

Public Employees Benefits Board Retreat

January 31, 2019

Public Employees Benefits Board

January 31, 2019

8:30 a.m. – 5:00 p.m.

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

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TAB 1

AGENDA

Public Employees Benefits Board Retreat
January 31, 2019
8:30 a.m. – 5:00 p.m.

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

Theme: “Ensuring Affordability and Value for our Members”

8:30 a.m.	Coffee		
9:00 a.m.	Welcome Introductions and Purpose		Susan Birch, Director Health Care Authority
9:10 a.m.	Retreat Overview		Marcia Peterson, Manager, Benefits Strategy & Design Section, Employees & Retirees Benefits (ERB) Division
9:15 a.m.	Addressing Health Care Affordability: Identifying and Addressing Waste	TAB 3	Mich’l Needham, Chief Policy Officer Clinical Quality & Care Transformation Division, Health Care Authority Nancy Giunto, Executive Director Washington Health Alliance
10:15 a.m.	Break		
10:30 a.m.	Panel Discussion: Pharmacy Challenges from the Physician Perspective	TAB 4	Emily Transue, MD, Assistant Medical Director, HCA - Moderator Norris Kamo, MD Virginia Mason Medical Center Matthew Mulder, MD Valley Medical Center Gurpreet Rawat, MD Kaiser Permanente of Washington Keith Bachman, MD Kaiser Permanente Northwest
11:30 a.m.	UMP Pharmacy Update	TAB 5	Marcia Peterson, Manager, Benefits Strategy & Design Section, ERB Division
12:00 p.m.	Working Lunch • 2019 Open Enrollment Summary	TAB 6	Renee Bourbeau, Manager, Benefits Accounts Section, ERB Division

12:45 p.m.	Disability Benefits	TAB 7	Cade Walker, Executive Special Assistant ERB Division, Health Care Authority Nick Streuli, Legislative and Executive Operations Director, Employee Security Department Kisha Turner, National Senior Accounts Underwriter Jared Benedetti, Consulting Actuary Dave Tappan, Employee Benefits Manager The Standard
1:45 p.m.	The Empowered Consumer & Personal Health Technology	TAB 8	Molly Christie, Strategic Planning Project Manager, ERB Division Matthew Toney, Strategic Planning Project Manager, ERB Division
2:30 p.m.	Break		
2:45 p.m.	Emerging Medications Update	TAB 9	Ryan Pistoresi, Assistant Chief Pharmacy Officer, Clinical Quality & Care Transformation Division
3:00 p.m.	Medicare Retiree Health Benefits Project Update Medicare Supplement Plans	TAB 10	Molly Christie, Strategic Planning Project Manager, ERB Division Betsy Cottle, Contract Manager, School Employees Benefits Section, ERB Division
3:30 p.m.	Retired and Disabled School Employees Risk Pool Analysis Report to the Legislature	TAB 11	Kim Wallace, SEBB Finance Manager Financial Services Division
4:00 p.m.	Governor's Budget Update 2019 – 2021	TAB 12	Tanya Deuel, PEBB Finance Manager Financial Services Division
4:30 p.m.	2021 Benefit Priorities Board Discussion		Marcia Peterson, Manager, Benefits Strategy & Design Section, ERB Division
5:00 p.m.	Adjourn		

PEB Board Members

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

PEB Board Members

Name	Representing
Tim Barclay 9624 NE 182 nd CT, D Bothell WA 98011 V 206-819-5588 timbarclay51@gmail.com	Benefits Management/Cost Containment
Yvonne Tate 1407 169 th PL NE Bellevue WA 98008 V 425-417-4416 ytate@comcast.net	Benefits Management/Cost Containment
Vacant*	Benefits Management/Cost Containment
Harry Bossi 19619 23 rd DR SE Bothell WA 98012 V 360-689-9275 udubfan93@yahoo.com	Benefits Management/Cost Containment
Legal Counsel	
Michael Tunick, Assistant Attorney General 7141 Cleanwater Dr SW PO Box 40124 Olympia WA 98504-0124 V 360-586-6495 MichaelT4@atg.wa.gov	

*non-voting members

11/28/18



Washington State Health Care Authority
Public Employees Benefits Board

P.O. Box 42713 • Olympia, Washington 98504-2713
360-725-0856 • TTY 711 • FAX 360-586-9551 • www.pebb.hca.wa.gov

2019 Public Employees Benefits Board Meeting Schedule

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

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

March 20, 2019

April 24, 2019

May 21, 2019

June 5, 2019

June 19, 2019

July 10, 2019

July 17, 2019

July 24, 2019

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

Updated 3/30/18

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: August 13, 2018

TIME: 8:07 AM

WSR 18-17-076

TAB 2

PEB BOARD BY-LAWS

ARTICLE I

The Board and its Members

1. **Board Function**—The Public Employee Benefits Board (hereinafter “the PEBB” or “Board”) is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB’s function is to design and approve insurance benefit plans for State employees and school district employees.
2. **Staff**—Health Care Authority staff shall serve as staff to the Board.
3. **Appointment**—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.
4. **Non-Voting Members**—Until there are no less than twelve thousand school district employee subscribers enrolled with the authority for health care coverage, there shall be two non-voting Members of the Board. One non-voting Member shall be the Member who is appointed to represent an association of school employees. The second non-voting Member shall be designated by the Chair from the four Members appointed because of experience in health benefit management and cost containment.
5. **Privileges of Non-Voting Members**—Non-voting Members shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.
6. **Board Compensation**—Members of the Board shall be compensated in accordance with RCW [43.03.250](#) and shall be reimbursed for their travel expenses while on official business in accordance with RCW [43.03.050](#) and [43.03.060](#).

ARTICLE II

Board Officers and Duties

1. **Chair of the Board**—The Health Care Authority Administrator shall serve as Chair of the Board and shall preside at all meetings of the Board and shall have all powers and duties conferred by law and the Board’s By-laws. If the Chair cannot attend a regular or special meeting, he or she shall designate a Chair Pro-Tem to preside during such meeting.
2. **Other Officers**—(*reserved*)

ARTICLE III
Board Committees

(RESERVED)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.
2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.
3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.
4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.
5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 10 days prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. Minutes summarizing the significant action of the Board shall be taken by a member of the HCA staff during the Board meeting, and an audio recording (or other generally-accepted) electronic recording shall also be made. The audio recording shall be reduced to a verbatim transcript within 30 days of the meeting and shall be made available to the public. The audio tapes shall be retained for six (6) months. After six (6) months, the written record shall become the permanent record. Summary minutes shall be provided to the Board for review and adoption at the next board meeting.
6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board Members at the meeting for the minutes.

ARTICLE V
Meeting Procedures

1. Quorum— Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.
2. Order of Business—The order of business shall be determined by the agenda.
3. Teleconference Permitted— A Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, A Member may attend a meeting by telephone conference call or video conference when in-person attendance is impracticable.
4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at board meetings may also occur in conjunction with a public hearing or during the board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.
5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .
6. Representing the Board's Position on an Issue—No Member of the Board may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.
7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted.
8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order [RONR]. Board staff shall provide a copy of *Robert's Rules* at all Board meetings.
9. Civility—While engaged in Board duties, Board Members conduct shall demonstrate civility, respect and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.
10. State Ethics Law—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW.

ARTICLE VI

Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.
2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

TAB 3

ADDRESSING HEALTH CARE AFFORDABILITY: IDENTIFYING AND ADDRESSING WASTE



Public Employees Benefits Board Retreat, January 31, 2019
Mich'l Needham, Chief Policy Officer, Health Care Authority
Nancy A. Giunto, Executive Director, Washington Health Alliance

Leveraging the Employer's Purchasing Power to address quality and affordability

Health Care Authority participates in multiple groups that seek alignment with other purchasers to advance quality initiatives, value-based purchasing initiatives, and a focus on affordability, e.g.,

- Align purchasing initiatives across Health Care Authority programs (with Medicaid, PEBB, and SEBB)
- Participate in Health agency subcabinet and others (DSHS, DOH, DCYFL, OIC, Exchange, L&I, DOC) focused on areas we can leverage projects together or link critical components
- Participate with other large private sector purchasers to align efforts – such as Pacific Business Group on Health and Washington Health Alliance



HCA and Alliance - Effective, Long-Term Partnership

Examples of Partnership Building on Purchasing Power:

- Initiation of public reporting on health care quality via the Community Checkup, started in 2008
- Governor's Performance Measures Coordinating Committee and Statewide Common Measure Set
- WA State Health Care Innovation Plan
- Healthier Washington and CMS State Innovation Model Grant
- Co-sponsorship of a Statewide Affordability Conference, October 2018
- Innovative approaches to measurement and reporting, e.g., patient experience, eValue8, resource use, health care waste
- Creation of Washington's first all payer claims database in the state through the Washington Health Alliance, started in 2006

We both prioritize achieving higher VALUE in health care for our state and believe our present system is unsustainable.

Context

We know that “value” in health care lies at the intersection of high quality (including clinical appropriateness), excellent patient experience, and affordability.



To achieve high value, we have to work on all of these separately and together, and with other purchasers and providers.

Health Care Affordability

Health care affordability is complicated and there are multiple factors, but research strongly indicates that the two BIG ones are:

PRICE PER SERVICE

- These are typically contracted rates and, more often than not, are fee-for-service . . . meaning the more you do, the more you make as a provider
- Contracting leverage (ability to negotiate higher or lower prices, depending on your perspective) has much to do with market influence/position in the market . . . the bigger you are, the more leverage you have for all stakeholder groups

RESOURCE USE

- Frequency with which health care treatments occur, including whether the care is clinically appropriate
- Service intensity of the treatment itself (i.e., complexity of care provided, settings for care delivery)

Examples of other important but less impactful factors: growing population, aging population, changes in disease prevalence and incidence

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RESOURCE USE

- 
- **Frequency with which health care treatments occur, including whether the care is clinically appropriate**
 - Service intensity of the treatment itself (i.e., complexity of care provided, settings for care delivery)

Quality and Clinical Appropriateness

High quality and clinically appropriate means health care that is:

- Delivered in a timely and well-coordinated manner
- Supported by well-established evidence
- Truly necessary to improve the outcome of care for a particular patient
- Not duplicative of other tests or procedures already received
- As free from harm as possible

Health Care Affordability

Identifying and Addressing Waste – Why We Care?

5.5%

Annual increase in national health care spending thru 2026

\$5.7 Trillion

Total spend on health care by 2026

19.7%

Percentage of GDP spend on health care by 2026

47%

Percentage of health care spend borne by federal, state and local governments

25% - 30%

Estimated Amount of Waste in Health Care Overall

And . . . We are Harming People

Physical Harm

Healthcare acquired infections
Surgical errors
Medication errors
Excessive radiation
False positives resulting in MORE . . .



Emotional Harm

Worry
Anxiety
Lower productivity
Absenteeism



Financial Harm

Debt
Bankruptcy
Devastating trade-offs: food, medication and other health care, education, housing, employment





NEW Results from the Health Waste Calculator



What will
this cost
me?

OMG ...
Can I
afford this?

Do I really
need this?

LESS

MORE



Medical tests, treatments, and procedures that *have been shown to provide little or no benefit to patients* in particular clinical scenarios and, in many cases, have the potential to cause harm.

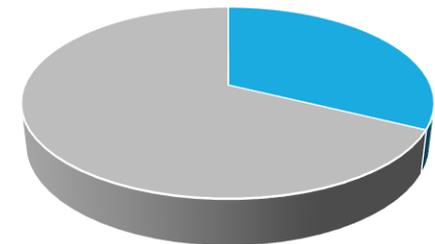
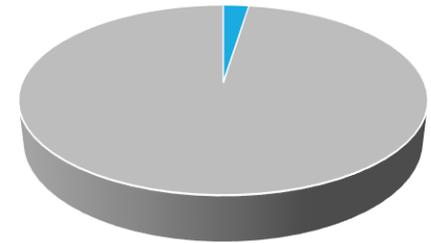
Overview of the MedInsight Health Waste Calculator™

- Analyzes data to identify and quantify wasteful services **as defined by national initiatives such as Choosing Wisely® and the U.S. Preventive Services Task Force**
- Version 7 used for this analysis - includes 48 measures
- Analysis done at the claim line level and includes both professional and facility-related claims
- The Health Waste Calculator creates an assessment of the degree of waste:
 - ✓ **Necessary:** Data suggests appropriate services were administered by the healthcare provider
 - ✓ **Likely Wasteful:** Data suggests the need to question the appropriateness of services rendered
 - ✓ **Wasteful:** Data suggests the service should not have occurred based on current evidence, clinical guidelines, and professional recommendations

Caveats

For all of the following reasons, the results should be viewed as *directional*, rather than absolute.

- 48 measures, representing a subset of the total potential areas of low-value healthcare in our state. *Extrapolation of these results to other types of care is not advised.*
- Claims data for approximately 2.2 million residents of Washington State - estimate of low-value services rather than a comprehensive analysis of services received by *all* Washingtonians during the measurement period. *Extrapolation of these results to other populations is not advised.*



Pie charts not to scale, for illustrative purposes only.

Caveats (*cont.*)

- Prevalence of waste noted, including number of services and individuals impacted, is based on *actual* utilization.
- Costs are *estimated*.
- Noted costs are only associated with the particular service in question, including professional and facility charges.
- When using claims data, there is always a time lag. The results in this report are from July 2016 - June 2017. We acknowledge that performance may have changed since June 2017.

Summary

- Today, I'll show you results for the commercially insured population, including **2,227,570** commercially insured individuals in Washington State
 - Includes PEBB and other self-insured purchasers, along with fully insured from Regence, Premera, KP-WA, Aetna, Cigna, UnitedHealthcare
- Results reflect examination of **48 common treatments, tests, and procedures** known by the medical community to be overused – all tie to Choosing Wisely recommendations
- Measurement period: July 2016 – June 2017

Summary (*cont.*)

Across the 48 measures for the commercially insured:

- **1,558,564** services were measured, totaling an *estimated* spend of \$560 million
- **48.6%** of measured services were found to be wasteful (757,106)
- 1,207,226 individuals received services: **50.9%** (614,779) received low value services
- An *estimated* **\$236 million** was spent on low-value care
 - 86.6% of wasteful services were “low cost” (<\$538) – the “little things really add up!”

Targeting Key Drivers of Waste

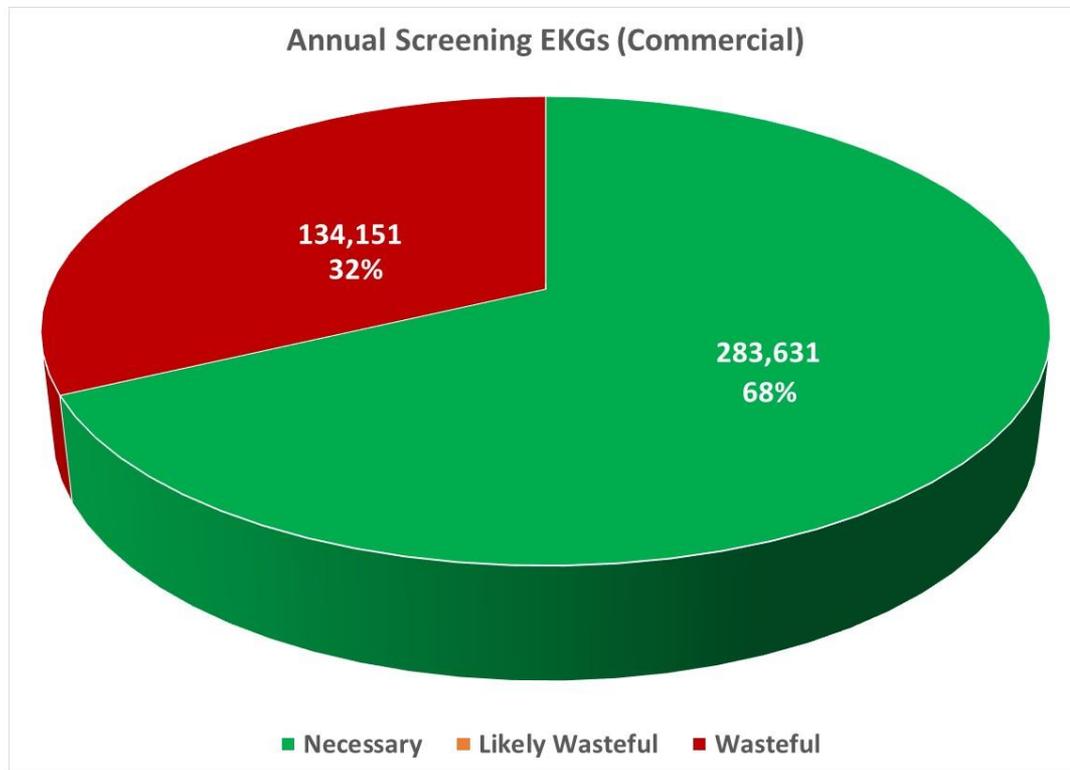
Nine out of 48 measures account for 90% of the waste measured for the commercially insured population, impacting a total of 553,785 individuals.

