way the policy has changed because of the Board's discussion. The individuals currently taking Tier 3 drugs are not impacted. The only way they're impacted is if something goes generic, which already would happen to them today under the current policy. I understand the sentiments you've raised through the members that are responding. But I want to make sure the Board knows the proposal before them wouldn't result in some of the concerns people reading the slides may think will occur under the policy, which gets back to plain talking and helping members understand the impact of a policy decision today.

Carol Dotlich: I think it's important that the resolution contains plain talking language, which is why I supported Tim's idea about putting the advantage to the member into the resolution itself, because whatever happens, it's a public document. They're not going to read all the notes around it. They're going to read the resolution and understand it as the resolution is written.

Tom MacRobert: The original draft of the resolution and subsequent draft said that people who were taking a Tier 3 drug and had been taking it for more than a year, would be grandfathered. And people who were taking it for less than a year would not. Has that been removed from the resolution and there's no timeframe? If you're taking it now and you've been taking it for a week, you're not going to be affected?

Dave Iseminger: Tom, you've hit the nail on the head as to the functional change of that third bullet. Before, there was a year grandfathering clause and a description of a transition period. This is a permanent grandfathering clause, so to speak.

Sue Birch: Tim, I would again ask for your specific recommendation. Or if you're asking staff to craft in a value statement, that's a different recommendation. I need to know.

Tim Barclay: Let me give you a first draft and we can dismiss it or edit as you see fit. I would propose adding a new second bullet point to the resolution that reads, "Non-grandfathered members that have qualified for Tier 3 drug coverage are eligible for reduced Tier 2 cost-sharing."

Sue Birch: Could you repeat that again?

Tim Barclay: "Non-grandfathered members that have qualified for Tier 3 drug coverage are eligible for reduced Tier 2 cost-sharing."

Sue Birch: Where do you want that placement on the resolution?

Tim Barclay: I would like that to become the second bullet point placed between what is now the first and second bullet points on the resolution as it sits.

Tom MacRobert: Could you read that one more time, please?

Tim Barclay: "Non-grandfathered members that have qualified for Tier 3 drug coverage are eligible for reduced Tier 2 cost-sharing."

Sue Birch: Thank you, Tim, for that clarification. We don't have a motion on the floor or an amendment. We are in discussion, so I would now like to ask staff to take us back through the testosterone example and help show that this language would either clarify, confuse, or how it might impact the examples that have been portrayed.

Ryan Pistorosi: It may help to move back to Slide 4 where we have the names of the drugs. To walk through this example with Tim's amendment, we'll be using Dave. Dave would be the example of the non-grandfathered member. Dave has tried the Tier 1 and the Tier 2 testosterone products and they're not working for him. Dave's provider requests one of the non-covered drugs, the Tier 3 non-preferred drugs. Dave qualifies

because he has tried those products and qualifies. Dave could also request the Tier 3 exception. And the Tier 3 exception requires that the members try the other products and if they don't work for them that then they can qualify for the Tier 2 cost-share. Is that what you intended with your amendment?

Tim Barclay: Yes.

Yvonne Tate: That just sounds so procedural to me. It's not policy.

Sue Birch: Yvonne, thank you for your comment. That was the purpose of asking these gentlemen to go through that process because it's still not very plain speak. I still don't think members are going to get it, but I see what you are trying to do. As Yvonne is pointing out, we're trying to figure out how best to help our members to assure that. It appears staff support this idea if it helps members be clearer. Yvonne, would you be okay with it? It's highlighting this value proposition.

Yvonne Tate: Yes, but if I were highlighting the value proposition, I would be using paragraphs and pages, more than just a sentence in a policy to highlight what the change is and to help people understand that. I just think it requires more interaction, more information than what the policy is typically designed to do. That's just my two cents. This isn't going to clarify it enough that you still won't have to have conversations with people to make it clear.

Sue Birch: So in the interest of time, I think it's important we keep discussing this but also move forward because we need to get public comment.

Dave Iseminger: Ryan is back with data for some of the prior questions.

Ryan Pistorosi: To respond to the questions asked earlier, there are a total of 758 Tier 3 drugs. The 350 that I said earlier is the number of single-source brands on Tier 3. To Carol's question, there would be 143 drugs impacted in the eight drug classes proposed at the last meeting. 71 of those are single-source and 72 are multi-source.

