Washington State Health Care Authority

# School Employees Benefits Board
# Meeting Minutes

April 10, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:00 p.m. – 5:00 p.m.

## Members Present
Pete Cutler
Patty Estes
Dan Gossett
Alison Poulsen
Terri House
Lou McDermott

## Members on the Phone
Katy Henry
Wayne Leonard

## Members Absent
Sean Corry

## SEB Board Counsel
Katy Hatfield

## Call to Order
**Lou McDermott, Chair**, called the meeting to order at 1:00 p.m. Sufficient members present to allow a quorum. Board self-introductions followed.

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

## Approval of October 4, 2018 Meeting Minutes
Patty Estes moved and Terri House seconded a motion to approve the October 4, 2018 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

## Approval of November 8, 2018 Meeting Minutes
Pete Cutler moved and Dan Gossett seconded a motion to approve the November 8, 2018 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

**Approval of December 13, 2018 Meeting Minutes**

Terri House moved and Patty Estes seconded a motion to approve the December 13, 2018 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

**March 7, 2019 Board Meeting Follow Up**

**Dave Iseminger**, Director, ERB Division. Slide 2. There was a request for links to the news articles that reference the SEBB Program. I can already tell you this slide is out of date because there were three this week in various newspapers. The links are from various Seattle Times articles, many of which were picked up by other regional newspapers and run through the Associated Press process.

Slide 3 is a link to all the core communications we are conveying out to the districts, educational service districts, and charter schools. Every month our communication team produces a packet of roughly three or four materials. These toolkits usually consist of a one-pager, an infograph, a poster, and a news article that could be put in either an email digest or anything else the districts are using to convey information. These toolkits have been produced monthly since November and are available on the HCA website, as well as the other fact sheets the agency has produced over the last year. A lot of people are accessing the 11x17 preliminary medical benefit design from November's meeting and a six-page document we created of a high level overview of the entire suite of SEBB Program benefits.

Slides 4 through 9 - SEBB Finance Follow up. Ben Diederich from Milliman talked about the adult unit ratio and how it's different from the dependent load, and to do the math. He did an illustrative example and then the real example. We committed all of that to writing so you have that in your packets. I won't go through it again, but this is the promised written format.

At the end of Mr. Troy Andrews public comment, there were questions as to whether the union employees that he represents are part of the SEBB consolidation. We reached out to Tacoma Public Schools, and understand those members of that bargaining unit are considered full-time employees of the Tacoma School District. That means, as the law exists today, they would be subject to consolidation. We have conveyed that information to Mr. Andrews.

**SEBB Finance 2019-2021 Budget Update**

**Megan Atkinson**, Chief Financial Officer. Slide 3 – Net Funding Rate versus Funding Rate. The net funding rate is a concept we started driving home on the PEBB side a few years ago. We found it helpful because frequently on the PEBB side, we end the year with a surplus. That surplus buys down the next year's funding rate. The net funding rate is the funding rate needed in its totality without the benefit of any surplus or paying back any deficit. The net funding rate for the SEBB Program, under the modeling we have been using and that we provided to the Legislature at the beginning of March, is the middle column, the $1,114. After I presented that at the last meeting, there were questions.

In the legislative conversations, there was discussion around the number in the last column, the $1,096. The conversation of, "is the $1,096 underfunding SEBB, what is the difference between the two," etc. The $1,096 amount is the sum of those rows

above. We've reviewed this chart with you many times. I think you're familiar with the format of it. The $1,096 benefits from an assumed surplus spend on a per subscriber per month basis -- $18. We've titled that surplus spend. That's the benefit of the starting loans from the General Fund-State. If you model using the scenario that we have right now with the initial $28 million loan, and the additional $10 million loan, we are currently projecting to underspend this year's administrative money, the $28 million. We don't think we'll fully spend it by June 30. There'll be a little bit left in the fund.

The additional $10 million that the Governor had in his budget, which was also picked up in the legislative budgets, would start with a surplus, a little bit of money already in the account. That money used would essentially buy down the funding rate. But again, the net funding rate is the funding rate regardless of any surplus spend or deficit payback. That's the true amount needed to fund the program operations. That is the $1,114 in the first year.