These nine measures include the following which are listed in priority order based on the number of wasteful services measured:

1. Annual EKGs or Cardiac Screening for Low-Risk Individuals
2. Antibiotics for Upper Respiratory and Ear Infections w/in 7 Days of Diagnosis
3. Opiates for Acute Low Back Pain in the First 4 Weeks
4. Imaging Tests for Eye Disease
5. Preoperative Baseline Laboratory Studies for Healthy People Prior to Low-Risk Procedures
6. Routine PSA-based Screening for Prostate Cancer
7. Too Frequent Cervical Cancer Screening for Women
8. Routine General Health Checks for Adults Under 65 Years of Age
9. Screening for Vitamin D Deficiency

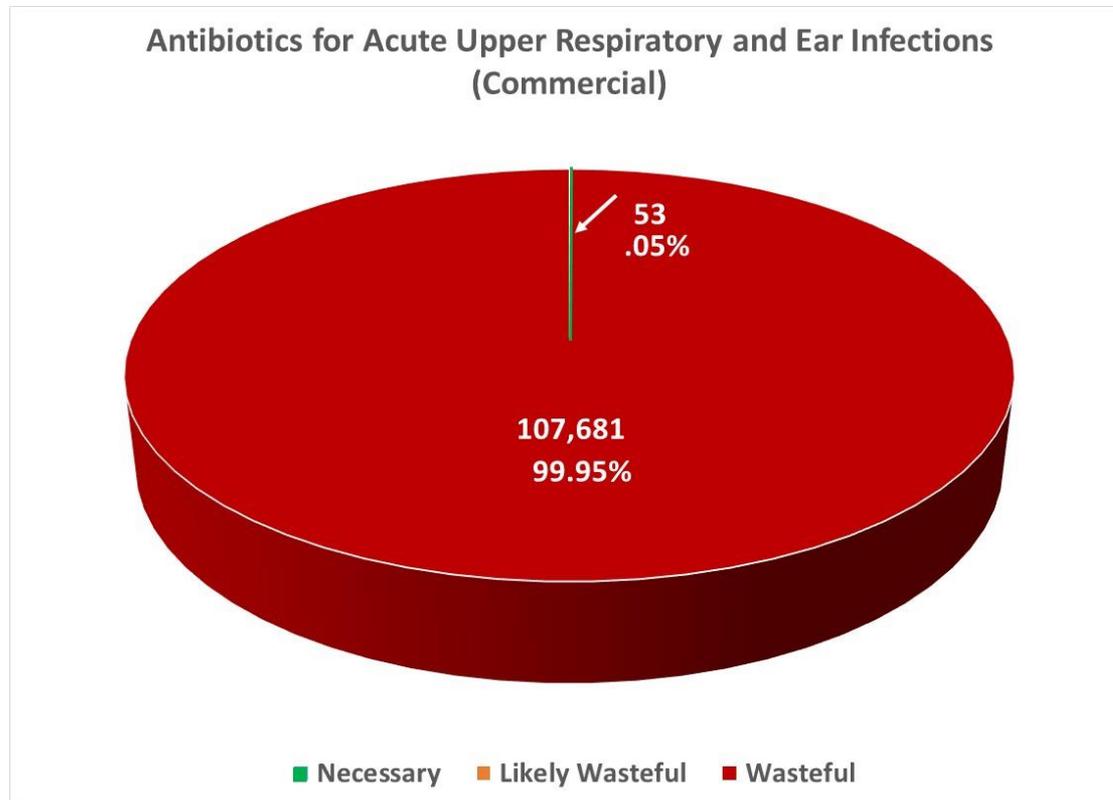
Annual EKGs or Cardiac Screening for Low-Risk Individuals

The overall Waste Index is 32%. **A total of 134,151 wasteful services were delivered, impacting 123,549 individuals at an estimated cost of \$47.5 million.**



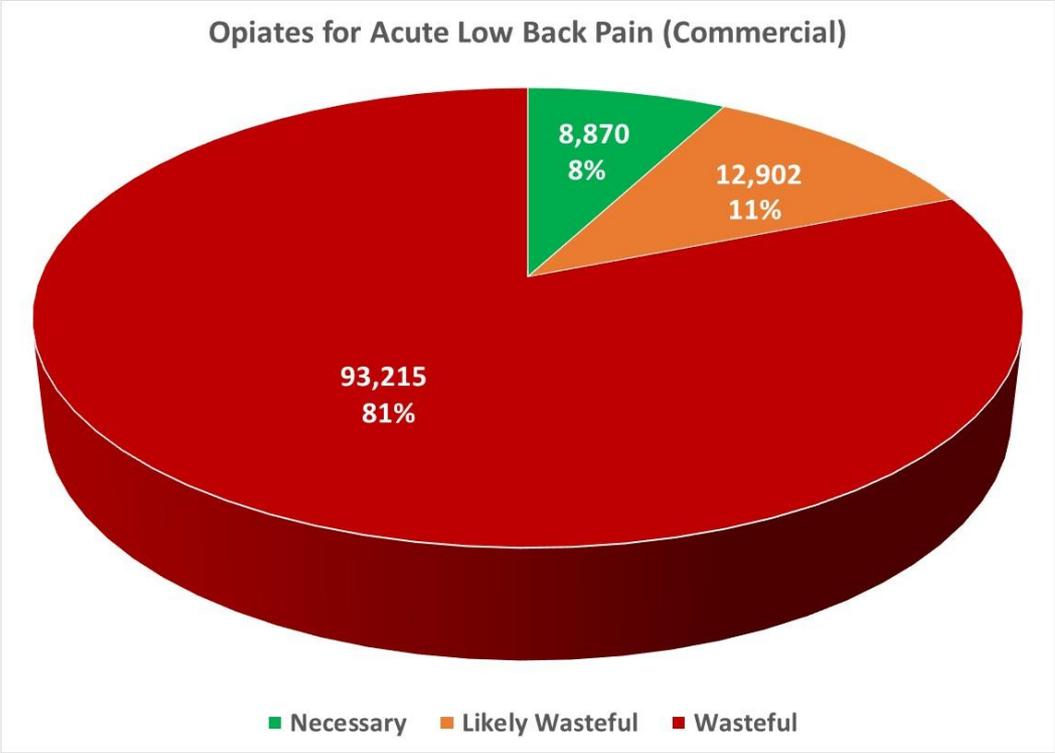
Antibiotics for Upper Respiratory and Ear Infections within 7 Days of Dx

The overall Waste Index is 99.95%. **A total of 107,681 wasteful services were delivered, impacting 94,642 individuals at an estimated cost of \$1.7 million.**



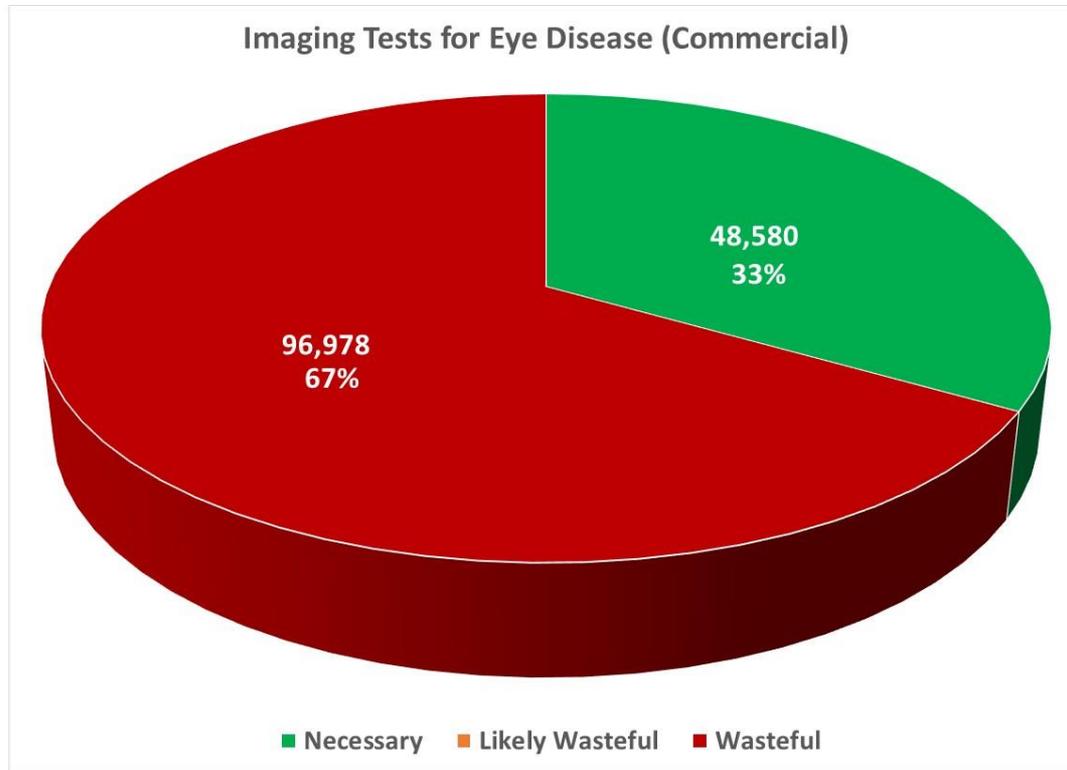
Opiates Prescribed for Acute Low Back Pain w/in 4 Weeks of Dx

The overall Waste Index is 92%. **A total of 106,117 likely wasteful and wasteful services were delivered, impacting 49,626 individuals at an estimated cost of \$9.4 million.**



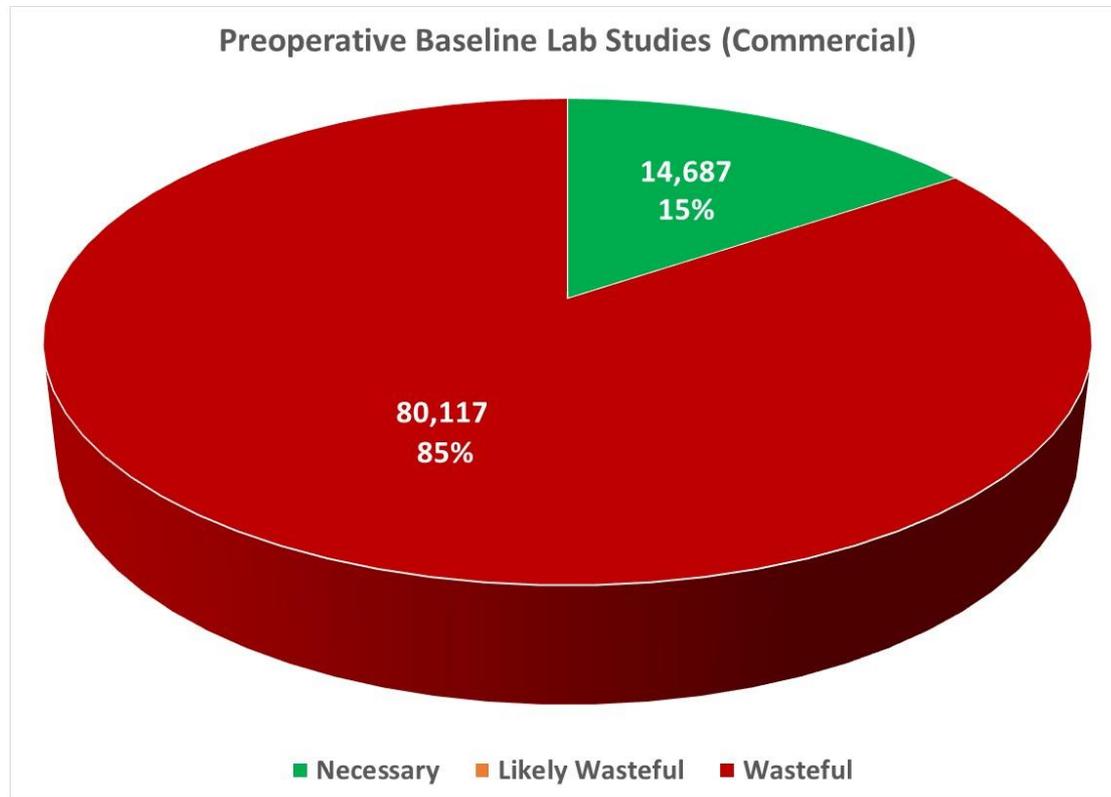
Imaging Tests for Eye Disease

The overall Waste Index is 67%. **A total of 96,978 wasteful services were delivered, impacting 65,480 individuals at an estimated cost of \$34 million.**



Preoperative Baseline Lab Studies for Healthy People Prior to Low-Risk Procedures

The overall Waste Index is 85%. **A total of 80,117 wasteful services were delivered, impacting 77,868 individuals at an estimated cost of \$66.6 million.**



Drop the Pre-op!

DROP THE PRE-OP!

Physicians Agree: All patients need pre-op EVALUATION, but a low-risk patient having a low-risk procedure does not need pre-op TESTING.

Providing high-quality care to patients includes eliminating unnecessary tests, treatments and procedures.

A recent study in Washington state¹, reveals that at least 100,000 patients received unnecessary pre-op testing during a one-year period, at an estimated cost of over \$92 million—a very conservative estimate.

Routine preoperative lab studies, pulmonary function tests, X-rays and EKGs on healthy patients before low-risk procedures are **not** recommended because they are unlikely to provide useful, actionable information.

Choosing Wisely® Recommendations

- “ Don't obtain baseline laboratory studies in patients without significant systemic disease (ASA I or II) undergoing low-risk surgery – specifically complete blood count, basic or comprehensive metabolic panel, coagulation studies when blood loss (or fluid shifts) is/are expected to be minimal.”
—American Society of Anesthesiologists
- “ Don't order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.”
—American Academy of Family Physicians

There are a variety of reasons why unnecessary pre-op tests are ordered, such as:

- Broadly ordering the same pre-op tests for all patients/procedures—based on habit without thoughtful reflection—regardless of a patient's health or a procedure's risk.
- A desire to be “thorough” and/or concern that an incomplete pre-op form may delay the procedure for the patient.
- Discomfort with uncertainty and concern about malpractice.
- A mistaken belief that all insurers require pre-op testing.

¹ First, Do No Harm. <https://www.wacomunitycheckup.org/media/47156/2018-first-do-no-harm.pdf>

Benefits of Reducing Unnecessary Pre-op Testing

For patients:

- Reduces unnecessary time spent at a lab or clinic.
- Reduces patient's financial burden.
- Reduces waiting for test results and anxiety from false-positive results.

For physicians:

- Reduces unnecessary delay before procedure.
- Provides evidence-based care to patients and avoids unnecessary care.
- Reduces time spent reviewing, documenting and explaining test results that add no value and won't impact a decision regarding procedure.
- Reduces risk exposure from not carefully documenting follow-up on all pre-op tests.

Pre-op Testing Prior to Low-Risk Procedures for Low-Risk Patients

	Physical Status of Patient Undergoing Low-Risk* Procedure (determined based on history and evaluation)		
	↓	LOWER RISK PATIENTS	HIGHER RISK PATIENTS ↑
Pre-op Test	ASA I A normal healthy patient	ASA II A patient with mild stable systemic disease	ASA III-V A patient with severe systemic disease or a patient who is not expected to survive without the operation
Chest X-ray	DO NOT ROUTINELY ORDER		DO NOT ROUTINELY ORDER
Coagulation studies			CONSIDER ORDERING PER GUIDELINES
Complete metabolic panel			
EKG or echocardiography			
Full blood count test			
Pulmonary function test	DO NOT ROUTINELY ORDER (unless anologic procedure)		
Urinalysis			

* Examples of Low-Risk Procedures: arthroscopy and orthopedic procedures that only require local anesthesia; cataract, corneal replacement and other ophthalmologic procedures; cystoscopy and other minor urologic procedures; dental restorations and extractions; endoscopy; hernia repair; minor laparoscopic procedures; superficial plastic surgery.

Recommended Actions

Physicians, Hospitals and Other Health Care Organizations

- Educate physicians and team members (e.g. RN, MA) involved in pre-op testing decision-making.
- Delete prompts for pre-op testing in electronic health record (EHR) order sets designed for low-risk patients undergoing low-risk procedures.
- Use evaluation checklists to optimize surgical outcomes (e.g. nutrition, glycemic control, medication management and smoking cessation).
- In hand-off communication to the surgeon or anesthesiologist after your pre-op evaluation, add this or similar language: “This patient has been evaluated and does not require any pre-operative lab studies, chest X-ray, EKG or pulmonary function test prior to the procedure.”
- Provide prompt and clear peer-to-peer feedback when unnecessary pre-op testing occurs; make this a topic of departmental and inter-departmental quality improvement discussions, including gathering patient data to inform discussions.
- Measure current rate of pre-op testing on low-risk patients prior to a low-risk procedure and track improvement.



Payers

- Review medical policies and prior-authorization requirements to ensure they clearly do **not** require routine testing prior to low-risk procedures on low-risk patients.
- Utilize health plan data and analytics to measure and monitor use of pre-op testing on low-risk patients prior to low-risk procedures.
- Provide feedback on pre-op testing on low-risk patients prior to low-risk procedures to physicians and health care organizations.