Sue Birch: For the proposed change to the resolution, Yvonne, I know it's somewhat procedural but I think it gives some of our Board Members more comfort and clarity. Would you be opposed to moving forward with Tim's suggestion?

Yvonne Tate: I want to do what's best for the good of the order.

Sue Birch: I would suggest at this point, we move forward with Tim's amended language.

Katy Hatfield: Probably the easiest way to proceed is to have somebody motion to approve it as written and then seconded. Tim can move to amend it. We will vote on the amendment. If the amendment passes, we will vote on it as amended. If the amendment fails, we will vote on it as originally stated.

Sue Birch: Katy, can you advise us at which point it's best to take public comment on all of those iterations?

Katy Hatfield: I would suggest we take public comment before each vote, before a vote on the amendment and then public comment before a vote on the ultimate resolution, regardless of whether or not the amendment passes or fails.

Tom MacRobert: Katy, two votes, correct? First on the proposed change, adding it in, and then second on the whole resolution whether it's amended or not?

Katy Hatfield: Correct.

Sue Birch: Let me restate that. I'm going to read the resolution as staff had originally prepared, ask for a motion to adopt and a second, Tim will come forward with his amendment to the motion, and we will continue to proceed through that process. Correct?

Katy Hatfield: We can take a five-minute recess for staff to type up the amendment so everyone can have it in front of them as they vote on the amendment. Then if it passes, we'll vote on the whole thing with that amendment. If it fails, we'll delete that amendment and vote on the original.

Myra Johnson: Isn't that the opposite of what we said? I'm so confused right now.

Sue Birch: So I think at this point I would like to take a five-minute break so that we can get the commensurate written documentation so people aren't just hearing it but they're reading it.

[recess]

Sue Birch: At this point, I'd like to read the original resolution, and ask for a motion to adopt and a second. Then we'll have discussion, and I imagine Tim will request an amendment. I'll ask for public comment at that point.

Policy Resolution PEBB 2018-01 – Value Formulary.

Resolved that, beginning January 1, 2019, all UMP plans require the use of value-based formulary with:

- a select mix of drugs within a drug class that are covered only when medically necessary and all preferred products have been ineffective or are not clinically appropriate, and
- Multi-source brand drugs being covered only when medically necessary and clinically appropriate, and
- Members who have been taking a non-preferred drug will be grandfathered at the Tier 3 cost-share unless they receive or have already received a cost-share exception, and
- The grandfathering for brand name drugs ends when a generic alternative or an interchangeable biologic becomes available (the drug becomes a multi-source brand and is subject to medical necessity)."

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

Tim Barclay: I move to amend the proposal to add the additional bullet point that non-grandfathered members who have qualified for Tier 3 drug coverage are eligible for reduced Tier 2 cost-sharing.

Myra Johnson: I would like to make an amendment to Tim's amendment. Is it a friendly amendment? Is that procedural? I would like to add the word "automatically" in front of "eligible" so it doesn't imply they would still have to apply for it. It would be an automatic given, which I think is what we're trying to clarify and make clear.

Dave Iseminger: Can I make a parliamentary inquiry, Katy? I believe if the mover and the seconder of the amendment accepted as a friendly amendment, nobody has to vote on the friendly amendment. Is that correct?

Katy Hatfield: That's correct.

Dave Iseminger: Thus, for my parliamentary inquiry, if Carol and Tim agree with Myra's point, then it's automatically incorporated. I think the parliamentary question is, do they agree.

Tim Barclay: I agree.

Carol Dotlich: I agree.

Sue Birch: I'd like to restate the amended resolution for the second bullet point which includes Myra's friendly amendment.

- The non-grandfathered members who have qualified for Tier 3 drug coverage are automatically eligible for reduced Tier 2 cost-sharing.

Is everybody clear?

Yvonne Tate: Just for clarifying purposes, can't you just say they will receive reduced cost to the Tier 2 cost-sharing? Isn't that what you're really trying to say is they'll get it, because even if you say "automatically eligible," it still implies there's another process or something else they have to go through to get that Tier 2 cost-sharing.

Sue Birch: It's my understanding you're looking for an alternative to "eligible." You want "automatically entitled" for reduced Tier 2?

Yvonne Tate: No, just that they will get the reduced Tier 2 cost-sharing. Isn't that what we're really trying to say?

Tim Barclay: This is Tim. I agree. I think if you eliminate the words "are automatically eligible for" and replace it with the word "receive" I think that meets Yvonne's point.