That's the difference between those two numbers. Is one underfunding or not? They both fund the program, just with a slightly different look at the funding needs.

Slide 4 – Monthly Funding Rate Comparison. The table on this slide shows the comparison between the House budget and the Senate budget. The green rows are the funding rates we modeled out using our assumptions we provided to the Legislature at the beginning of March. The $1,096 amount is for fiscal year 2020. We haven't talked much about fiscal year 2021, but we had a funding rate modeled for fiscal year 2021, which was $1,127. Comparing the green row with the tan row, you see the House has lower funding rates in both years, and the Senate has larger differences. Larger, lower funding rates.

Slide 5 – Funding Rate Assumptions. We need to understand the assumptions being used to drive the funding rates. One is higher than the other. I'll walk through the House budget and then the Senate budget.

The big differences are the House went through and made some detailed assumption changes in the model. They made different assumptions about our loan repayment, our premium stabilization reserve build (PSR), and our medical trend. The loan repayment and PSR build are straight math. If you assume we repay the loan differently, and the House pushed it out, then we don't have those expenditures to repay the loan immediately. We don't need the funding rate to cover that expenditure. It's essentially lowering the expenditures, which means you can have a lower funding rate because you need less revenue. It's the same thing on the premium stabilization reserve. We had initially modeled an immediate build-up to 7% of the PSR. The House budget pushes that out as a more gradual build. Still getting to the 7%, but into the next couple biennium out. We wouldn't need as much revenue to build a reserve more quickly, so we can have a lower funding rate.

For the inflation assumption, the House is essentially saying the state is going to bear more risk, take on a lower trend assumption, and by lowering the trend assumption from our best estimate, they're essentially having a higher probability that they're going to miss on trend. They're bearing more risk, but they're not directing a change in the program structure. It doesn't appear to be in any way tied to approval or disapproval of

the Collective Bargaining Agreement. I don't think it's anything we necessarily have to be worried about. There is the potential that if we end up with a higher trend a year from now, when we're coming into next legislative session and our financial performance appears to be poor and the conversation doesn't include the fact that they lowered our trend assumptions, there's a possibility the conversation can be why isn't the SEBB Program better managing trend. We will just have to remind them that we are managing our trend and they underfunded our trend. Those are the House assumptions.

The Senate budget does something different. They took our funding assumptions on the PEBB Program and carried them over to the SEBB Program. It's a very different approach and drives a considerable difference in the funding rates. If you want to try to discern what the logic is on the Senate budget, you could draw the conclusion that they're essentially saying, "you have one large body of public employees, state employees, and here's what our experiences are with them. We're going to assume the second large body of public employees, school district employees, are going to have the exact same financial needs." We all know there are some differences between the populations. We believe there will be considerable differences in our enrollment across self-insured and managed care. There will be differences across the plan offerings. It's a unique approach to the modeling. Unless the Legislature takes action to change the collective bargaining, the structure of the program, the eligibility requirements, the Senate is driving more risk into subsequent budget periods.

Let's say the final conference budget ends up with the Senate funding rates and our experience ends up closer to what we're actually modeling. So the funding rate we have in the first year is $100 and some less, on a per-member-per-month basis, than what we need. That would drive the fund into a deficit situation and we would be coming to the Legislature for a supplemental budget fix. It would be really rare for that supplemental budget fix to drive out different employer and employee contributions in an active year. There are different permutations, but it would look something like the fund would get a loan to get us through fiscal year 2020. We would then have higher funding rates in fiscal year 2021 to pay that back. That's one example of how it could look. It wouldn't be a scenario where employer and employee contributions would change mid-year for a plan year.

**Pete Cutler**: On the inflation assumption in the House budget, apparently the model they used has a 5% trend assumption for both years?

**Megan Atkinson**: Yes.

**Pete Cutler**: Given the very small dollar impact, I would guess the model used a number not much bigger.

**Megan Atkinson**: It went down one point.

**Pete Cutler**: Apparently, the Senate just decided we like, or we choose to believe the assumptions used in the model forecasting cost in PEBB Program, we think that's what's going to unfold. Even though the Health Care Authority thinks that other numbers are more appropriate, they're going to take a roll of the dice and hope the school employee experience mirrors the PEBB experience closely.