WASHINGTON STATE TASK FORCE



For more information and resources, visit:
wsma.org/Choosing-Wisely



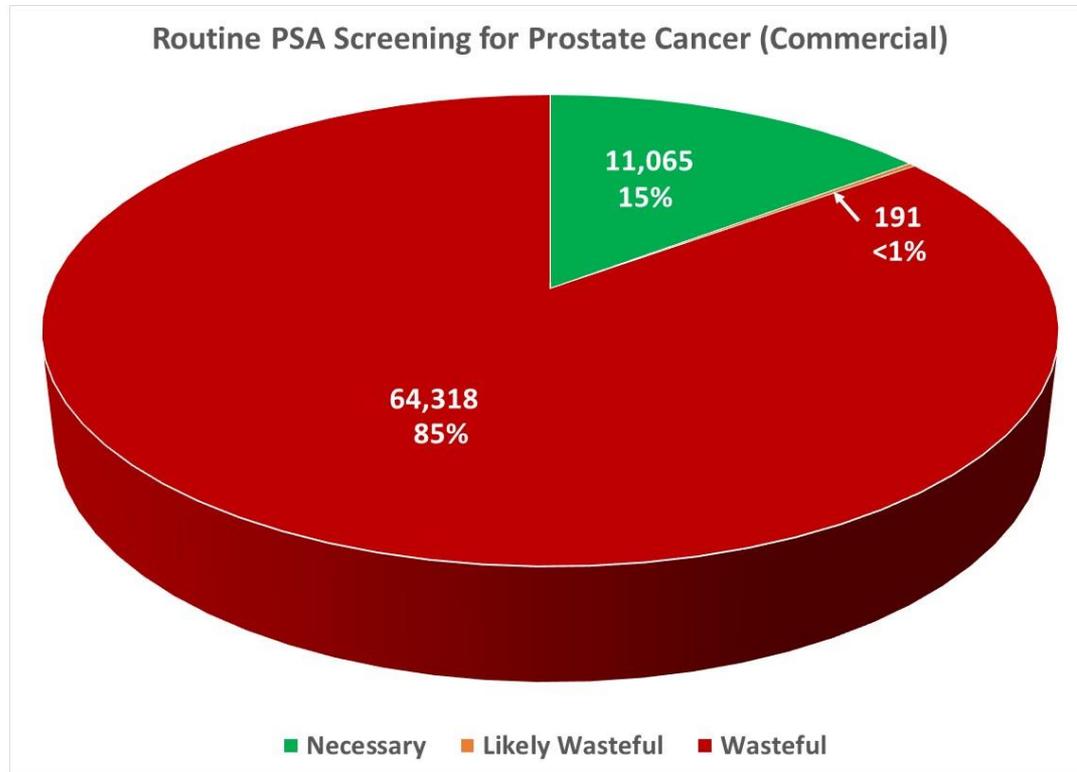
WASHINGTON STATE TASK FORCE



For more information and resources, visit:
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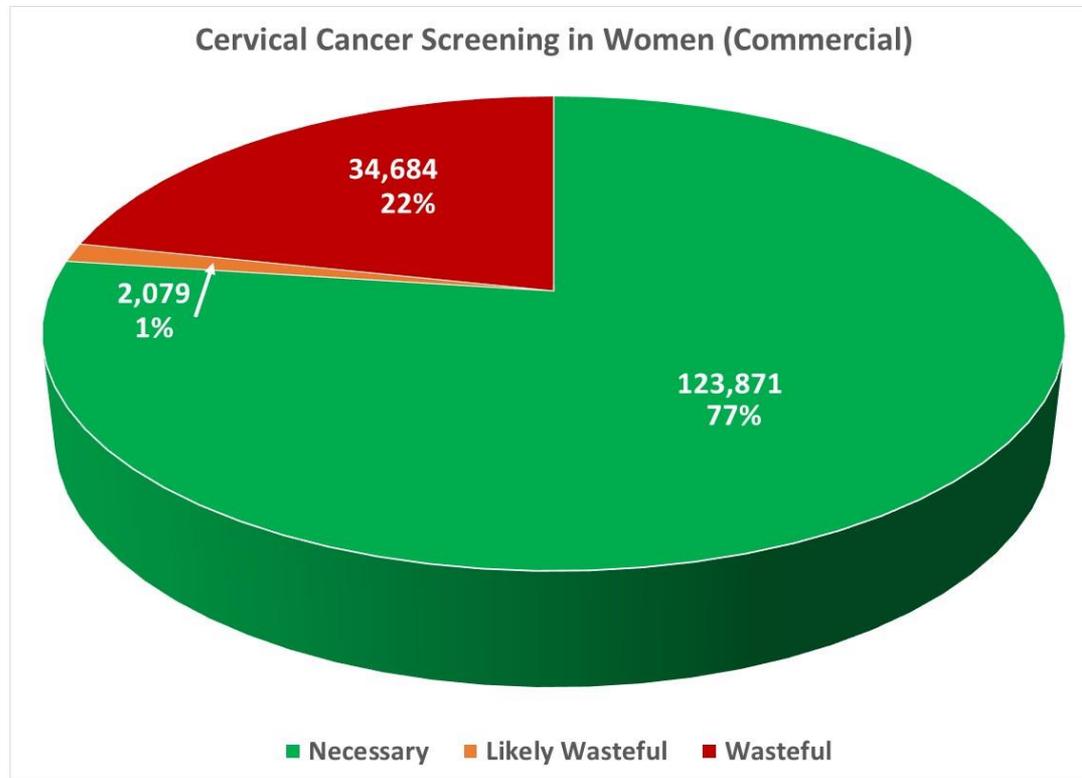
Routine PSA-based Screening for Prostate Cancer

The overall Waste Index is 85%. **A total of 64,509 likely wasteful and wasteful services were delivered, impacting 60,457 men at an estimated cost of \$7.2 million.**



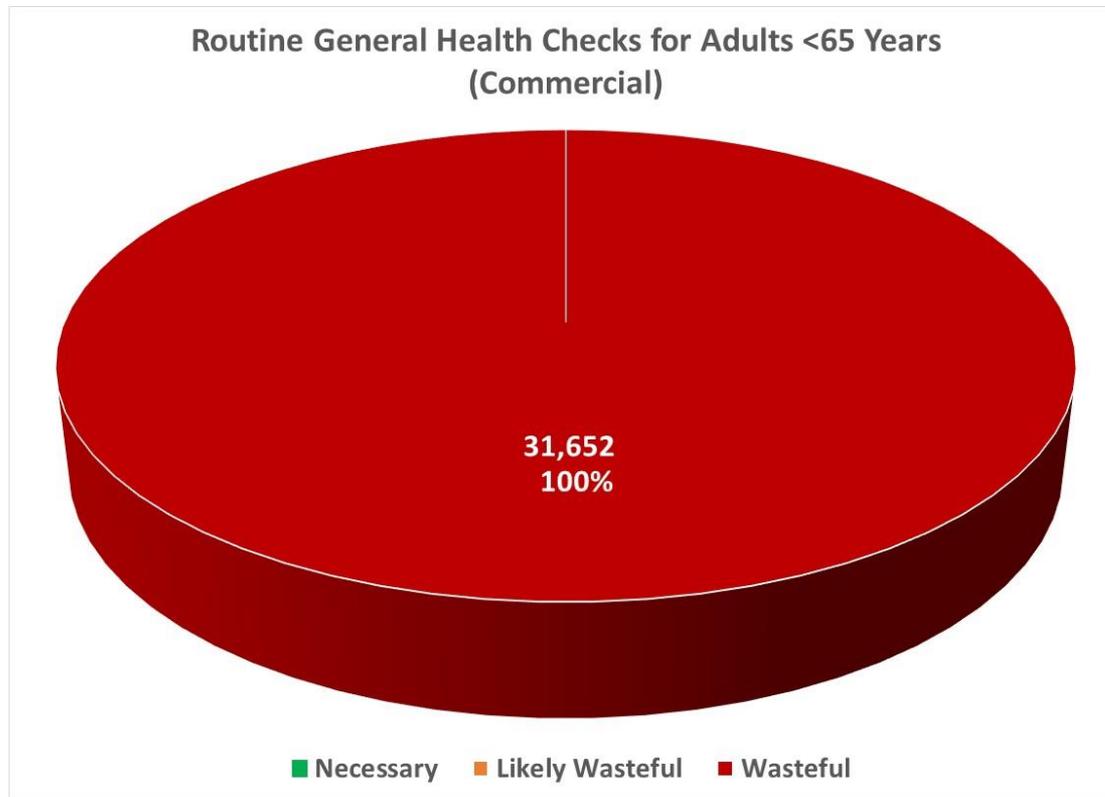
Too Frequent Cervical Cancer Screening for Women

The overall Waste Index is 23%. **A total of 36,763 likely wasteful and wasteful services were delivered, impacting 36,416 women at an estimated cost of \$4 million.**



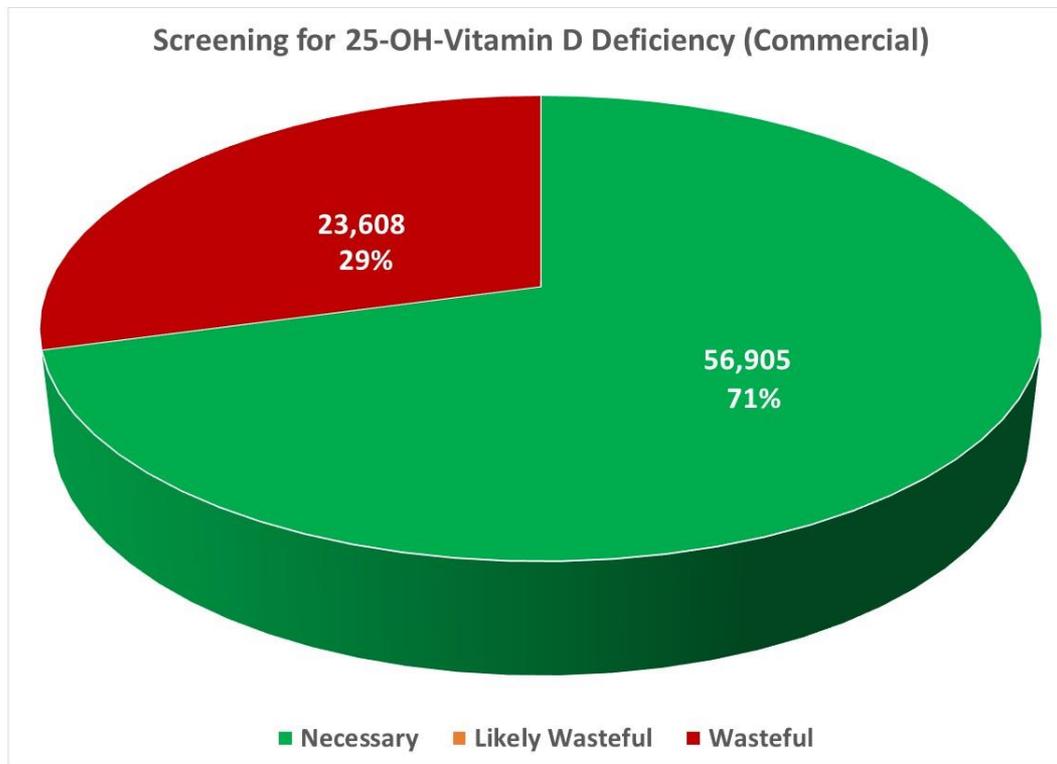
Routine General Health Checks for Adults <65 Yrs

The overall Waste Index is 100%. **A total of 31,652 wasteful services were delivered, impacting 31,354 individuals at an estimated cost of \$6.7 million.**



Population-based Screening for Vitamin D Deficiency

The overall Waste Index is 29%. **A total of 23,608 wasteful services were delivered, impacting 22,941 individuals at an estimated cost of \$5.9 million.**





We are just starting our search for low-value care. We know that our early results – while a great start and a place to focus specific interventions – are just the tip of the iceberg.

**Find our report “First, Do No Harm”:
www.wacommunitycheckup.org**



Washington State
Health Care Authority

Thank You!

Nancy A. Giunto
Executive Director
Washington Health Alliance

Mich'l Needham
Chief Policy Officer
Health Care Authority

TAB 4



Panel Discussion: Pharmacy Challenges from the Physician Perspective

Emily Transue, MD
Assistant Medical Director
Clinical Quality & Care Transformation Division
January 31, 2019

Physician Bios

Emily Transue, MD

Emily Transue, MD, MHA, FACP, is the Associate Medical Director for the Washington State Health Care Authority (HCA). She received her B.S. from Yale University, M.D. from Dartmouth Medical School, and Master of Health Administration from the University of Washington. She is a general internist who practiced for 15 years as a primary care provider before shifting to roles in leadership and management. She is the author of two books, On Call and Patient by Patient, about the experience of practicing medicine. At the HCA, her role includes clinical leadership of the Employees and Retirees Benefits Division, leading the Quality Management Team, and supporting the work of Healthier Washington and the Medical Transformation Project.



Physician Bios (*cont.*)

Norris Kamo, MD

Norris Kamo is a primary care internist at Virginia Mason Medical Center. He serves as the Department of Primary Care's Director of Quality and Innovation, as well as the Medical Director for Puget Sound High Value Network. He has co-authored peer-reviewed journal articles on quality improvement efforts at Virginia Mason as a fellow at the Center for Health Care Improvement Services. Dr. Kamo underwent medical training at Harvard Medical School and completed an internal medicine residency at Massachusetts General Hospital. He also earned a Master in Public Policy degree from the John F. Kennedy School of Government at Harvard University.



Physician Bios (*cont.*)

Matthew Mulder, MD

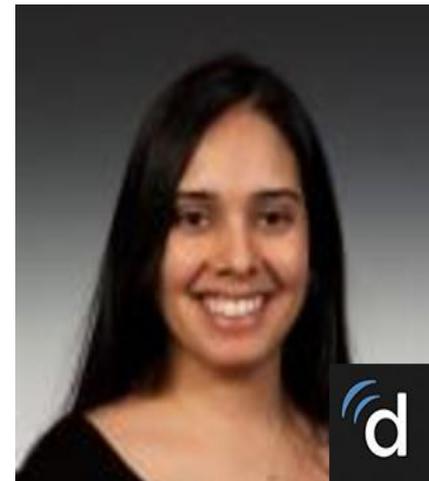
Matthew Mulder, MD, MMM, is a board-certified family medicine physician, and Senior Vice President, Chief Medical Director for Ambulatory Services at UW Medicine/Valley Medical Center, where he provides leadership for over 320 multispecialty providers. He joined UW Medicine/VMC in 2012. Dr. Mulder's background includes experience as a Certified Public Accountant for a Big Six accounting firm, in addition to extensive healthcare administrative and clinical experience in SE Asia. Prior to joining Valley, he was the CMIO for The Everett Clinic. At Valley, he is responsible for the oversight of providers in the Ambulatory System, and is intimately involved in the growth of this network, and assuring its delivery of high quality, patient-centered care.



Physician Bios (*cont.*)

Gurpreet Rawat, MD

Gurpreet Rawat is a rheumatologist at Kaiser Permanente of Washington since 2011 (formerly Group Health). She completed medical school in Canada at the University of Toronto and then did her residency at Legacy Health Systems in Portland, Oregon and Fellowship in Rheumatology at the University of Washington. She is the Pharmacy Medical Director for KP Washington and has been in this position since 2017. She works with the medical group and clinical pharmacy teams to improve quality, affordability, and safety for KP Washington's members.



Physician Bios (*cont.*)

Keith Bachman, MD, FACP

Physician, Department of Internal Medicine

Physician Ambassador, NW Permanente

Northwest Permanente Board Member (2018)

Keith Bachman, MD, is a primary care internist in the Northwest Region practicing in Portland, Oregon since 1998. In addition to his clinical work, he serves as a Permanente Quality Ambassador, connecting the needs of our employer group customers to Kaiser Permanente Care delivery, and is the Medical Director for Kaiser Permanente NW Workforce Health team. In the community, he has served on the Oregon Health Improvement Commission for the Oregon Health Authority and on the Portland Public Schools Wellness Advisory Committee. He has been recognized by his peers as a “Portland Monthly Top Doc” and a NW Permanente Distinguished Physician. Dr. Bachman has clinical interests in weight management and health behavior change, and previously served as Medical Director for the NW Regional Bariatric Surgery Program, and as physician lead for Kaiser Permanente Care Management Institute’s Obesity Prevention and Treatment Program.



Questions?