Sue Birch: So let me be clear. It's my understanding that I'm hearing the language would read: "Non-grandfathered members who have qualified for Tier 3 drug coverage receive reduced Tier 2 cost-sharing."

Tom MacRobert: Will receive?

Sue Birch: Will receive.

Dave Iseminger: Point of order for parliamentary purposes. I believe the question now is Yvonne's made another friendly amendment and do Carol and Tim agree with it?

Carol Dotlich: I agree.

Tim Barclay: I agree, also.

Dave Iseminger: I believe the amendment before the Board for discussion and then eventual vote is now adding a bullet: "Non-grandfathered members who have qualified for Tier 3 drug coverage will receive reduced Tier 2 cost-sharing." As the current motion, as friendly amended twice, is before the Board.

Katy Hatfield: Yes, and so the discussion from the Board and from the audience will be only about whether or not we should add this amendment. It's not about the entirety of the rest of the motion. There will be a second chance to vote. Right now, we're only voting on Tim's motion to add this proposed amendment. We should have discussion and public comment on that.

Sue Birch: I would ask for the Board to have any further discussion on just this proposed amendment that is inclusive of both Myra's and Yvonne's improvements. Any further discussion from the Board? I will be asking for comments from the public next if you've exhausted all of your comments.

I would invite public comment specific to this proposed amendment.

Yvonne Tate: Just a point of clarification. On the amendment, not the overall resolution, right?

Sue Birch: Correct, on the amendment. Seeing no further public comments and no further Board discussion, I would call for the vote.

Voting to Approve: 6

Voting No: 0

Sue Birch: Amendment to Policy Resolution PEBB 2018-01 passes.

I'll now read Policy Resolution PEBB 2018-01 in its entirety.

Policy Resolution PEBB 2018-01 – Value Formulary.

Resolved that, beginning January 1, 2019, all UMP plans require the use of value-based formulary with:

- a select mix of drugs within a drug class that are covered only when medically necessary and all preferred products have been ineffective or are not clinically appropriate, and
- non-grandfathered members who have qualified for Tier 3 drug coverage will receive reduced Tier 2 cost-sharing, and

- multi-source brand drugs being covered only when medically necessary and clinically appropriate, and
- members who have been taking a non-preferred drug will be grandfathered at the Tier 3 cost-share, unless they receive or have already received a cost-share exception, and
- the grandfathering for brand-name drugs ends when a generic alternative or an interchangeable biologic becomes available (the drug becomes a multi-source brand and is subject to medical necessity)."

I would like to call for discussion from the Board. Seeing none, I'll call for public comment.

Fred Yancey: I'm here on behalf of school administrators and school retirees. I'm in support of this policy but you alluded and Carol's testimony from the emails really point out the problem and that is that this system is not user friendly. You outlined a resolution that says what you can do, how you can grandfather, and how you can get your materials. But point of fact, I left my email and Dave alluded to the fact that I think they're working on a better communication scheme. But if you are a user of a prescription medication, first of all, the newsletter you got, what did you do with it? You read it when it came and then you filed it somewhere, probably in the recycle bin. You can't reference the resolution that's been publicized already. You can certainly read your policy, but I challenge -- I don't challenge the Board because this is your expertise. You probably read your policies. I certainly have never ready my policy defined for coverage.

So my doctor gives me a prescription. I go to the pharmacy. The pharmacy says, "Your insurance doesn't cover it," or "Here's what you pay." Pharmacy doesn't know anything about the tiers. My doctor doesn't know anything about the tiers. And I don't know what I can do as an alternative to paying that. I would just urge the most important step is not the passage of this resolution, but is a clear, FAQ section on the website that helps users work through affording their medication. If you've checked the website, and I have, and I pretended that I'm somebody that wants to figure out how to save money on my drugs, I can't do it on the website. I just can't. It is not user friendly for determining that question. I would share those thoughts that the members are telling us about. Thank you very much for your time, and again, your hard work on this very technical field.

Sue Birch: Thank you for your comments. We'll now vote on the resolution with the amendments.

Yvonne Tate: Yes.

Tom MacRobert: No

Well, first of all, I want to thank Dave and everybody who's done a lot of work changing this and making it much better than, I think, where we started. But unfortunately, I still have some deep concerns.

Tim Barclay: Yes.

Carol Dotlich: No

I also would like to thank the hard work that went into this and tell you how deeply I appreciate how you received the input that I provided from my membership. I think my membership is not ready for this yet and so I'm forced to vote no. But I'm hoping that as time goes by, we will find that the membership is more in support than it is today.