**Megan Atkinson**: I think that's one interpretation. There's not intent language with it, so I'm guessing. I think what I know for certain is they did take the model as we proposed it on the PEBB side for the PEBB Program, and then they just carried those numbers over for the SEBB Program.

**Dave Iseminger**: They then used the net funding rate for the PEBB Program. They didn't use the operational budget number. They used the net funding rate from that model. So it's not a number you would see in the current operating budget for PEBB, because the operating budget doesn't include the net funding rate.

**Megan Atkinson**: For the PEBB Program, rolling back to the prior slide about the difference between net funding rate and the budgeted funding rate, on the PEBB side, the budgeted funding rate is benefiting from spending down surplus. To Dave's point, they did take the net funding rate for the PEBB Program, which is the funding rate for the true program cost, and rolled that over for the SEBB Program.

**Lou McDermott**: Megan, I would assume our concerns have been expressed to the Legislature about the various funding rates and impacts from our perspective?

**Megan Atkinson**: Yes. When the budgets are proposed by the chair of each committee and move through the process, the initial introduction of the chair's proposal, as it passes out of the fiscal committee and passes off the floor, we have a process by which we communicate agency concerns to the Office of Financial Management. They roll those up for concerns that are communicated by the Director of Financial Management, David Schumacher, to the fiscal chairs on behalf of the Governor. We did communicate our concerns.

**Alison Poulsen**: I want to make sure I understand what the implications are in terms of the decisions we have in front of us. If we were to assume that there will be some sort of compromise between the House and the Senate budgets, does that change any of our design work we have done? Or are you saying, generally, we think we're still in the sweet spot and the gap is more in the risk that would have to be cleaned up in 2020 or 2021?

**Megan Atkinson**: I would say more of the latter. I think, for where we are in development of this program, without the Legislature giving you direction to change the path that we're on in setting up the program, and without a change in the structure of the program, the eligibility, etc., then we stay the course. The Legislature is making decisions as the appropriating body of how to fund that program. And again, this may feel like it's really specific and personal to the SEBB Program, but they're doing this across the entire suite of state agencies. All state programs. There are times when the Legislature, as the appropriating body, disagrees and gives us the amount of money they think we need.

**Lou McDermott**: To Megan's point, she said it's based on the assumptions we have for the program already. If they were to see one of our assumptions, like our average deductible rate, and they think it should be $1,000, then they will change the funding rate to X. That would be a clear signal we need to change something. But right now they're saying we think this is the number. They are pushing out the loan and the PSR,

and looking at a different trend. We don't have any indication they want us to make programmatic changes.

**Dave Iseminger**: The very levers that you see on Slide 5 are assumptions within the modeling provided to the Legislature. They decided to crank those levers differently. That modeling, although very complex, has an underpinning to it of similar financial expenditures as the PEBB Program but with a different enrollment number. Where we have come to you as an agency and explained that zero sum game, the starting assumption is the same pot of money, yet a different enrollment number is embedded. Neither the House nor the Senate budgets cranked those levers differently. That's why we don't have any belief that this Board has any obligations, as it stands right now, to make any benefit design changes to drive a lower number.

**Megan Atkinson**: Typically, based on our experience on the PEBB Program side, if they were trying to communicate that intent to us, either to the Board or to the agency, they would have given us a model with those differing assumptions. For example, on the Senate side, we didn't get a model back. On the House side, we did get a model back with those discreet assumptions. We don't have any additional direction.

**Pete Cutler**: My understanding is that both budgets assume and fund the Collective Bargaining Agreements dealing with health care benefits. And that within itself basically creates a concept of an entitlement, which means that if there's a budget shortfall, unlike some areas like Parks, you can just say, well it costs more than we thought so we're going to have to cut back Parks. In this case, we have contractual agreement commitments that the Board and the level of benefits and premium share have to meet. Certainly, from my past experience, be treated more as it's a mandatory hole we have to fill if it comes in costing more than you thought. In my mind, I think this is really a subject for the budget committees and OFM. They'll have a lot of areas in which they're going to be asking themselves how much risk do we want to take for next biennium, or for next year? It wouldn't even be a biennium thing.