Emily Transue, MD

Assistant Medical Director

Clinical Quality and Care Transformation

Emily.Transue@hca.wa.gov

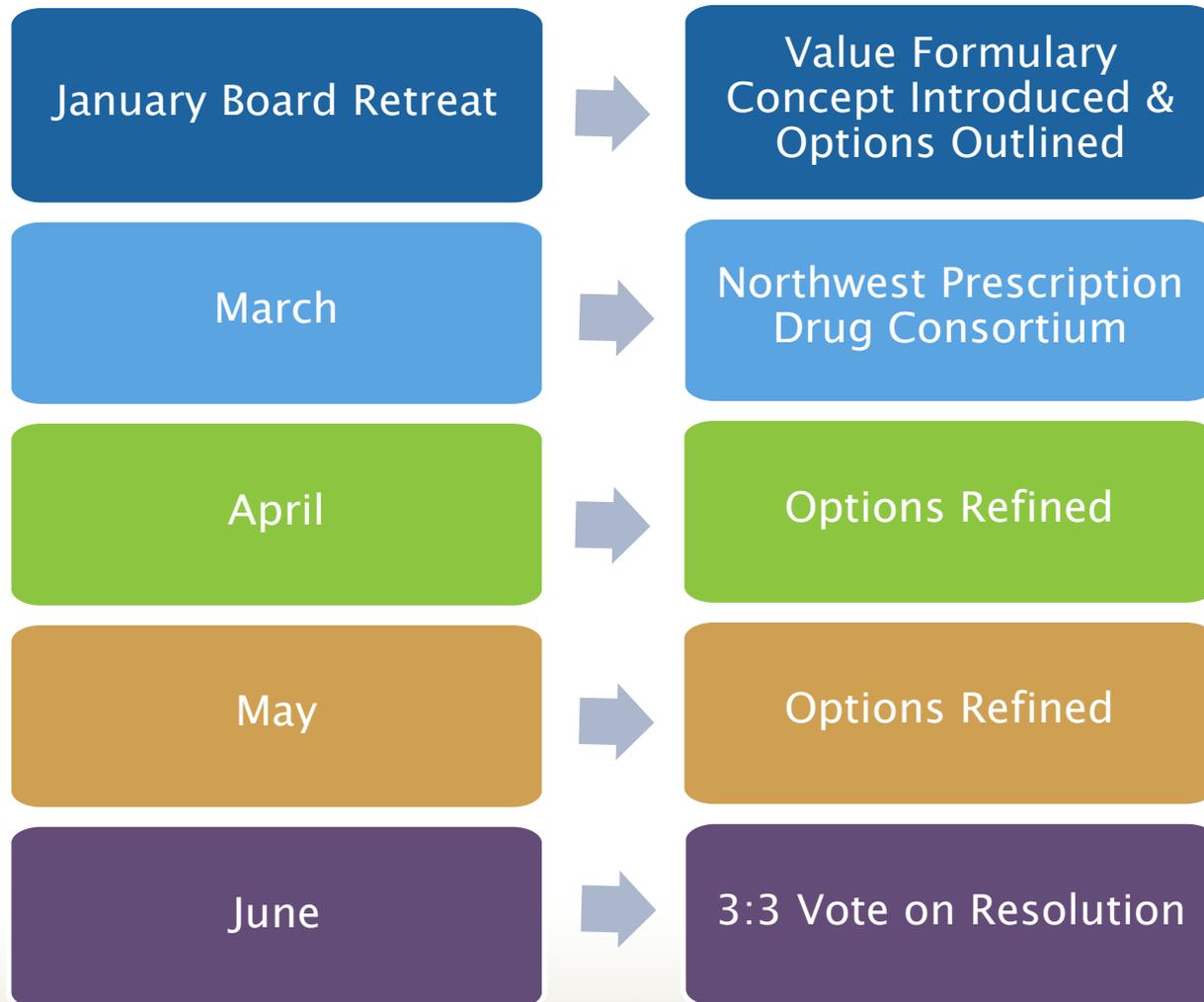
TAB 5



UMP Pharmacy Update

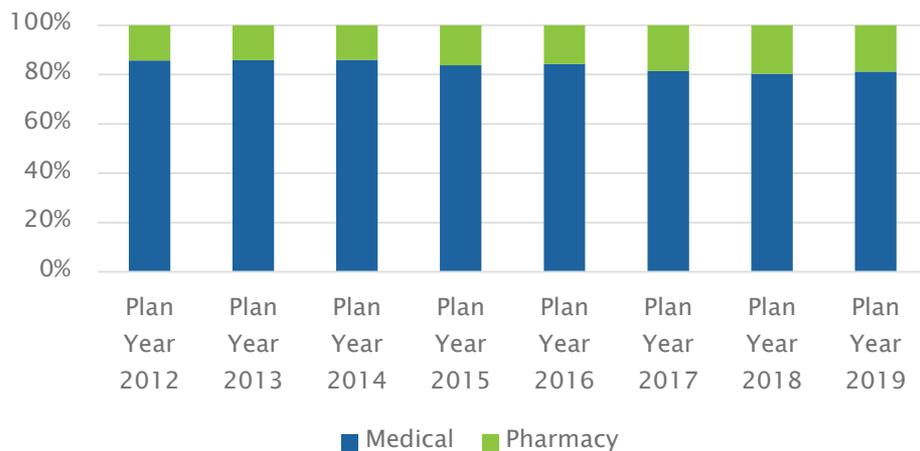
Marcia Peterson, Manager
Benefit, Strategy, and Design Section
Employees and Retirees Benefits Division
January 31, 2019

2018 Value Formulary Journey

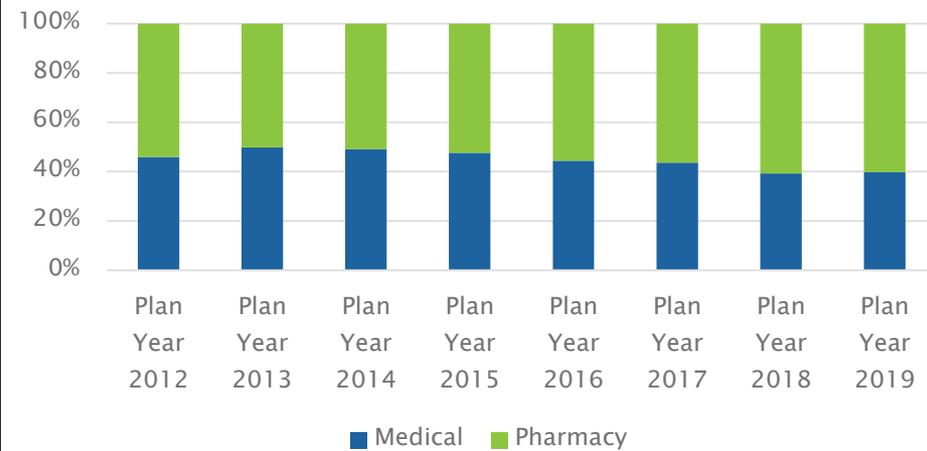


Bid Rates for UMP Plan Medical vs. Pharmacy Costs

UMP Classic non-Medicare



UMP Medicare



Pharmacy costs are growing as a percent of overall premium

2019 Pharmacy Strategies



Procure one or more Medicare Advantage Part D Plans which receive subsidies from CMS to hold down prescription drug costs

Expand the size of Consortium

Educate members on the value of generics and their options

Explore revising and simplifying the tier structure to make it more user friendly

Reconsider the Value Formulary Proposal

Pharmacy Benefit Tiers – PEBB UMP Classic

Tier	Member Coinsurance ¹	Member Out-of-Pocket Max ²
Preventive	No coinsurance or deductible	\$0
Value	5% coinsurance No deductible	\$10
1 (select generics)	10% coinsurance No deductible	\$25
2 (preferred drugs)	30% coinsurance Deductible ³ applies	\$75
3 (non-preferred drugs)	50% coinsurance Deductible applies	Specialty drugs ⁴ only—\$150 No cost limit for non-specialty drugs

1. All network pharmacies retail & mail order
2. Network pharmacies only; Maximum Out-of-Pocket (MOOP) reflects 30-day supply; total MOOP is \$2,000 per person per year
3. UMP Annual Prescription Drug Deductible is \$100 per person
4. Filled through UMP's specialty pharmacy, Ardon Health

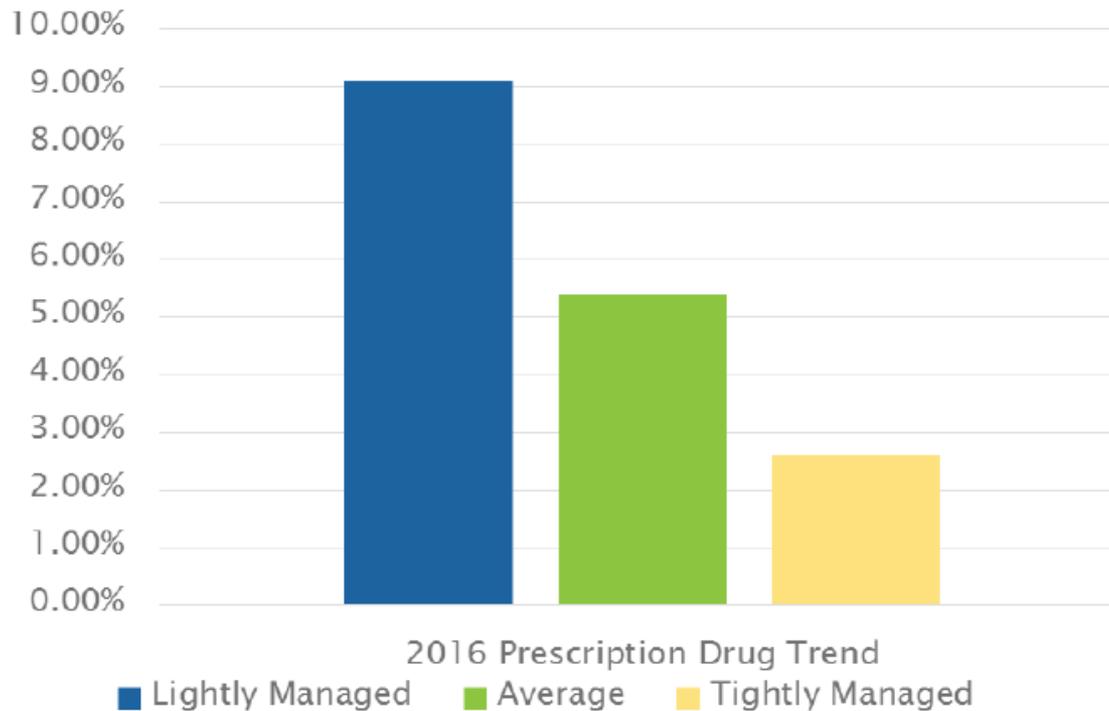
Value Formulary

Purpose: Establish a formulary in order to manage our pharmacy spend

Principles guiding the design

- Ensure fairness and equity among members
- Contain future cost increases by moving toward a value-based design
- Minimize inconvenience to members
- Focus on drugs with cost savings
- Don't spend more than you save in administration of the benefit

Tightly managed plans can help to hold down spending increases



Total drug spend for tightly managed plans at Express Scripts had a significantly lower trend than lesser managed plans

Source: Express Scripts. 2016 Drug Trend Report.
Express Scripts Holding Company. February 2017.

Policy Resolution PEBB 2018 – 01 Value Formulary

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

- a select mix of drugs within a drug class that are covered only when medically necessary and all preferred products have been ineffective or are not clinically appropriate, and
- multi-source brand drugs being covered only when medically necessary and clinically appropriate, and

7

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

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

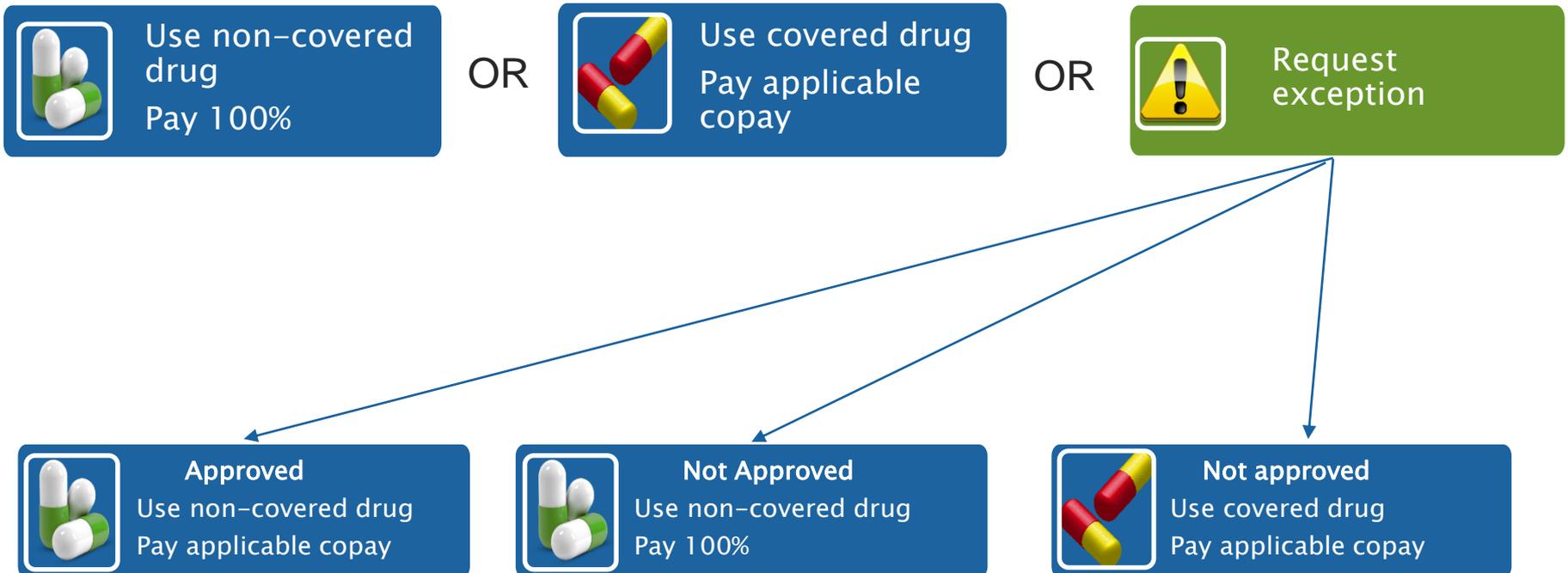
8

Tim's amendment:

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

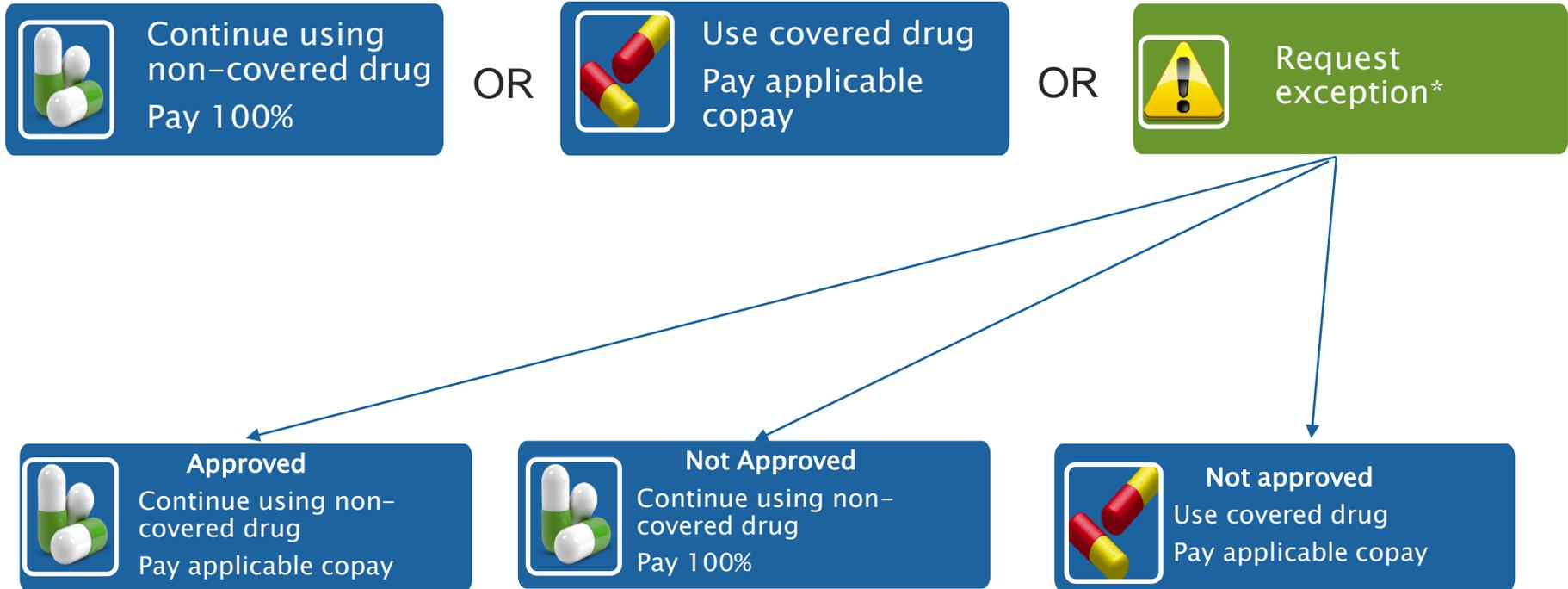


Member is newly prescribed a non-covered drug





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



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

Protected Drug Classes

- Antipsychotics
- Antidepressants
- Antiepileptics
- Chemotherapy
- Antiretrovirals
- Immunosuppressives
- Immunomodulatory/antiviral treatment for Hepatitis C

Discussion

- If this is to be implemented, are there additional changes to the Resolution that you feel should be made?
- Is there additional information that the Board needs?

Questions?

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

Marcia.peterson@hca.wa.gov

Tel: 360.725.1327

TAB 6



2019 Open Enrollment Summary

Renee Bourbeau, Manager
Benefits Accounts Section
Employees and Retirees Benefits Division
January 31, 2018

Open Enrollment Extension

- Technical difficulties with *My Account* server on the last day of open enrollment.
- Subscribers could not log in for a couple of hours after the close of the workday on November 30.
- Extended open enrollment by 72 hours.
- Provided alert to agencies via GovDelivery messaging and FAQs to Customer Service.
- Open enrollment changes accepted via *My Account* and forms through extension.
- Lower call volume on the 1-800 retiree line, and less inquiries from agencies, post open enrollment.

Open Enrollment Engagement

Benefits Fairs and Messaging

- 23 benefits fairs conducted across the state.
 - 8 benefits fairs in eastern Washington
 - 14 benefits fairs in western Washington
- Approximately 2,200 attendees at these fairs.
- Health plans and vendors participated at the benefits fairs.
- Eight GovDelivery email messages distributed to employees' personnel, payroll, and benefits offices at Open Enrollment.

My Account

- Access from www.hca.wa.gov/my-account.
- Use of *My Account* for open enrollment change rather than paper form.
- For 2017: 79.4% changes made online out of 8,700 plan changes.
- For 2018: 86.4% changes made online out of 10,811 plan changes.
- For 2019: 86.1% changes made online out of 8,187 plan changes.

Home > Employee and retiree benefits > Public employees

Employee and retiree benefits

My Account

Forms & publications News Wellness PEB Board SEB Board Rules & policies Contact

Public employees

- > [Retiree Coverage Election Form \(form A\) tutorial](#)
- > [School employees FAQs](#)
- > [Choosing the best medical plan \(video\)](#)



Open Enrollment Engagement

E-Subscription

Increased E-subscription:

- 2015: 22% subscribers signed up (42,781 subscribers/out of 193,188)
- 2016: 28% subscribers signed up (55,785 subscribers/out of 199,068)
- 2017: 29% subscribers signed up (58,862 subscribers/out of 203,851)
- 2018: 32% subscribers signed up (66,939 subscribers/out of 208,856)



[PEBB Home](#)
[About HCA](#)
[Contact PEBB](#)
[Login](#)

PEBB/My Account login

Log into My Account to view your coverage and premium surcharge information, get your statement of insurance, and make open enrollment changes. To learn more about working with My Account, visit our [Help with My Account](#) webpage.