Greg Devereux: No.

Sue Birch: Yes.

Voting to Approve: Yvonne Tate, Tim Barclay , Sue Birch

Voting No: Tom MacRobert, Carol Dotlich, Greg Devereux

Sue Birch: Policy Resolution PEBB 2018-01 – Value Formulary is not approved.

Dave Iseminger: I want to remind the Board that what this means is we will go forward with no change to the UMP formulary, or no change fundamentally to the pharmacy benefit for the 2019 calendar year. We will go forward with the rate development process knowing the outcome of this vote and bring rates back to the Board in July.

Yvonne Tate: Unfortunately, I think what the impact of this is going to be is that for the next rating period, drugs are going to be more expensive. That's the outcome of this.

Sue Birch: Thank you for those comments, Yvonne. I do want to reiterate my thanks to the staff. I know you worked hard to drive a greater value for the clients. I guess we'll be back at it in other ways to look at how we're going to curtail the premium increases.

Policy Development

Barbara Scott, Policy, Rules, and Compliance Section Manager, ERB Division. As a reminder about the process, typically, we introduce policy resolutions to you for discussion at one meeting and bring them back for a vote at a subsequent meeting.

Slide 2 – Introduction of Policy Resolutions. Today I'm bringing three policy resolutions for discussion and plan to bring them back for a vote on July 17. At the same time, we'll have a rules briefing so you can see where we're at with rule making for the PEBB Program for this year.

Proposed Policy PEBB 2018-02 – Enrollment Error Correction. The error correction policy has evolved over time, especially the last several years. I've brought a change to the Board's policy in a meeting for each of the last several years. This year, we had a case brought to us identifying a gap in the Board's policy as it stands today. It doesn't handle instances where an individual is not eligible for coverage. The agency enrolls them in coverage and doesn't find the error until later. This policy provides guidance to agencies in order for them to correct this error. For the most part, the PEBB Program uses a decentralized system for enrollment to occur. Staff at state agencies and higher education institutions across the state make eligibility determinations and key in the information. When they get something wrong, the error correction policy provides them guidance.

In this case, the policy is recommending that if coverage is entered in error, that coverage would not be removed retroactively. Instead, coverage would be removed prospectively and any premiums that would have been deducted from the employee's

pay would be refunded to the employee. For example, if I hire an employee who's not eligible for benefits on June 1 and accidentally enroll them in benefits, and I don't discover my error until September 15, coverage would be removed effective September 30. If premiums had been deducted from the employee's paycheck June through September, the agency would need to refund the employee dollars equivalent to what was withheld from their paycheck. At the same time, Health Care Authority, because coverage isn't retroactively removed, would not be taking premiums back from the carrier.

Yvonne Tate: During the time the error occurred, the person is covered, right? So if they had a major illness or what have you, they would get whatever the coverage was, right?

Barbara Scott: Yes.

Yvonne Tate: So why refund their premium retroactively?

Barbara Scott: Because they weren't responsible for the coverage being enrolled. A case from last year identified a gap when an employee enrolled in benefits. They received the letter from their agency saying they were not eligible for benefits so they weren't anticipating being enrolled in them. They were enrolled in coverage elsewhere. The agency didn't discover the error for a number of months. When the employee brought it to their attention, they didn't fix it because they didn't really know how to fix it. Because of that, it sat for a number of months. They did end up giving the employee their money back what was withheld from the employee's paycheck, but the employee had to ask for it to be resolved a number of times. By the time the error was corrected, enough time had gone by, the plans had already been paid, and plan changes had been in place. The employee didn't use the services, but they still ended up getting their money back.

We didn't retroactively take dollars back from our health plan who would have paid claims, had a claim occurred. In this case, the employee really did have claims. They've had to clean up the mess of the claims processing because there was confusion around which plan should pay primary. We were the primary insurer for the employee, because they were our employee and were covered as a dependent on the other plan. The employee was trying to correct the issue. At the same time, the agency didn't know exactly how to resolve it. They tried a number of different attempts trying to clean it up. This policy would have cleaned it up so the employee wouldn't be out any dollars. At the same time, we wouldn't take dollars back from our health plan, who would have paid claims and who ended up paying claims in this instance. It is somewhat of a penalty to the agency for not cleaning up the error. The statute does allow for the Board to put in place penalties. We haven't actively put those on the table. In many cases, the penalty has been that the agency is out both the cost of the coverage for them and the employee, and on top of that, refunding the employee dollars taken from them.