**Megan Atkinson**: That's a good reminder, Pete. I didn't mention that. In the back of the budget sections, there is language in both the House and the Senate budget explicitly funding the Collective Bargaining Agreements.

Slide 6 – Flow of Funding Rate. I mentioned there was a proviso difference between the two budgets. There was a little difference in the flow of the funding rate. Currently, in the current K-12 world, the employee health benefit funding is appropriated to the Office of the Superintendent of Public Instruction (OSPI). It goes through their apportionment process and distributed to the school districts once a month. That schedule is in statute. The House budget doesn't change that. The money for state-funded staff is appropriated to OSPI, goes through the apportionment process where it is allocated out to school districts, and then we would invoice the districts and collect employer and employee contributions for both the state and the locally funded staff.

The Senate budget has a different direction where the money is appropriated to OSPI. But, rather than it flowing through the apportionment process out to the districts, OSPI would transfer that money directly into the HCA benefit account. That is on the basic education funded staff. It is not for the health care benefits associated with the special

education program and the transportation program. The language isn't in every portion of the budget and we have not started conversations with OSPI yet on how that would work. We are waiting to get through the conference budget process and see how it would work. I'm clearly not an apportionment expert. This is different language in the Senate budget.

Slide 7 – Decision Packages. This slide is a comparison. It compares all three budgets, the Governor's, the House's, and the Senate's, and shows the decision packages we requested, specific funding requested, and the differences between what the Governor funded in his budget versus what's in the House and Senate budgets. They are largely the same. There are two items highlighted in yellow indicating one was not in the House budget and one was not in the Senate budget. One is the online decision tool and the other was an additional study looking at the Pay1 replacement project.

**Dave Iseminger**: For the online decision tool, the original decision package we put forward was for about $800,000-$900,000 to create a selection tool that would exist in perpetuity for the program. We knew of the possibility of 16-20 plans in some parts of the state. If there were upwards of a dozen or more plans, we wanted to make sure there was something available to help people navigate plans.

In starting this program, we didn't always hire staff on the exact day we expected. We built a variance within the program. We were able to secure, with our existing funding, a one-year licensure to do this for this initial open enrollment. We will use this as a pilot project to make a pitch for more sustainable funding in the future. I want to assure the Board that we are proceeding with this pilot, if you will, for this fall's open enrollment to achieve that goal and help school employees navigate all of their new choices. So not a super big concern with the status of that decision package.

The Pay1 replacement. We have talked a lot about the front-end SEBB My Account enrollment system. It is the front-end user experience enrollment process. On the back end are the accounting functions that we call Pay1. Pay1 at this agency has been around since the late seventies. There's been perpetual conversations about replacing Pay1. We are leveraging Pay1 as the back-end accounting functionality for the SEBB Program. We are using both of those, that original coding refined for both the PEBB Program and the SEBB Program. This is funding to continue the discussion about the ways to replace that component of our IT system. If not picked up, that means Pay1 will probably turn 45 or 46 years old, at least.

**Lou McDermott**: That's COBOL, right?

**Dave Iseminger**: Yes. It's one of the state run programs that's still around. Our CIO was surprised it was still here when he joined the agency. Gerald Ford was president when Pay1 was created! The individual Apple computer was not yet on the market.

I want to highlight the second line item, employee retirees benefit staff. That is a decision package split between the programs. This isn't funding attributed solely to you.

**Megan Atkinson**: I also need to correct myself. A moment ago when I was discussing the language difference, I said the Senate language was only in the basic education

portion, it wasn't in special education or the transportation. That's not correct. It's in all the necessary different sections of the K-12 part of the budget. There were some conversations going around on how to peel that piece of apportionment off for the different pieces of staff, basic education staff versus the special education and the transportation sections. But the language is in all the sections of the budget. Sorry about that.

**Pete Cutler**: Megan, curiosity on that particular proposal from the Senate to have the K-12 benefit funding be allocated by OSPI directly into the SEBB fund. It would seem to me it would require that you have school districts clearly being able to identify which of their employees are the state-funded positions that correlate to whatever dollar amount was associated with that school district versus which positions are funded from other sources.