Returning member login

Email Address

Password

[Log into My Account](#)

[Forgot Email?](#) [Forgot Password?](#)

New to My Account? [Register now](#)

Actions you can take using My Account year-round

- View your medical and dental coverage information
- View your basic employer-paid life and AD&D insurance information (employees only)
- View your long-term disability insurance information (employees only)
- Download your statement of insurance
- View your premium surcharge attestations (if applicable)
- Make changes to your tobacco use premium surcharge attestation (if applicable)

**Actions you can take during open enrollment (November 1-30)
(some restrictions may apply)**

- Make changes to your medical and dental coverage
- Attest to the spouse or state-registered domestic partner coverage premium surcharge
- Remove medical and/or dental for dependents
- Waive coverage for yourself (employees only)

PEBB Program Enrollment Changes 2018-2019

Employees and Non-Medicare Retirees

Carrier	2018	2019	Change	% Change	% of Members
Kaiser NW CDHP	462	506	44	9.5%	0.2%
Kaiser NW Classic	3,408	3,341	-67	-2.0%	1.2%
Kaiser WA CDHP	4,973	4,928	-45	-0.9%	1.7%
Kaiser WA Classic	27,358	25,852	-1,506	-5.5%	9.1%
Kaiser WA Sound Choice	2,922	4,891	1,969	67.4%	1.7%
Kaiser WA Value	43,592	39,922	-3,670	-8.4%	14.0%
UMP Plus Puget Sound High Value Network	8,545	10,532	1,987	23.3%	3.7%
UMP Plus UW Medicine Accountable Care Network	17,172	20,372	3,200	18.6%	7.1%
Uniform Medical Plan CDHP	19,536	20,682	1,146	5.9%	7.2%
Uniform Medical Plan Classic	157,566	154,399	-3,167	-2.0%	54.1%
Total Members	285,534	285,425	-109	0.0%	100.0%

Medicare Retirees

Carrier	2018	2019	Change	% Change	% of Members
Kaiser NW Classic	2,472	2,502	30	1.2%	2.6%
Kaiser WA Classic	491	469	-22	-4.5%	0.5%
Kaiser WA Medicare	22,708	23,431	723	3.2%	24.3%
Kaiser WA Sound Choice	26	37	11	42.3%	0.0%
Kaiser WA Value	423	407	-16	-3.8%	0.4%
Premera Blue Cross Medicare Supplement F	13,701	15,795	2,094	15.3%	16.4%
Uniform Medical Plan Classic	53,020	53,884	864	1.6%	55.8%
Total Members	92,841	96,525	3,684	4.0%	100.0%

Customer Service Strategies

- Revised enrollment forms.
- Self-service online interactive tutorial.
 - Step-by-step instructions on completing the Retiree Coverage Election form.
 - Direct links to more information from the tutorial.
 - Great tool for members.
 - Available 24/7, no wait time, works at the retiree's pace.
 - Alternative to calling the 1-800 line.
 - Contributed to a lower call volume at open enrollment.

Customer Service Strategies (*cont.*)

Pre-Open Enrollment Activities:

- Four additional staff in 2018.
- Devoted more time to document processing.
- Increased phone queue size.
- Revised internal training process.
- Created a new trainee phone menu line.

Open Enrollment (November 1-December 3, 2018):

- Seven fully trained staff/nine staff in training.
- Put rolling messages on the main phone menu.
- Scheduled trainees to answer general questions.
- Scheduled trainees to process open enrollment forms.
- Scheduled October hired trainees to process returned mail.

Customer Service Strategies (*cont.*)

New strategies we are considering:

- Simplify phone messaging.
- Update Frequently Asked Questions on phone menu.
- Update internal staff training.
- Revise the online tutorial on how to complete the open enrollment form.

2017-2018 Comparison

1-800 Line and Documents Received

	2017	2018
Calls Received	18,790	8,652
Calls Answered	4,217	5,325
Wait Time Average	25 minutes and 15 seconds	24 minutes and 44 seconds
Callback Feature Utilized by Caller	969	882
Open Enrollment Forms Received	1,651	1,600

Questions?

Renee Bourbeau, Manager
Benefits Accounts Section
Employees and Retirees Benefits Division

Renee.bourbeau@hca.wa.gov

Tel: 360-725-0823

TAB 7

Disability Benefits

Cade Walker, Executive Special Assistant
Health Care Authority

Nick Streuli, Legislative and Executive Operations Director
Employment Security Department

Kisha Turner, Senior National Accounts Underwriter
Jared Benedetti, Consulting Actuary
Dave Tappan, Employee Benefits Manager
The Standard

January 31, 2019

AGENDA

- Brief overview of disability insurance – Cade
- Paid Family & Medical Leave Program – Nick
- Trends in employer-sponsored disability benefits – The Standard
- Panel Discussion - All

What is Disability Insurance?

- Disability Insurance is used to replace an employee's income when they become disabled and can no longer work in their usual job.
- Disability insurance replaces a portion of an employee's gross monthly income.
 - Under the PEBB Program, the basic benefit is taxable and the optional benefit is non-taxable.

What is the definition of disability?

Disability Insurance Industry Definition: A disability means being unable to perform with reasonable continuity the duties *of your job* as a result of sickness, injury, or pregnancy during the benefit waiting period and the first 24 months for which disability benefits are payable.

Social Security Administration Definition: A disability is the inability to engage in *any substantial gainful activity* by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Employer-Paid Disability Plan Design Components

- All disability insurance products have several components that affect the value of the product and its cost. They are:
 - Benefit Waiting Period (BWP) which is the length of time between the beginning of a disability claim and the first payment a member would receive.
 - The value of the maximum monthly payment.
 - Choice or No Choice options for both pension and sick leave.

***Choice** option allows a member to choose to receive payment from their employer for either sick leave or pension. If a member chooses to receive the benefit it is deducted from their disability payment.*

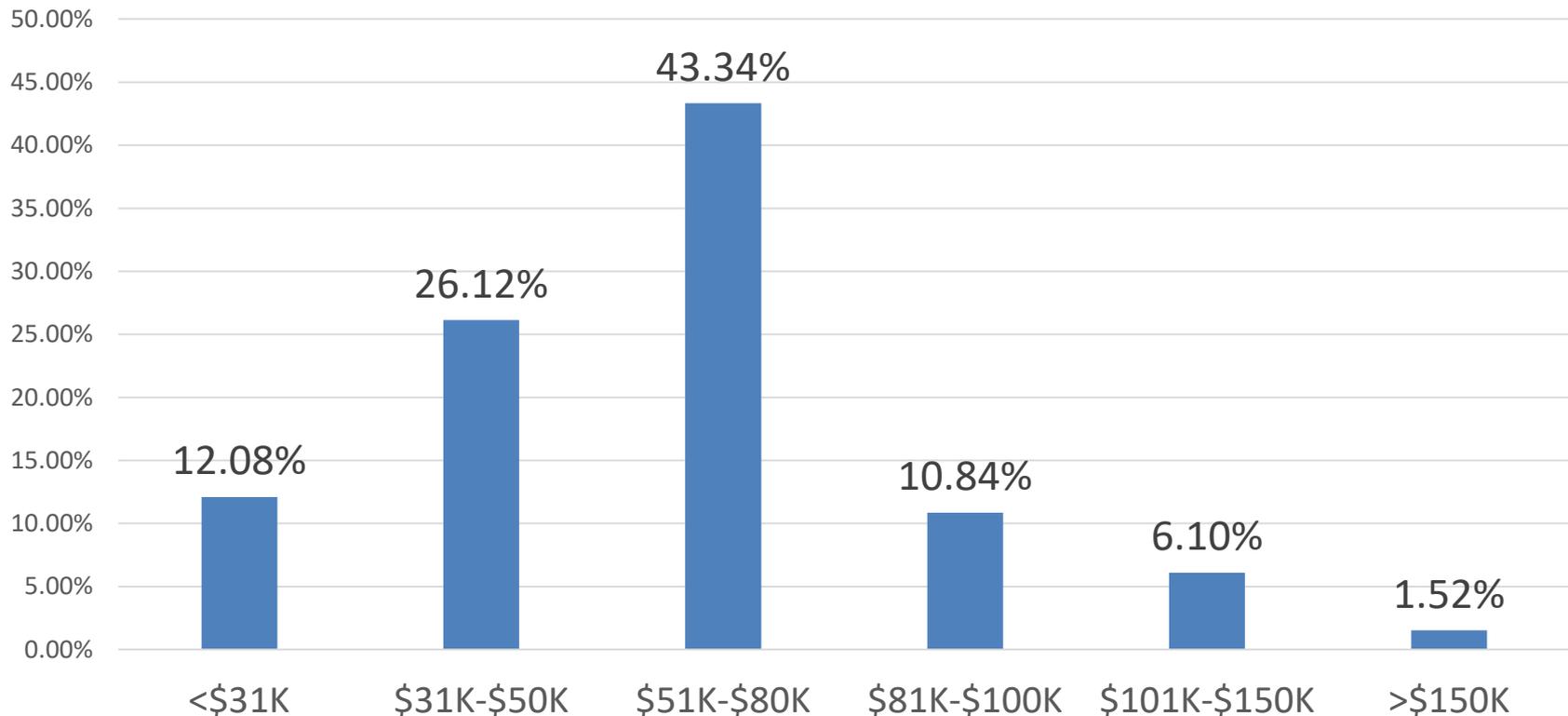
***No Choice** option deducts either sick leave or pension from the disability payment whether or not the member receives that benefit.*

PEBB Program's Disability Benefit - 2019

- The basic LTD benefit is a maximum of \$240/month
- Supplemental LTD benefit:
 - Special Open Enrollment: March 1 - 31, 2019
 - Retiring 30/60 day plan the end of 2019

PEBB Program Member Income

State Employee Salary Range



Data provided by OFM from their 2017 – 2019 Budget Data.

Employer-Paid Basic LTD Plan Design

PEBB								
EMPLOYER-PAID BASIC LONG-TERM DISABILITY								
Base Waiting Period	Later of 90 days or End of Paid Family and Medical Leave							
Pension Offset	Choice							
Sick Leave offset	No Choice							
Maximum Monthly Benefit	\$240	\$417	\$554	\$704	\$874	\$1,053	\$1,224	\$1,408
	60% of \$400	60% of \$695	60% of \$923	60% of \$1,173	60% of \$1,457	60% of \$1,755	60% of \$2,040	60% of \$2,374
PSPM* Cost	Current PEBB	+\$1.00 PSPM	+\$2.00 PSPM	+\$3.00 PSPM	+\$4.00 PSPM	+\$5.00 PSPM	+\$6.00 PSPM	+\$7.00 PSPM
Annual Cost	~\$3.5M	~\$5.1M	~\$6.7M	~\$8.4M	~\$10.1M	~\$11.7M	~\$13.4M	~\$15.0M

*PSPM = Per Subscriber Per Month

Washington Paid Family & Medical Leave



Nick Streuli
Legislative and Executive Operations Director



Why Paid Family and Medical Leave



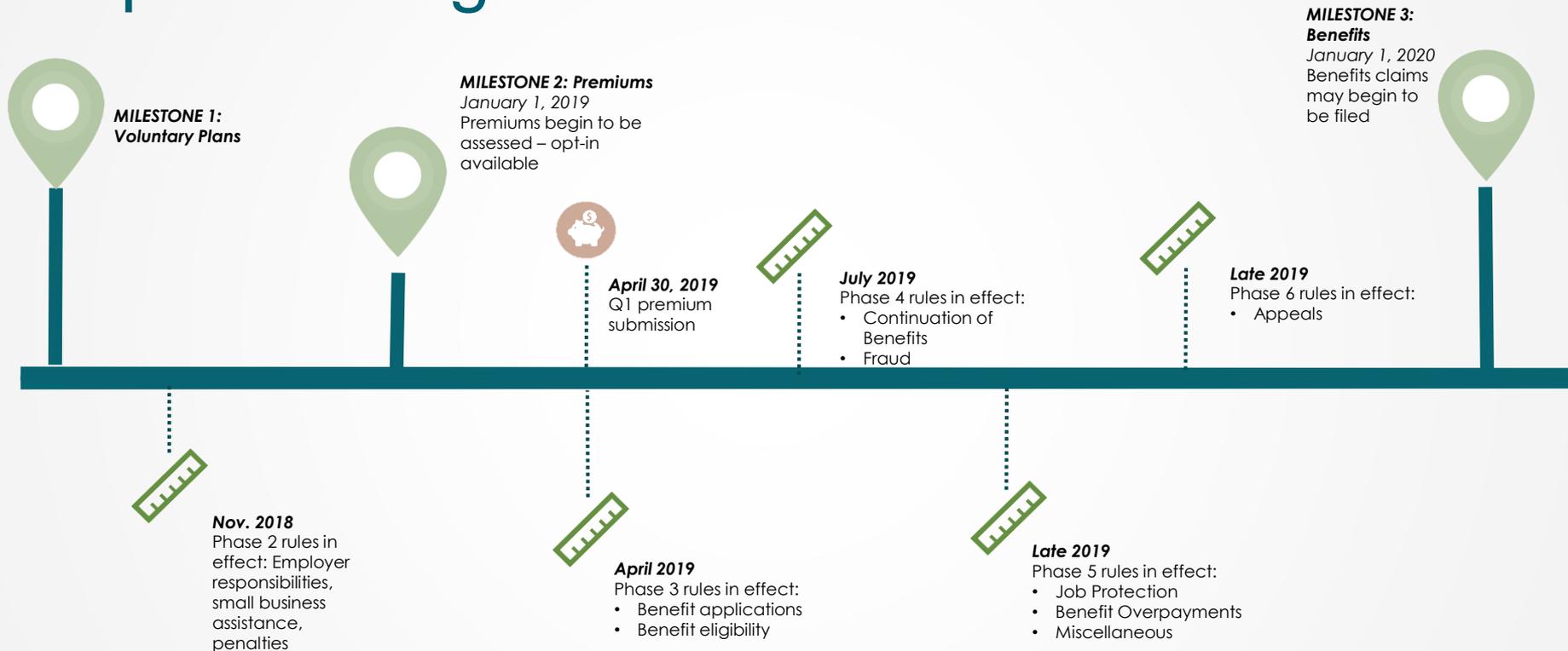
- ✓ An essential benefit that gives eligible Washingtonians support when they need it most.
- ✓ Strengthens companies of every size by making it possible to give every employee a way to be there for care.
- ✓ Share the costs associated with leave among employers and workers.

Who Does This Apply To?



3.5 million
workers &
240k employers

Implementing in Phases



This timeline is an approximate timeframe for the implementation of the Paid Family and Medical Leave.

Paid Family and Medical Leave

Family Leave



Caring for family members



Birth or placement of a child



Certain military-related events

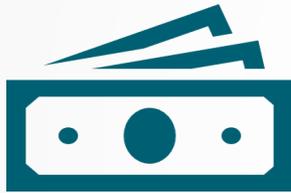
Medical Leave



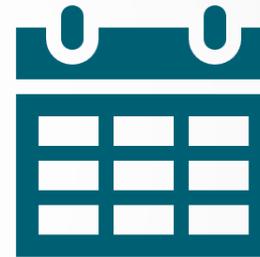
Your own medical condition

Be there for care.

Benefits



Weekly wage replacement
Proportion of weekly wages
from \$100 to \$1,000



Typical leave of up to 12 weeks,
18 weeks in exceptional
circumstances.

Benefit Examples

Weekly Wage Weekly Benefit

\$400	▶	\$360
\$700	▶	\$647
\$900	▶	\$747
\$1800	▶	\$1000

Your exact benefit is determined by your earned wages, the state median income, and other factors.

Eligibility



820 Hours

worked during the qualifying period.

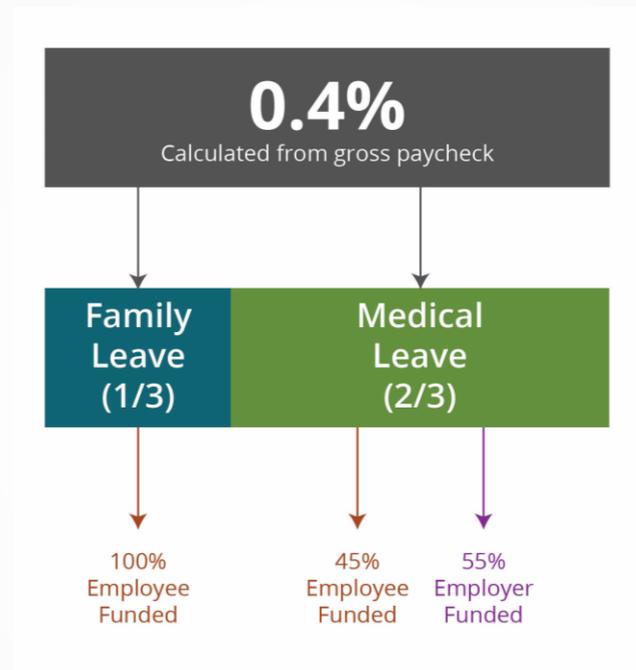
Portable across employers.

20 Hours/week -> 41 Weeks

40 Hours/week -> 20.5 Weeks

Qualifying period is the first four of the last five completed calendar quarters from the leave date.