Yvonne Tate: Well, it's confusing because I can understand where the employee's actually been paying two sets of premiums. But what about a situation where they're only paying one premium and getting the benefits? It's hard to anticipate all situations that will occur as a result of this. But clearly, the example you gave is understandable.

Barbara Scott: We tried to include in the resolution that it wasn't a misrepresentation by the employee or fraud in order to protect the agency to some degree. But at the same time, I would be amiss if I didn't say this is applying a penalty to agencies where they have errors.

Tim Barclay: I want to make sure we're not setting ourselves up for a problem. In a sense, it feels like we're retroactively disenrolling the person and I would hate to put ourselves in a position with the insurance carrier. Let's say they pay a large claim and come back to us and say, "This person wasn't eligible. You refunded their premium. We would like you to pay us for the claim that we shouldn't have paid for this person." The carrier can then claim they shouldn't have been covered and they shouldn't be out the dollars. I'm not the legal expert. I just want to make sure we're not setting ourselves up for a claim refund as well as a premium refund.

Barbara Scott: That's why I described that we wouldn't take the coverage away retroactively. We'd take the coverage away prospective, the refund to the employee would not be that premiums had been taken back from the health plan. It would be out of the agency's own dollars. For example, if Health Care Authority enrolled my daughter in coverage who's not eligible for coverage under me and that error was not caught. I didn't ask for her to be enrolled. I didn't turn in an enrollment form, but accidentally, somebody enrolled her. Say she was enrolled for a number of months and then it was found. Under this policy, coverage would have to be taken away end of month, in which the error was discovered, not retroactively taking away coverage.

Dave Iseminger: To clarify, coverage wouldn't be rescinded, it would be the premium that's refunded. Coverage would be canceled prospectively because under federal law, coverage couldn't be rescinded. Barb, the part that you were just describing isn't the words on this page. Could you clarify that's elsewhere in the error correction rule that already exists based on prior PEB Board policy decisions? You were describing first of the next month is when coverage ends. It doesn't say those words in this resolution. That's elsewhere in the enrollment policy that exists today. Isn't that correct?

Barbara Scott: Today, coverage in the policy is removed prospective rather than retroactive. That does exist in the current Board error correction policy. It is more overlaid, though, by the mere fact that you can't rescind coverage once given based on federal regulation. Part of what supported this was the federal regulation. If an employee wanted to. I were to say it's okay for you to take my coverage away retroactively. That is okay and is not considered a rescission because the employee voluntarily did it. If an employer were to coerce them in any way, it's a violation of federal law. It's difficult to put in place a policy for correcting an error that would allow for it to be taken away in some instances and not in others unless we were to clearly write it in a way that says if the employee voluntarily authorizes the employer to retroactively rescind the coverage. The Board could have a policy that reads that way under federal law. Instead, the entirety of the policy really is a prospective effect date for changes. Most of the policy the Board has in place today effects enrollment rather than disenrollment. That's why it's written prospective. I'd be happy to write it into the policy, though if that adds clarity for the version that I bring before you next time.

Tim Barclay: I wasn't asking for a policy change. I just wanted to make sure we weren't in a position where the carrier could come back to the Health Care Authority and claim

the member wasn't eligible and responsibility of the claim cost shifts to the Health Care Authority. Not anything to do with the member. It's a transaction between the Health Care Authority and the insurance carrier. That's all I was trying to clarify and you clarified that. So thank you.

Barbara Scott: Proposed Policy PEBB 2018-03 – Retiree Term Life Insurance Eligibility. This policy addresses eligibility for retiree term life insurance for state agency and higher education retirees who lose eligibility for PEBB benefits due to not paying their health care premiums or due to not maintaining their enrollment in Medicare Parts A and B.

The requirement to maintain enrollment in Medicare Parts A and B, if eligible for it, is a portion of PEBB retiree eligibility. It's one of the criteria for PEBB eligibility. The requirement to pay your premiums is a given, but when we made the transition to move the administration of life insurance over to MetLife, we stopped keeping life insurance enrollment within our own Pay1 System. We broke the link to the retiree account that we maintain here and the retiree account that's maintained by MetLife. Because of that break we haven't been sending termination notices to MetLife for retirees enrolled in retiree term life insurance when we have terminated their coverage here on our end because they stopped paying their premiums for their health care coverage or because they didn't maintain their enrollment in Parts A and B of Medicare.