**Megan Atkinson**: Thanks Pete, that's a good question. We've had a lot of conversations about this. Depending on the conversation and who is around the table, we go down various rabbit holes trying to think this through. There are several complicating factors. I'll set aside whether the OSPI systems can do this or not because it's outside of my purview. From the Health Care Authority perspective, one thing we really don't want to be doing is having to reconcile with districts the color of money associated with each individual person. Our invoicing process is such that we will provide on a monthly basis, as we do now for the PEBB K-12s, a full membership enrollment file detailed by employee, plan, and tier. That is given prior to the month of coverage for the school district payroll office to essentially reconcile to make sure they made the right benefit changes, employment changes, or eligibility changes for their employees. That is used in calculating the total amount due.

From our perspective at the Health Care Authority, it's easiest and most straightforward for us if we can treat the amount due to the school districts as a total sum. You have x amount that you owe us for these employees' coverage. If we end up in the situation where a portion of the funding, and again it would only be the employer contribution for the state funded staff, comes directly to our benefit fund, then we would end up in a situation of some type of reconciliation. Obviously, a school district is going to want their membership file, and as an example, what the total amount due is, say $10,000. But how much did the OSPI already pay you? The school district would only want to pay HCA the net difference. While those conversations could occur still at an aggregate level, I do fear that it would set up the situation where the school district says OSPI was supposed to pay you $7,500 not $5,000. It would be difficult to ever have those conversations without all three players involved, the school district, HCA, and OSPI because we each would have a piece of the story. I am concerned about that reconciliation workload and I've elevated that as a concern of how it changes our role, and then the need for a reconciliation.

**Legislative Update**

**Cade Walker**, Executive Special Assistant, Employees and Retirees Benefits Division (ERB). A lot of the bills we've been tracking have not substantially changed since our last meeting. I will highlight what bills have passed and what new bills have come out since our last meeting.

Slide 2 – Number of Bills Analyzed by ERB Division. As of today, the Division has done 287 bill analyses. The ERB Division had 32 high impact bills that we were lead on and 32 high impact bills that we were support. ERB was lead on 77 low impact bills and support on 120. Slide 3 shows where the bill have landed in the process. As of today, there are two bills that have made it to the Governor's desk for signature.

Slide 4 – SEBB Program Impact Bills. Specific to the SEBB Program, House Bill 1547 concerns basic education funding and House Bill 2096 concerns educational service districts health benefits. Both stalled in committee. We will continue to track them. There has been no additional action since our last meeting.

We are also following recently introduced House Bill 2140 relating to K-12 education funding. It has potential impacts on the SEBB Program even though it is directly related to K-12 funding, not to SEBB funding. Similar to HB 1547, it addresses levies.

**Dave Iseminger**: House Bill 2096. A flavor of that did get generated within the Senate budget. That's an example of how topics can get breathed into life in different areas. This bill would have delayed implementation of non-represented educational service district (ESD) employees into the SEBB Program to 2024. The Senate, in its committee as it was passing amendments to the budget, included a back of the budget provision that would similarly delay implementation of non-represented ESD employees until July 1, 2021. Not exactly the same time frame, but the same concept, that same population.

The Senate budget also made a reduction of funding of a couple hundred thousand dollars that was associated with that change. That exists within the Senate budget. It doesn't exist within the House budget. There are questions about if that's a change that really needs to go through a statutory vehicle, or if that is eligible for back of the budget provisions. I want you to know the Senate did include that within their budget modeling of a shorter term delay of non-represented ESD employees.

**Alison Poulsen**: A question on that. Do you have a sense of how many employees that would be potentially covering? And is it just how ESDs generate revenue to pay for employees that wouldn't be part of the initial funding package?

**Dave Iseminger**: When we did the analysis on 2096, and this is the same population, I believe we estimated it was somewhere between 2,000 and 3,000 employees that could fit in that model. That wasn't enough for us to change our underlying modeling assumptions. It was well within the confidence intervals, if you will. It didn't require any sort of refresh to the March model that Megan has previously presented. That is the kind of scope it looks like it could impact.

**Alison Poulsen**: Is there concern that they don't have a levy structure in the way a school district would? I don't know if I'm saying that quite right.