Premiums



\$50,000/year wage \Rightarrow Employee: \$126.67/year • Employer: \$73.33/year
Small businesses with fewer than 50 employees don't pay employer premium.
Still required to remit employee portion of premium and all reporting requirements

Continue the Conversation



Our Website:
paidleave.wa.gov



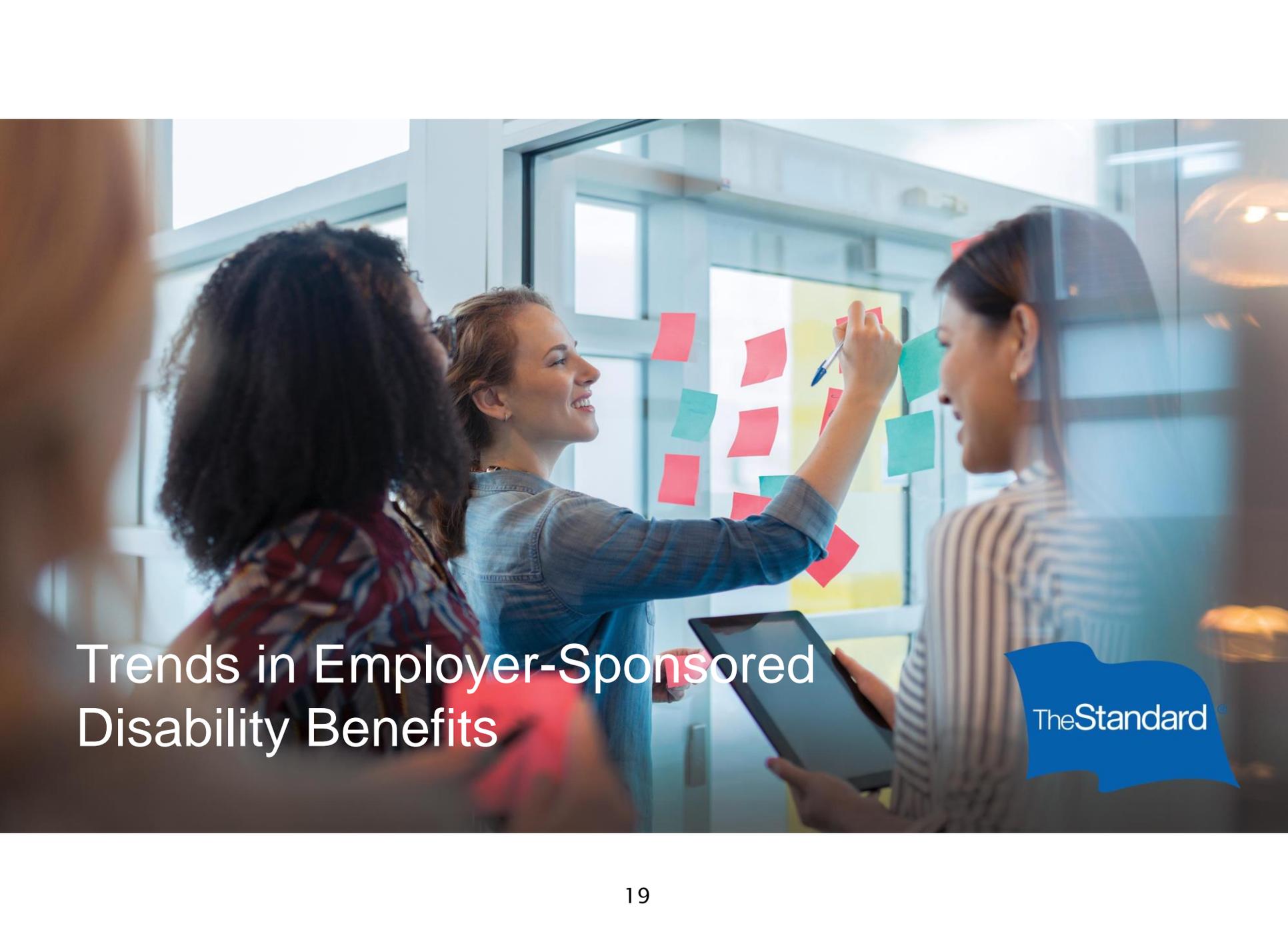
Follow us:
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Sign up for Newsletter:
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Public Comment Forum:
bit.ly/CommentForum

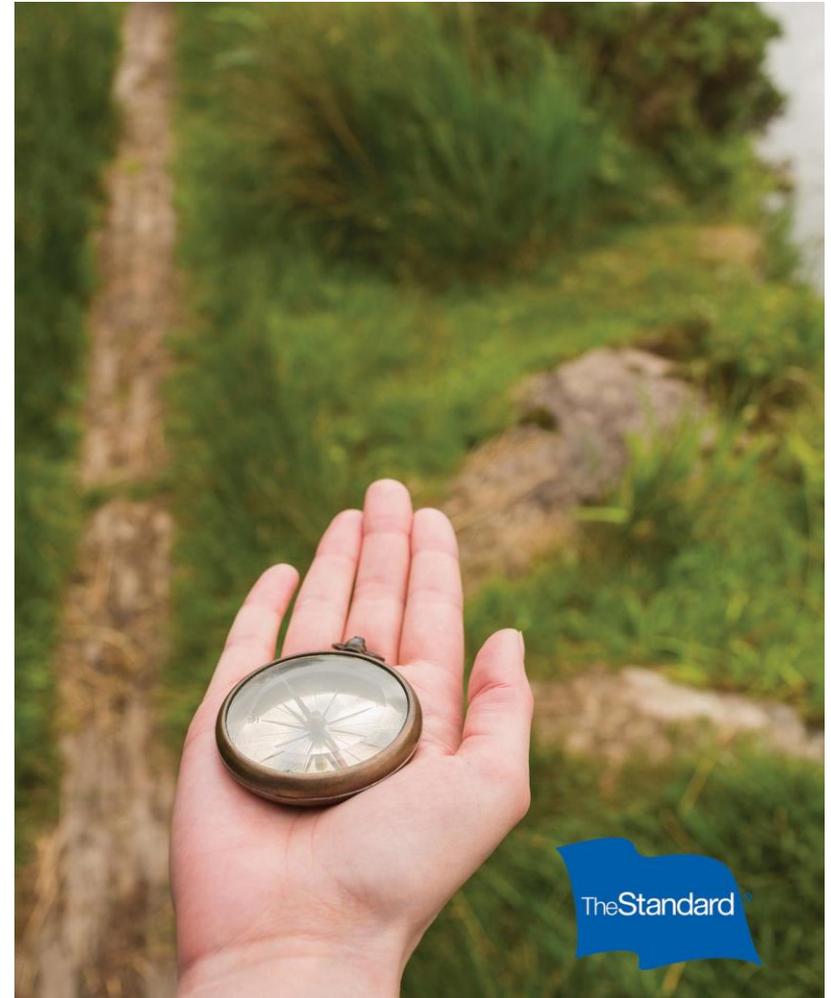
A photograph of three women in a modern office setting. They are gathered around a glass wall covered with colorful sticky notes (red, green, yellow). One woman in the center is pointing at a note with a blue pen. Another woman on the right is holding a tablet. The scene is brightly lit, suggesting a collaborative work environment.

Trends in Employer-Sponsored Disability Benefits

TheStandard®

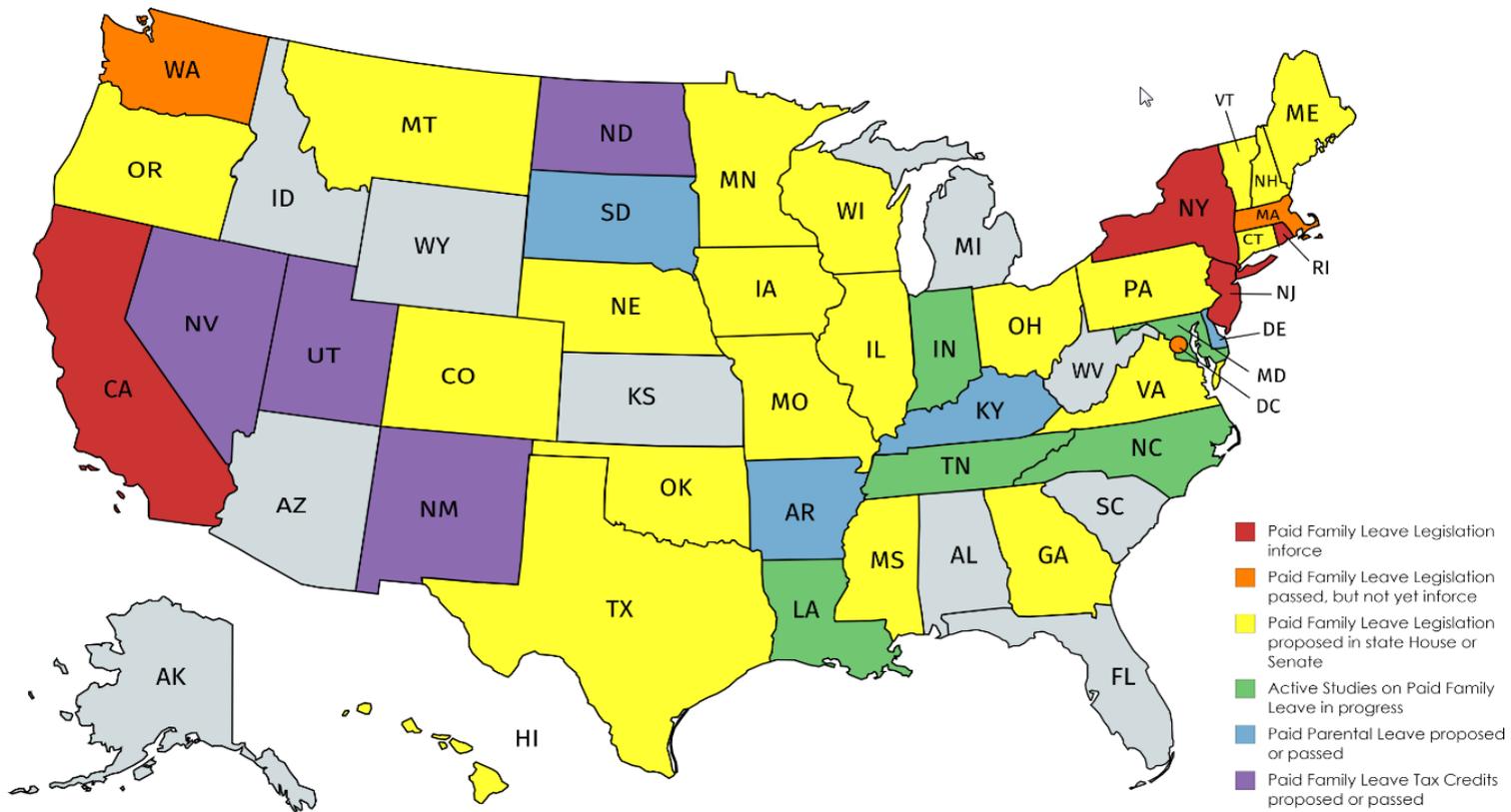
Agenda

- Industry Trends – PFML
- Public Employer Plan Designs – Benchmarking
- State/Schools Plan Designs
- State/Schools and Long Term Disability risk differences



Group Long Term Disability Trends

Paid Family (and Medical) Leave – A Major Disruptor



Paid Family and Medical Leave

- Depending on income replaced and duration of benefits, Short Term Disability will be redundant and therefore Short Term Disability plans will be eliminated.
- Long Term Disability plans should be amended to have the Benefit Waiting Period (BWP) align with the duration of PFML.
- Depending on the richness of income replacement, PFML will most likely increase LTD costs.
 - It is well known in the Group LTD industry that higher income replacement prior to LTD taking effect leads to higher LTD costs.
 - Most carriers load their LTD rates if they write Short Term Disability in front.

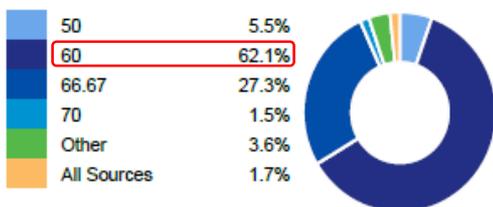
Paid Family and Medical Leave

- Still too early to tell how much PFML will increase LTD costs.
 - How rich is the PFML?
 - Different claims administrators versus same administrator?
 - Did the group have Short Term Disability in front of LTD in the past?

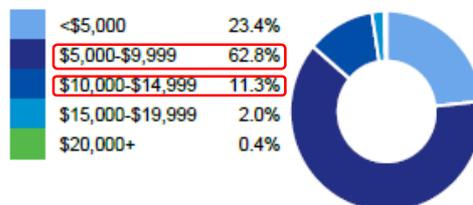
Plan Design Benchmarking Report – Public Employers

Here's an analysis of LTD plan design across our in-force public administration groups:

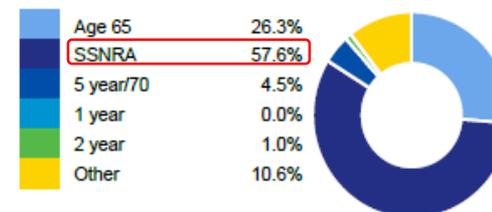
Benefit Percentage



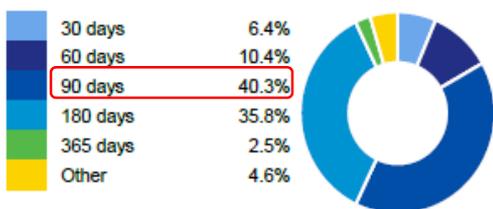
Maximum Benefit



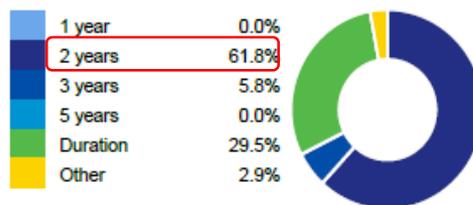
Maximum Benefit Period



Benefit Waiting Period



Own Occupation Period



Employer Contribution



State Long Term Disability Plan Designs

State	Funding	Benefit %	Benefit Waiting Period (Days)	Monthly Maximum	Maximum Duration	Fully Covered Annual Earnings
Washington	Shared	60%	30 to 360	\$6,000	SSNRA	\$4,800 \$120,000
Oregon	Voluntary	60% or 66 2/3%	90 or 180	\$8,000	To Age 65	\$144,000
Idaho	Employer	60%	180	\$4,000	To Age 70	\$80,000
Nevada	Employer	60%	180	\$7,500	To Age 65	\$150,000
Montana	Voluntary	60%	180	\$9,200	To Age 65	\$184,000
Utah	Employer	66 2/3%	90	None	To Age 65	N/A
New Mexico	Voluntary	40%	180	\$2,000	2 years	\$60,000

*Information from public websites



School Long Term Disability Plan Designs

State	Funding	Benefit %	Benefit Waiting Period (Days)	Monthly Maximum	Maximum Duration	Fully Covered Annual Earnings
Washington	Shared	60%	90	\$10,000	SSNRA	\$200,000
Oregon	Varies	<ul style="list-style-type: none"> • Through Oregon Educators Benefit Board (OEBB) • Districts choose between various plans and funding options (ER and EE) 				
Idaho	Benefits at District Level					
Nevada	Benefits at District Level					
Montana	Benefits at District Level					
Utah	Benefits at District Level					
New Mexico	Voluntary	66 2/3%	30/60/90	\$5,000	SSNRA	\$90,000

*Information from public websites



Long Term Disability Risk

For the PEBB Program, the following are the highest LTD claim occupations:

Occupation	% of Claims
Hospital/Health Services	12.4%
Correction Officers	9.1%
Nurses	8.0%

Long Term Disability Risk

States vs. Schools

- Occupational risks are very different between states and schools.
 - Schools tend to be more white collar and with less physically demanding occupations.
 - Teachers have advanced degrees, making it easier to return them to work in alternative occupations.
- Through our actuarial rate studies and review of our competitors' rate filings, most price states between 30-100% higher for LTD cost
 - These can vary based on pension disability benefit offsets and other factors.



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Questions?

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TAB 8



The Empowered Consumer and Personal Health Technology

Molly Christie & Matthew Toney
Strategic Plan Project Managers
ERB Benefits Strategy and Design Section
January 31, 2019

“Patients are taking a greater interest in their care and are **more willing to self-manage** ... Leveraging available health information, **new technology, and mobile health (mHealth)**, the empowered consumer knows more, wants more, and is able to do more for themselves.”

PwC Global, “The empowered consumer”

“Consumerism in health care can be defined as the **personalization of care** to facilitate health outcomes.”

New England Journal of Medicine Catalyst. “Consumerism in Health Care.” 2018

“For health systems, consumerism is the shift from a provider-centered way of doing business to a business model based on the **election of services by end users.**”

Advisory Board. “So you’re bought into the idea of consumerism. Now what?” 2016

And health care CEOs say consumerism will become a bigger part of their strategic plan in years to come.

In a recent *Modern Healthcare* CEO Power Panel Survey:

- 83% of respondents said at least ¼ of their strategic plan currently includes consumerism
- 75% said they expect more than half will focus on consumerism within the next 3-5 years

Source: Advisory Board. "How Stanford Health, Allina Health, and others are embracing the rise of consumerism." 6/13/18.

Americans increasingly think health care organizations should aspire to be like...



amazon

Walmart 

Google

Specifically, more people are looking for ***personalized and convenient*** services available in other sectors, such as digital solutions for:

Provider
search and
scheduling

Health
records and
personal
health
tracking

Price
estimation
and bill pay

Prescription
orders/
refills

Sources:

McKinsey & Company 2017 Consumer Health Insights Survey

Sahadevan, Robert. "Consumerism in Health Care."

New England Journal of Medicine Catalyst. 1/11/18.