The number related to maintaining enrollment in Parts A and B of Medicare are probably fewer than retirees termed for non-payment. Even those termed for non-payment, because there are a number of months and processes that they go through before they lose their coverage. The one thing we wanted to get your direction on is whether to allow them to maintain their enrollment in retiree term life insurance with MetLife. It's my understanding from the contract manager that MetLife is happy to allow them to stay on coverage even though they're no longer eligible for PEBB health care coverage through the PEBB Program. That is what this policy resolution is here to do.

Sue Birch: The payments for the ongoing term life just go to the retiree and are between MetLife and the retiree, correct?

Barbara Scott: Yes, we no longer get them here at all.

Sue Birch: I certainly don't have any problem with allowing that business arrangement to roll forward because we've delinked the account and it becomes the retiree's decision. But I don't know if there are other comments or thoughts from Board Members.

Barbara Scott: Proposed Policy PEBB 2018-04 – Retiree Insurance Coverage Deferral - ChampVA. The last time we met, you provided direction to go ahead and pattern this policy after what we've done with TriCare. We looked to see if ChampVA coverage was somewhat comprehensive in services and supplies. It appears it is. The only services that seem to be at question were preventive care services. Under the regulation, not all of those would have been covered, but when staff took a closer look at the operational manual used by Veteran Affairs, those services are being covered and they are trying to get their regulation amended so those will be covered like they are for TriCare. So right

now, those services are provided. It just wasn't clear in the regulation itself. The other piece we looked at was who's eligible for the coverage to get an idea of the population, and especially if there are periods of time when they would lose coverage and then want to come back. We patterned it after the one time back in pattern that we use for TriCare. It looks like the surviving spouses and surviving children, up to a limiting age, would be eligible. The survivors of the veteran who passes away. In addition, there is some eligibility for primary family caregivers. These would be folks caring for an eligible veteran who is disabled but not deceased. That eligibility appears to end when the veteran passes away. If they utilize this provision, they would probably want to come back into PEBB coverage at the point when the veteran passed away and they lose eligibility. The limiting age for children was age 18 unless they're a student. For the most part, they're not going to fall into this population who would be deferring coverage anyway. It's mainly surviving spouse that you're going to see.

As far as the proposal today, I did go ahead and put the effective date as January 1, 2019. Ms. Svete, who testified the last time, it's my understanding her retirement date is August 1. It is within the Board's authority to decide a different date. As we explained before, typically, we use a January 1 effective date. It's consistent with the new plan year, allows for us to get rule making and communications out the door and done for the coming plan year. But it's something the Board could change. If that were the case, I would need you to tell me what effective date you want and we would amend the policy in order to reflect that.

Greg Devereux: So her date is August --

Barbara Scott: I'm going to look back at her and confirm the effective date of her retirement, but I believe it is August 1, 2018.

Irene Svete: That's the effective date.

Greg Devereux: So this would not cover her if we kept this date?

Barbara Scott: Correct.

Greg Devereux: And the whole point of this --

Barbara Scott: She would have to keep a different coverage in place in order to secure her PEBB eligibility until January 1, 2019 if you did not choose an earlier date. Do you want me to explain what we provided to her earlier today?

Greg Devereux: I just want her to get coverage and anybody after her. That's all. As long as she's happy, I'm happy.

Barbara Scott: Then you could choose to move forward, but with the August 1, 2018 effective date. It is not your norm, but you could choose to do that. It's within your ability.

Greg Devereux: Then so moved.

Yvonne Tate: Could we just say effective on signing or approval, effective approval?

Barbara Scott: Yes.

Dave Iseminger: We brought forward what has been the standing practice. It's the responsibility of this agency to remind you of your standing practice, and make sure if you made a separate effective date, you went into it with open eyes and knowledge that it is a deviance or a change from your normal practices. We have brought forward to you the effective dates and standing with your normal practices. But as Barb highlighted, you do have the authority to vary from that practice.

Sue Birch: Thank you, Dave, for that clarification and the action will be taken at the next Board meeting. We have time to consider the solution. I hear that there's likely Board Members directing staff to consider an exception to the process or recommended language.

Yvonne Tate: Right. I think it's a fairness issue versus what is our normal procedure. I think most of us lean on the side of fairness in this situation.