The Personal Health Tech Market



Health and Wellness Apps

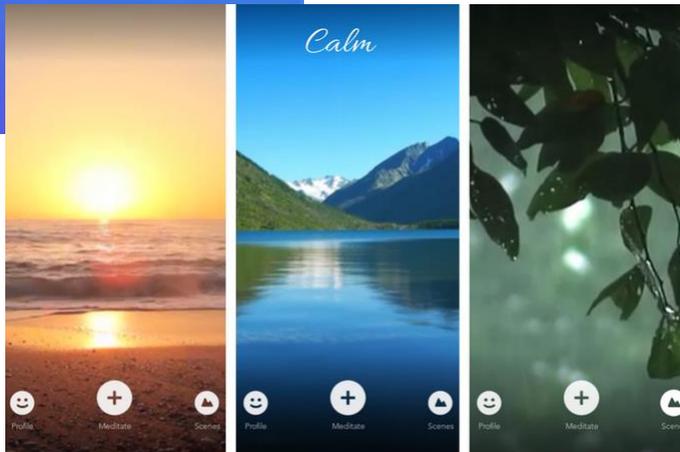
- Mobile applications supported by smartphones, tablets, computers, and communication devices
- Convey health and fitness related information to users through technological interface
- Address a variety of health goals and needs (weight loss, physical performance, nutrition, pharmacy, stress reduction, etc.)



Health and Wellness Apps Examples



- Relaxation and meditation app
- Geared to **reduce stress**, encourage mindfulness, and improve sleep quality



Health and Wellness Apps

Examples (*cont.*)



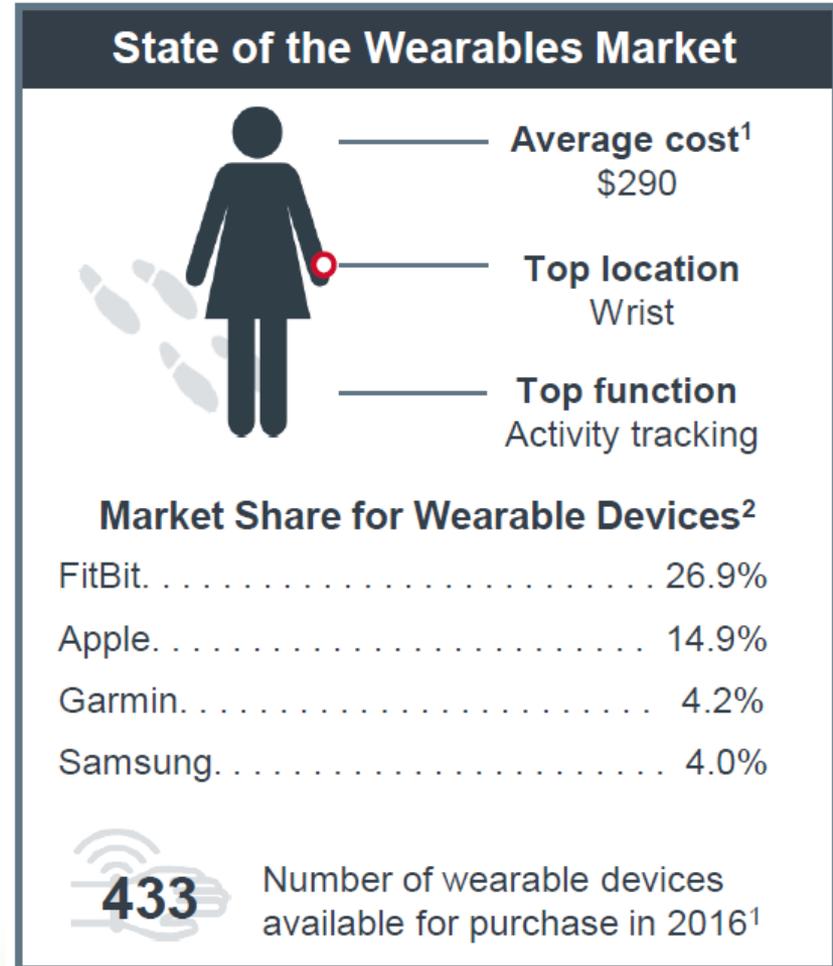
- Sobriety app
- Social platform where consumers can find support from other sober users in their geographical area

Wearables & Ingestibles

- Devices that are usually Wi-Fi enabled that track health and activity data (**biometrics**)
- Different products collect user information from being worn on the body, implanted, or ingested



Source: Advisory Board. "Telehealth Primer Wearables." 5/16.



Wearables & Ingestibles Examples



- Wearable **fitness trackers** (activity bands, fitness watches, or clip-on trackers) that focus on heart rate monitoring, daily steps, sports tracking, stress, sleep, and nutrition

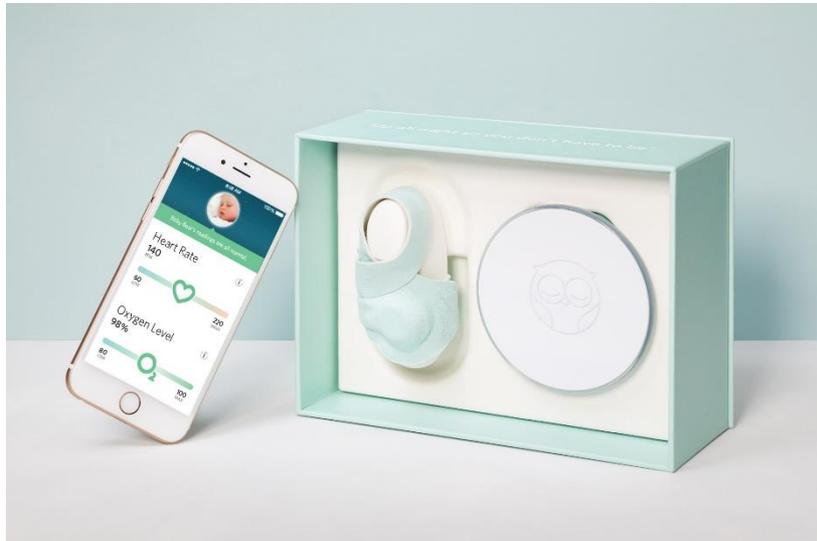


Wearables & Ingestibles Examples (*cont.*)



- Portable electrocardiogram (EKG) with mobile application to read results
- Detects atrial fibrillation (AFIB), irregular and rapid heartbeat, within 30 seconds

Wearables & Ingestibles Examples (*cont.*)



- Wearable **baby monitoring** to track infant heart rate and oxygen levels
- Digital camera with a magnetic base feeds real-time video and audio to mobile app

Wearables & Ingestibles Examples (*cont.*)

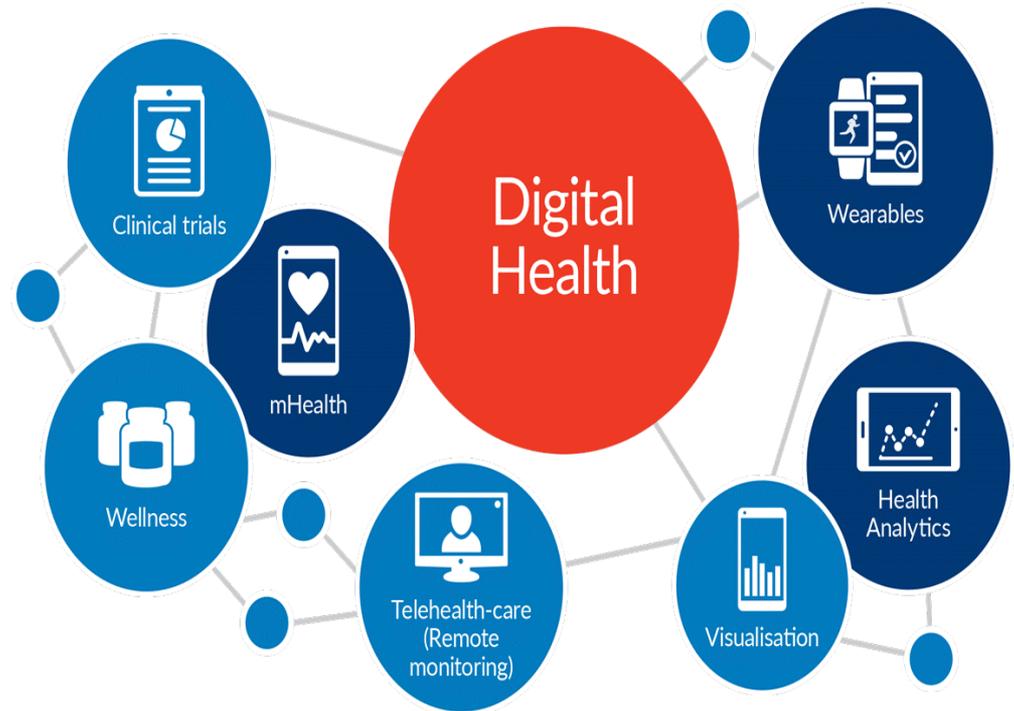


proteus[®]
DIGITAL HEALTH

- FDA-approved ingestible sensors that feed real-time data to physicians for **medication compliance**
- Also includes a wearable sensor patch, mobile app, and a digital provider portal

Virtual Health Clinics

- **Direct-to-consumer virtual clinics** with real-time access to providers by text, phone, and/or video
- Usually no in-person source of care; clinicians work remotely
- May address a variety of health issues/conditions, including chronic care management, primary care, and women's health



Virtual Health Clinics Examples

98point6

- Mobile application that connects patients to primary care physicians through text-based communication

Virtual Health Clinics Examples (*cont.*)



- Virtual health clinic for **women's health and family care**
- Patients can video chat with a range of providers (OB-GYN, Mental Health, Nutritionist, Pediatricians, Midwifery, PT, and relationship coaching)

Trends in the Personal Health Tech Market

“The global connected health and wellness devices market expected to reach **\$612 billion** by 2024.”

Grand View Research, Connected Health and Wellness Market Analysis 2016

“The global mobile health app market is projected to be valued at **\$28 billion** in 2018 and is expected to reach up to **\$102 billion** by 2023.”

IQVIA The Growing of Digital Health 2017

Future Considerations in the Personal Health Tech Market

- Privacy and Security
- Attrition Rates
- Overmedicalization
 - Unnecessary Utilization
 - Selection Bias

“The problem I’ve had with some patients is that they are **constantly sending you data**. In the extreme cases, you have to tell them you’re not going to look at it any more because they don’t have any problems.”

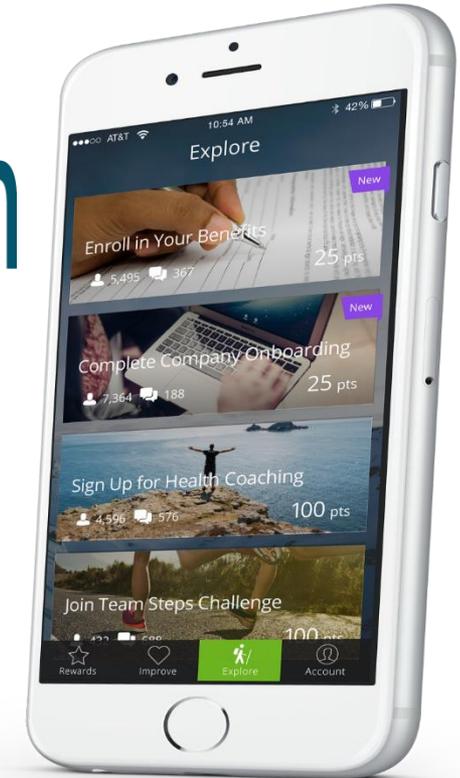
Dr. Ann Curtis STAT At a Glitzy Vegas Tech Show, Chronic Disease Gadgets Take Center Stage 2019

What is the PEBB Program Currently Doing?



Smart [Heart] Health

omada



2020 Regence Contract and Beyond...



Service	What is It?
Baby Wise Maternity Management with Due Date Plus	A maternity management program that tracks a members' pregnancy through key milestones and connects members directly with their pregnancy care team through the mobile app Due Date Plus
Advice24 (Nurseline)	24/7 nurse hotline to assess symptoms, health information and advise UMP members

Kaiser Permanente WA & NW



KAISER
PERMANENTE®

Service	What is It?
KP Mobile Application	In-app email messaging to providers , appointment scheduling, pharmacy management, etc.
Care Chat (WA)	Text SMS based messaging to KP clinical care team 7 days a week 8 a.m. to 10 p.m.
24-Hour Advice Nurse Hotline (WA & NW)	24/7 nurse hotline for advise and symptom assessment to KP members

Questions?

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TAB 9



Emerging Medications Update

Ryan Pistoiresi, PharmD, MS
Assistant Chief Pharmacy Officer
Clinical Quality and Care Transformation
January 31, 2019

Presentation Overview

- **Orilissa (elagolix)**
 - ▶ Moderate to severe pain associated with endometriosis, an inflammatory disease of endometrial cells outside the uterine cavity
- **Lutathera (lutetium La 177)**
 - ▶ somatostatin receptor-positive GEP-NET, a type of cancer found in the stomach, intestines, or pancreas
- **Palynziq (pegvaliase-pqpz)**
 - ▶ Blood phenylalanine concentrations in adults with phenylketonuria (PKU), a disease where patients are unable to break down phenylalanine
- **Andexxa (andexanet alfa)**
 - ▶ Reversal of anticoagulation effects for patients using apixaban or rivaroxaban
- **Jynarque (tolvaptan)**
 - ▶ Slows kidney decline in autosomal dominant polycystic kidney disease (ADPKD), a genetic disorder of the kidneys
- **Epidiolex (cannabidiol)**
 - ▶ Lennox-Gastaut syndrome or Dravet Syndrome, pediatric seizure disorders
- **Onpattro (patisiran) & Tegsedi (inotersen)**
 - ▶ Polyneuropathy with hereditary transthyretin-mediated amyloidosis, genetic disorder with protein deposits

Orilissa (elagolix)

- Orilissa (elagolix) was approved by the FDA on July 23, 2018
 - Indicated for the management of moderate to severe pain associated with endometriosis
- First medication to be approved for endometriosis in over 10 years
- Clinical guidelines recommend oral contraceptives, non-steroidal anti-inflammatory (NSAID) agent, and gonadotropin-releasing hormone agonists as first-line treatment for endometriosis
 - In Phase III trials for menstrual bleeding related to uterine fibroids

Orilissa (elagolix) (*cont.*)

- We anticipate that around 1% of women between 18 to 50 have endometriosis and that 6 to 9 members may request this over the next 12 months
- The list price for 30 days of Orilissa is ~\$845
 - This means it costs UMP ~\$9,200 per year and members ~\$900 per year
- Potential budget impact for UMP would be between \$60,000 and \$90,000 over the next 12 months
- Members will pay \$150 per 30-day supply

Lutathera (Lutetium La 177)

- Lutathera was approved by the FDA on January 26, 2018
 - Approved for the treatment of somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs)
- Other treatment options for GEP-NET include surgery, chemotherapy, and pharmacotherapy depending on the location, profile, and severity
 - Surgery is the primary method of treatment, but is often used in combination with chemotherapy and pharmacotherapy
 - Lutathera is the first radiopharmaceutical approved treatment, which means it is a radioactive molecule that is absorbed by the tumor and works on destroying the malignant cells

Lutathera (lutetium La 177) (*cont.*)

- Annual incidence of GEP-NET in the United States is 3.56 per 100,000 persons
 - We estimate 1-2 patients in UMP per year
- The list price for a course of treatment is \$190,000
 - FDA approved 4 doses - one dose every 8 weeks
 - Does not include other required pre-treatment and concomitant medications
- Potential budget impact for UMP would be between \$200,000 and \$400,000 over the next 12 months
- Members would pay 15% of the allowed amount, depending on the setting of administration

Palynziq (pegvaliase-pqpz)

- Palynziq was approved by the FDA on May 24, 2018.
 - Approved to reduce blood phenylalanine concentrations in adult patients with phenylketonuria (PKU) who have uncontrolled blood phenylalanine concentrations
 - Patients with PKU are unable to break down phenylalanine, an amino acid (found in all proteins), that accumulates in the blood and manifests in intellectual disabilities and other symptoms
- Current PKU treatment includes strict dietary restrictions limiting protein
- Palynziq is a recombinant form of an enzyme that breaks down phenylalanine

Palynziq (pegvaliase-pqpz) (*cont.*)

- Incidence of PKU in the United States is approximately 1 per 13,500 to 19,000 newborns
 - There are less than 200,000 people living with PKU in the US.
- The annual cost of Palynziq is ~\$215,000 per patient
- Potential budget impact for UMP would be ~\$42,300 per year
 - This suggests we are unlikely to see use in UMP

Andexxa (andexanet alfa)

- Andexxa was approved by the FDA on May 3, 2018
 - Approved to reverse anticoagulation needed due to life-threatening or uncontrolled bleeding for patients using rivaroxaban or apixaban
 - First antidote for patients taking those inhibitors
- There are current treatment options, including antifibrinolytic therapy or drug removal by activated charcoal
 - Andexxa provides a new option if these therapies do not work or there is imminent risk of death or need of emergent surgery
- Andexxa was not available for widespread distribution because of the original manufacturing process
 - An updated process has been approved by the FDA, so there should be widespread access to the drug in early 2019

Andexxa (andexanet alfa) (*cont.*)

- There are ~4,500 members on UMP who are currently using either apixaban or rivaroxaban
 - It is unknown how many will have uncontrolled or life-threatening bleeds while one of these inhibitors
- One course of treatment is ~\$30,000 to \$60,000, depending on the level of antidote needed
- Potential budget impact for UMP is up to ~\$140,000 per year

Jynarque (tolvaptan)

- Jynarque was approved by the FDA on April 23, 2018
 - Used to slow kidney function decline in patients with autosomal dominant polycystic kidney disease (ADPKD)
- ADPKD is a genetic disease which causes progressive kidney decline, often leading to renal replacement therapy
 - ADPKD is the cause for ~5% of all patients who start dialysis each year
- Standard ADPKD treatment is strict blood pressure control, a low protein diet, and low sodium intake
- Jynarque is reserved for patients with very severe renal disease due to its history of serious and potentially fatal liver injury
 - Liver transplant was required since the drug has been approved by the FDA.
 - The FDA requires Jynarque have a REMS program where the medication is only available through select, certified providers and pharmacies.

Jynarque (tolvaptan) (*cont.*)

- ADPKD occurs in about 1 in every 400 to 1,000 live births.
 - Screening for ADPKD now occurs in patients at risk for the disease (known family history)
- The cost of Jynarque is ~\$102,000 per patient per year
- The anticipated budget impact is less than \$0.01 per member per month, meaning UMP is not likely to see a member use this medication

Epidiolex (cannabidiol)

- Epidiolex was approved by the FDA on June 25, 2018
 - Approved for the treatment of seizures associated with Lennox-Gastaut syndrome (LGS) or Dravet syndrome (DS)
- LGS and DS are rare, early onset epilepsy disorders beginning in early childhood
 - Patients with DS are often non-responsive to most anti-epileptic medications
- Treatment of LGS and DS may include any anti-epileptic medication and often in combination.
 - This includes importing medications not yet reviewed by the FDA
 - Providers often have to balance seizure control with medication side effects

Epidiolex (cannabidiol) (cont.)

- The annual cost of Epidiolex depends on the patient's weight and their personal dose required for seizure control
 - The price for a 50kg patient needing a high dose is about \$37,000 per year
- Potential budget impact for UMP is up about ~\$37,000 per year

Onpattro (patisiren) / Tegsedi (inotersen)

- Onpattro was approved by the FDA on August 10, 2018;
Tegsedi was approved by the FDA on October 5, 2018
 - Both approved for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults (ATTR)
- ▶ Amyloidosis is a disease caused by the accumulation of defective proteins that form deposits on organ tissues
 - ▶ - Onpattro and Tegsedi work by blocking creation of the defective proteins

Onpattro (patisiren) / Tegsedi (inotersen) (*cont.*)

- Standard of care in the US is liver transplant, which removes the liver with the defective gene that results in defective protein production
 - In Europe and Japan, tafamidis is available; Tafamidis stabilizes the defective protein to prevent it from developing into deposits
 - Tafamidis was rejected by the FDA in 2012, but is now undergoing re-review
- The annual cost of Onpattro is around \$120,000 per patient; The annual cost of Tegsedi is around \$360,000 per patient
- Potential budget impact for UMP is up about ~\$140,000 per year (1 case per year)

Questions?

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TAB 10



Medicare Retiree Health Benefits Project Update

Molly Christie
Strategic Plan Project Manager
Benefit Strategy & Design Section
January 31, 2019

PEBB Program Retiree Health Benefits

A Work in Progress

In July 2018, HCA presented plans for an **evaluation of the PEBB Program Medicare retiree health benefits**.

The overarching goal of this evaluation was to understand **sustainable** and **supportive** plan offerings for Medicare retirees. This includes understanding reliable strategies for maximizing federal resources/revenue and **stabilizing member premiums**.

The purpose of today's presentation is to provide a brief update of our progress and identify next steps.

Reminder – Why we're doing this

1

It's time!

- Medicare has changed and so have PEBB Program Medicare retirees

2

The value of the Retiree Drug Subsidy (RDS) has declined

- The value of the RDS has declined as prescription drug costs have climbed; other federal subsidy options may provide greater value to members

3

Prescription drug spending is compromising affordability of PEBB Program Medicare plans

- Prescription drug market is highly volatile
- Prescription claims account for ~60% of UMP rates for Medicare members

Employer strategies

Employer Group Waiver Plan (EGWP)

- Self-insured or fully insured Part D plans authorized by the Centers for Medicare and Medicaid Services (CMS) and available only to an employer's retirees
- Optional wraparound provision allows for benefits similar to an employer's current prescription coverage

Medicare Advantage + Part D (MA-PD)

- Private plans that cover all Medicare benefits, including prescription drugs
- Typically offer enhanced benefits compared to standalone Part D plans

Private Exchange

- Portfolio of group coverage Medicare plans (Supplemental, Part D, Medicare Advantage) managed by insurance carriers or consultancies
- Allows for greater plan choice compared to typical employer offerings for retirees

PEBB Program considerations

Quality

Access

Cost

Sustainability

Customization

MA-PD Request for Information

- ▶ In September 2018 HCA released a brief RFI to learn more about **employer group MA-PD** benefit plan options in WA
 - Coverage areas/provider networks
 - Benefit designs
 - Costs*
- ▶ We conducted phone interviews with 8 of 9 vendors offering MA-PD plans in Washington.

*Due to limited time and information, plans were unable to provide reliable estimates for member premiums; however, HCA was able to infer that employer group MA-PD premiums for similarly sized large employers would likely be less than UMP Classic Medicare.

Medicare Advantage + Prescription Drug (Part D)

- ▶ **MA-PDs are private insurance plans that cover all Medicare benefits, including Part D drug benefits**
 - CMS* pays MA-PD insurers a capitated (per enrollee) subsidy to provide Original Medicare** benefits
 - MA-PD plans also receive subsidies from CMS that cover at least 74.5% of the cost of Part D drug benefits
 - Drug manufacturer discounts are also available to Part D plans under the Patient Protection & Affordable Care Act (ACA) to help keep premiums low
 - Many Medicare Advantage plans offer benefit enhancements over Original Medicare

*Centers for Medicare & Medicaid Services.

**Medicare Parts A & B

MA-PD RFI: Coverage/Network

Most Medicare Advantage plans operate as:

- Preferred Provider Organization (PPO)
- Health Maintenance Organization (HMO)
- Health Maintenance Organization Point of Service (HMO POS)

However, some large plans are able to offer **national Medicare coverage** through an Extended Service Area (ESA) waiver from CMS

- Plans with this waiver are called PPO ESAs, or “non-differential” PPOs
- Members are able to receive care from **any provider who accepts payment from Medicare**, and **benefits are the same regardless of whether providers are ‘in’ or ‘out’ of the plan’s network.**

MA-PD RFI: Benefit Design

MA-PD plans must include the **standard benefits under Medicare Parts A, B, and D**, however plans set their own limits on how much members pay for covered services.*

This means plan designs can vary widely in terms of:

- Premiums
- Copay/coinsurance
- Deductibles
- Maximum out-of-pocket
- Network providers
- Pharmacy tiers, formulary** and utilization management tools

Many also offer **supplemental benefits** (those not traditionally covered by Medicare), such as **vision, dental, hearing, and alternative therapies** (chiropractic, acupuncture, massage).

➤ **Large employer group plans have many options for customization in benefit design.**

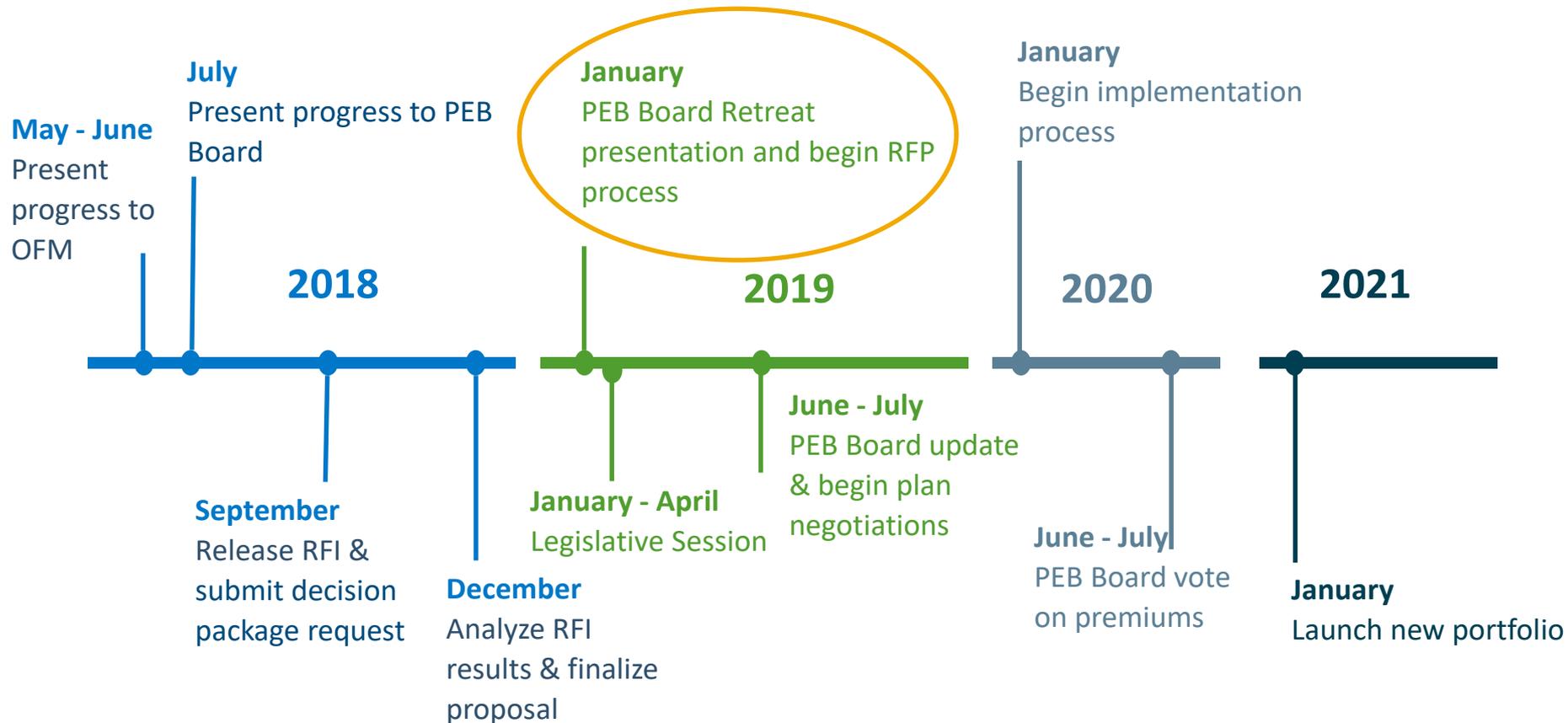
*Up to a limit established by CMS (\$6,700/year)

**Part D formularies must be approved by CMS and abide by certain rules and regulations governing coverage

Next steps

- ▶ HCA received administrative funding in the Governor's proposed budget for FY 2019-2021 to **procure one or more MA-PD plans** under the PEBB Program.
- ▶ We recommend that at least one of these new plans operate as an **Extended Service Area PPO**.
- ▶ These plans would be offered **in addition** to options under the current PEBB Medicare portfolio.

Timeline



Questions?

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Appendix

Medicare plan types

Plan Type	Description	PEBB Program Offered Plans
Original Medicare	Traditional fee-for-service health insurance program offered directly through the federal government (Centers for Medicare and Medicaid Services). Includes Medicare Part A (inpatient/hospital coverage) and Medicare Part B (outpatient/medical coverage). No drug coverage.	None. PEBB Program offers 4 Original Medicare Coordination of Benefits (COB) ¹ Plans
Medicare Advantage (MA)	Also referred to as “Medicare Part C.” MA plans are offered by private companies approved by Medicare. If you have an MA plan, you receive your Part A and B coverage through the MA plan, not Original Medicare. CMS provides subsidies to MA plans to help cover the cost of Part A and B coverage.	Kaiser WA Medicare Advantage Kaiser NW Senior Advantage
Medicare Part D	Optional outpatient prescription drug benefits offered through private or employer-sponsored plans approved by CMS. Part D plan types include: <ul style="list-style-type: none"> • Standalone prescription drug plans (PDPs); • Medicare Advantage plus prescription drug plans (MA-PDs) that cover all Medicare benefits, including drugs; or • Employer-Sponsored Group Waiver Plans (EGWPs, pronounced “egg whip”), which are self-insured or fully insured Part D plans authorized by CMS and available only to an employer’s retirees. 	None. All PEBB Program plans (except Plan F) have creditable drug coverage . ²
Medicare Supplement Plans	Also referred to as “Medigap” plans, Medicare Supplement plans help offset out-of-pocket expenses for Original Medicare including deductibles and coinsurances. Medicare Supplement plans are sold by private companies but have been approved by CMS.	Premera Supplement Plan F

1. CMS is primary payer for services covered by Original Medicare; COB plans are billed secondary. Enrollees in PEBB Medicare plans must also be enrolled in Original Medicare.
2. Prescription drug benefits that are equivalent to, or more generous than, standard defined Part D benefits.

PEBB Program Medicare retiree plan offerings and enrollment*

Plan Name	Subscriber	Spouse	Dependent	Total
Kaiser NW Senior Advantage ¹	1,808	713	1	2,522
Kaiser WA (Classic Medicare ² and Medicare Advantage ¹)	17,400	6,887	38	24,325
Premera Medicare Supplement Plan F	10,733	4,435	0	15,168
UMP Classic Medicare ²	38,828	15,221	86	54,135
Total	68,769	27,256	125	96,150

1. Medicare Part C (aka Medicare Advantage) with creditable drug coverage
2. Original Medicare coordination of benefits with creditable drug coverage

*Reflects December 2018 enrollment numbers



Medicare Supplement Plans

Betsy Cottle
Contract Manager
Employees & Retirees Benefits Division
January 31, 2019

Medicare Supplement Plan F Closing

- Effective 1/1/2020, Medicare supplement plans that pay both the Medicare Part B deductible and copays are repealed by the federal government,
 - No new enrollments except for any individual who does not attain age 65 or become newly disabled before 1/1/2020.
- Premera's Medicare Supplement Plan F will need to be replaced with a new supplemental plan.
- Plan G is the most similar to Plan F, covering all copays and coinsurance.
- HCA Recommendation is to continue Plan F coverage as long as feasible, and offer a new Medicare Supplement Plan G effective 1/1/2020.

Plan F Details

- Plan F is currently the only Medicare Supplement insurance (Medigap) plan offered by PEBB.
- Plan F helps members pay for some health care costs that Medicare Parts A and B do not, such as deductibles, copayments, and coinsurance.
- There is no prescription drug coverage under Plan F.
 - Members may need to purchase a Medicare Part D plan or have other creditable drug coverage.
 - PEBB does not offer a Medicare Part D plan, so members must shop for a Part D plan from a private insurance carrier.

Plan G Details

- Plan G helps members pay for some health care costs that Medicare Parts A and B do not. Plan G covers a members' copayments and coinsurance, but does not cover the deductible.
- There is no prescription drug coverage under Plan G.
 - Members may need to purchase a Medicare Part D plan or have other creditable drug coverage.
 - PEBB does not offer a Medicare Part D plan, so members must shop for a Part D plan from a private insurance carrier.

Questions?

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TAB 11



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

Kim Wallace, SEBB Finance Manager

Financial Services Division

January 31, 2019

Background

- Legislature charged HCA with analyzing the most appropriate risk pool for the retired and disabled school employees, including:
 - analysis of the size of the non-Medicare and Medicare retiree enrollment pools
 - impacts on cost for state and school district retirees of moving retirees from one pool to another
 - the need for and the amount of an ongoing retiree subsidy allocation from the active school employees, and
 - the timing and suggested approach for a transition from one risk pool to another.

Status

- Consulted with the PEB and SEB Boards on September 17, 2018
- Completed the draft report
- Completed all levels of review and approval
- Submitted the report to the Legislature on January 17, 2019
- Available for download here:
 - <https://www.hca.wa.gov/about-hca/legislative-reports>

Recommendations

- There are two appropriate risk pool structures for school retirees:
 - Desired future state – Create a non-Medicare risk pool for SEBB
 - little to no cost impact on retirees or employees and minimizes disruption for members
 - implementation date of January 1, 2022 at the earliest due to statutory and budget constraints
 - Until the constraints are addressed and resolved, HCA recommends continuing the current risk pool structure for SEBB, i.e., active employees in one SEBB risk pool and non-Medicare retirees in the PEBB non-Medicare risk pool
- Continue to include Medicare-eligible school retirees in the PEBB Medicare risk pool

Questions

Kim Wallace

SEBB Finance Manager

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TAB 12



Governor's Budget Update 2019-2021

Tanya Deuel
PEBB Finance Manager
Financial Services Division
January 31, 2019

Funding Rate

- \$977 FY20 State Funding Rate
- \$978 FY21 State Funding Rate
 - Per employee per month
 - Adequate to maintain current level of benefits

Medicare Explicit Subsidy

- \$168 Medicare Explicit Subsidy (per Medicare retiree per month)
 - Maintained level from Calendar Year 2019

Fully Funded Decision Packages

Title	FTE	Dollar
TPA Fees UMP, UDP, and FSA Admin Fees. Increase in Spending Authority for three accounts.	none	\$6 Million
Medicare Retiree Portfolio Administrative costs associated with a procurement.	3.8 Biennial Average – Temporary Staff	\$1.5 Million
Centers of Excellence Admin for current TJR and Spinal Fusion bundles, plus funding for a third bundle calendar year 2021.	none	\$1.3 Million

Partially Funded Decision Packages

Title	FTE	Dollar
<p>Pay1 Replacement Replacement of the 40-year old Pay1 eligibility system.</p>	<p>Requested 10 (biennial average) Received 0</p>	<p>Requested \$20.4 M Received \$150 K</p>
<p>ERB Staffing Customer service for retiree support, additional outreach/training, and increased responsiveness.</p>	<p>Requested 8 FTE Received 5 FTE</p>	<p>Requested \$1.5 M Received \$850 K</p>

Other Funding

Title	Dollar
<p>Nutritional Counseling Visits Beginning in calendar year 2020, funding was requested to increase the covered lifetime nutritional visits from 3 to 12 in the Uniform Medical Plan.</p>	<p>\$1.3 Million/CY</p>
<p>LTD Allows the board the authority to make changes within the benefit structure.</p>	<p>NA</p>
<p>Collective Bargaining Impacts Funding will be transferred to HCA to fund a \$250 FSA contribution for represented employees who make less than \$50,004.</p>	<p>\$3 Million/CY</p>

Questions?

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