Barbara Scott: I hadn't planned on you voting on it today. Are you asking to amend it and vote on it today or amend it and bring it back on the July 17? And the date you would like on it is August 1, or as of the date you vote, which would be July 17?

Yvonne Tate: I think that would make more sense, July 17, when we vote.

Barbara Scott: I can bring it back that way next time around.

Tom MacRobert: It's not a question but you keep mentioning our next meeting, July 17. Our next meeting is July 11.

Sue Birch: We'll be discussing that timeframe. It's clear the Board is signaling that they'll want resolution prior to August 1.

Procurement Overview Questions and Answers

Beth Heston, PEBB Procurement Manager. I'm here to talk about follow-up questions from my last presentation. The first question was whether the durable medical equipment (DME), continuous ambulatory delivery device under discussion was the pump or the monitor for diabetes. It is the insulin pump. The monitor is a separate piece of equipment and not included in this list of DME.

The second question was what is the UMP rate of coinsurance for DME? In network it is 15% and out-of-network is 40%. The situation was that Kaiser Northwest is asking to go from 0% coinsurance to 20% coinsurance to match Kaiser Washington. UMP has 15% in network.

Dave Iseminger: As Betsy comes up to discuss Long-Term Disability Insurance, I want to say I'm excited to be able to start this conversation with the Board. It's been a long time since we've focused on possible changes within the long-term disability benefit. I'm happy Betsy has an opportunity to start the discussion with you. We will bring more analysis because we've been working on this for the Board in the past couple of weeks, really solidifying a proposal to bring to you. I know you'll probably have a variety of

questions and we're working on materials for the next Board meeting, but I wanted Betsy to come forward and give you an introduction on this topic.

Long-Term Disability Insurance

Betsy Cottle, Contract Manager, ERB Division. We haven't talked about long-term disability in a very long time. I have a very brief description of what long-term disability insurance provides for members. It's income replacement. If you are determined to be disabled from your job, a disability insurance program provides you with a percentage of your pre-disability earnings at a tax-free basis. Our current long-term disability program is administered by The Standard Insurance Company and replaces up to 60% of the first \$400 of a monthly income on our basic plan. Our optional plan currently replaces 60% up to \$6,000 of your monthly income.

Long-term disability insurance is available only to employees. During their initial election, employees are able to elect optional LTD without answering any health questionnaires. Presently, our population has 31% enrolled in optional long-term disability. Optional long-term disability is very critical to employees because our basic really does not provide enough protection. In the meantime, I've been able to figure out a way to offer all of our employee subscribers a new opportunity to purchase optional long-term disability.

Slide 4 is a graph that shows what I was talking about. The proposed future plan in basic is unchanged at this time. We're hoping for big and wonderful things in the future. But for right now, we propose offering our subscribers an opportunity to replace up to \$10,000 per month of their income. This is an opportunity to offer everybody a new enrollment without evidence of insurability. I've already mentioned that the offer increases the maximum monthly benefit from \$6,000 to \$10,000. The offer is open to every eligible employee, even if they had been previously denied. If 10 years ago you attempted to increase your optional long-term disability and were denied because of a health issue, that employee will be eligible for this benefit. Premium rates for this new opportunity are guaranteed through 2021. We propose to start working on this immediately and offer it to our subscribers in Winter 2019. Plan effective date would be shortly thereafter because this is a unique open enrollment and there's a lot of work that goes into enrolling people. We're trying to give our agencies extra time so there'd be an enrollment one month, a month pause to do data entry, and then the plan would become effective on the third month. If we did it in February, it would be effective April. If we did it in March, it would be effective May.

Greg Devereux: Betsy, the difference is 60% of \$6,000 versus \$10,000. It goes from \$6,000 to \$10,000, 60%? And what is the difference in the premium the person's paying for this completely. What's the difference in cost?

Betsy Cottle: Yes. Between \$6,000 and \$10,000? I did not calculate it in that way. But I can tell you the rate they would be paying has been the same for all optionals for the almost ten years. I can bring back math the next time and we can explore how it would change things, depending on how much people insure. I don't have that calculation and I don't want to say the wrong thing because I want us to all understand what our employees will be paying.

Greg Devereux: Thank you.

Tim Barclay: I have a slightly different premium question. If I'm an employee making \$60,000 a year salary, \$5,000 a month, this policy change would not affect my coverage. However, with all of the bells and whistles of letting people enroll who previously declined, and all the other things that are happening, I would like to know what happens to that person's premium, so the person who's not getting any enhanced benefit. If we do this, what happens to their premium?

Betsy Cottle: It stays the same.

Tim Barclay: It does stay the same for sure?

Betsy Cottle: You are only able to insure the income you make. You cannot replace income you do not make. I can't insure myself for twice my salary.

Tim Barclay: I just didn't know if the rates per thousand of coverage would be changing as a result of the new open enrollment process. Thank you.

Betsy Cottle: No.

Dave Iseminger: I'll just add, as Betsy said, they would be guaranteed until December 31, 2020. After that, the entire rate schedule could change. The rates currently existing would not be impacted by this open enrollment, nor for the year after this open enrollment.

Myra Johnson: My question is back on the 31% are eligible. Is that subscribers are enrolled in this long-term --

Betsy Cottle: It's not 31% who are eligible. It's 31% of our subscribers who are taking advantage of the optional long-term disability. Our goal is to increase that because we feel our population is not financially protected.

Myra Johnson: Okay. Do you know why, or in your crystal ball, only 31%?

Betsy Cottle: It's a very complex and odd benefit. It's important and for many people, it's just a detail lost in the original election period. After 31 days, you have to fill out a questionnaire and that is a barrier for a lot of people, even though most of us would generally pass initially.

Dave Iseminger: Myra, I've told this story many times to staff and I don't care about saying it publically. I still have my original enrollment packet from when I joined state service and I wrote on my life and LTD packets "look at this later." I still have those packets. After 31 days, I was worried about failing underwriting and I didn't want to be blackballed so I've never touched it. If we learned anything from our life insurance refresh two years ago, there was a lot of pent up demand. We had an amazing uptake with people having an ability to elect additional coverage in life insurance without having to go through underwriting. That's when our partner, The Standard, started a discussion about whether there would be an opportunity to do same thing on the disability side. When people start their state service, they go, "I'm going to focus on this medical and dental thing," and they put the others to the side. Time creeps by and they get diagnoses, life happens, and then they go for it, and realize they may not pass

underwriting or they have something that will not allow them access to the insurance. I think many people start off in state service, many of them young and invincible and not thinking about the potential of lack of insurability later.

Yvonne Tate: I just wanted to say, I think this is a really good thing. I'm really excited to hear it. To the notion of how fickle employees can be, my employer had a dollar for dollar match in a 401K plan and not all employees were contributing in enough to get the full match. It's free money and they weren't going for it so you never know. But I'm very impressed with this.

Betsy Cottle: We expect to spend a great deal of effort educating people because this product is not well understood.

Public Comment

No public comment received.

Sue Birch: Our July 11 Board Meeting is likely to be canceled due to rate negotiations. As we get closer to that date, we'll confirm.

Pending the decision of the July 11 meeting, our next meeting is July 17, 2018 in this room from 1:30 p.m. to 4 p.m.

Preview of Upcoming Board Meeting

Dave Iseminger: We always over-schedule in July not knowing when rates are coming in. We usually cancel at least one meeting. At the likely next meeting, July 17, Betsy will bring more information, member examples, and walk through some of the advantages and additional information about the long-term disability benefit offering before you, and bring you a proposed resolution to consider, and hopefully take action on at a subsequent meeting this season.

Hopefully the rate process will be finalized and the finance team will bring information about what the rates are looking like for 2019 on both the Medicare and non-Medicare side, and bring proposals for you to take action on at a later meeting in July.

We will bring the resolutions Barb presented today up for action. Staff will do an overview of the rule making process and remind everyone as to after the policies are passed by the Board, what the process is that the agency goes through to roll those into rules.

At the last meeting, we had an emerging medication update on Trogarzo. We will probably have another update on other drugs that are in the pipeline to keep you informed.

And finally, we're preparing to bring you information about the K12 retiree study. In House Bill 2242 with the enactment of the School Employees Benefits Board Program, there was a requirement for a legislative report about the possible future of risk pool arrangements for K12 retirees. Nothing changed with the creation of the SEBB Program legislation to K12 retirees. They stay in the PEBB pool but there was the requirement for a legislative report. It's due at the end of the year and the legislation

requires consultation with both the PEB and SEB Boards. We're planning on having those discussions with both Boards in July.

Greg Devereux: I think both Carol and I are in Boston on the July 17 so I would love to call in. I assume we would get on the line together. Okay, thank you.

Sue Birch: Thanks for letting us know.

Meeting adjourned.