**Dave Iseminger**: Alison, that is the crux of the question because the ESDs are funded as a service model from the districts, and then they have Early Childhood Assistance Program (ECAP) funding for some of their positions. They do have a fundamentally different funding structure. That is part of what prompted this very topic from the ESDs to the Legislature.

**Alison Poulsen**: The ESDs would need to cover those employees whether they feel like they have the money or not? Is that a fair statement?

**Dave Iseminger**: Alison, let me make sure I understand. I think you're saying if they are delayed, it's not that they don't have coverage, it's just that they don't have coverage through the SEBB Program. They otherwise would have coverage --

**Alison Poulsen**: Yes, that would be another way. Or that if they have to meet the timeline, they've just got to figure out how to fund that. There isn't a way for them to be exempted from receiving their health insurance through the SEBB Program as a school employee.

**Dave Iseminger**: I think the way you just said it is what it's doing. It's delaying their mandatory participation in the SEBB Program until July 1, 2021. It would carve out and exempt from the mandatory participation. If an ESD wanted to voluntarily join earlier than that, they could. But their mandatory participation date would be July 1, 2021. Whereas everyone else under the whole SEBB Program consolidation, mandatory participation is January 1, 2020.

**Alison Poulsen**: And so an ESD would have to continue to have an insurance relationship in addition to…

**Dave Iseminger**: They would maintain the authority and have the responsibilities for benefit offerings to non-represented ESD employees.

**Alison Poulsen**: Excellent. Thank you.

**Cade Walker**: Slide 5 – PEBB Program Impact Bills. Bill numbers not in bold or not italicized are still in their current committee. They haven't moved past the cut-offs. For the bills related to Medicare eligible retirees in the PEBB Program, those have stalled in committee. The paying state retirement benefits until the end of the month in which a beneficiary dies stalled as well. House Bill 1220, adding a member from the Office of the Insurance Commissioner to the PEB Board, is still moving through the process, meeting all its cut-off deadlines. We are tracking that closely for the PEB Board.

Slide 6 – ERB Impact Bills. House Bill 1065, regarding balanced billing and out-of-network billing had a second reading. We have been following this very closely for the last five years. It is a good consumer protection bill that we support.

House Bill 1074 raises the tobacco purchasing age and vapor product purchasing age from 18 to 21. This bill passed and went across the Governor's desk for signature. We will continue to assess what that means for our programs, given we do have tobacco surcharges and this may have some implications that the Board will need to take future action on related to tobacco surcharges.

**Dave Iseminger**: We'll continue monitoring exactly the implications. As a reminder, the tobacco surcharge, you did have some resolutions you voted on about the definition of tobacco product and what the duration of the look back period is for use of tobacco products. We have to overlay if there are any changes that might be necessary

because of this legislation. The current tobacco surcharge does not include vapor products. That would be the implementation for 2020. If there's future changes that we would bring to the Board for 2021, we would bring similar recommendations to both the PEB and SEB Boards. There will be some housekeeping things that need to be done. But the Board doesn't need to chime in on those. A lot of the language that's in our rules references that 18-year old date, so those will all be shifted to 21. But we don't bring things to the Board that are mandatory requirements under either federal or state law. We only bring you things where there's discretion in policy choices for you to make.

**Cade Walker**: House Bill 1099 provides notice about network adequacy to consumers. It passed and was signed by the Governor's office. This bill requires that a health carrier must prominently post the following information on its website: whether the health carrier classifies mental health treatment or substance abuse treatment as primary care or specialty care; the number of business days an enrollee must have access to covered mental health treatment or substance abuse treatment services under the network standards; and information or action an enrollee must take if they are unable to access covered mental health treatment or substance abuse treatment. This is another good consumer bill that we were support.

Senate Bill 5889, which also passed, relates to the disclosure of information to protected individuals. This requires health carriers to recognize that you may have adult dependents on your coverage over the age of 14, I think, and are considered a protected individual. When requested, the health carrier must communicate solely with the adult dependent and must respect their request for non-disclosure unless they receive written authorization otherwise to disclose that information to the subscriber on the plan.

Both of these bills have had input from our health carriers -- both ones HCA is working to contract with and our current contracted carriers. None of the carriers that we heard back from expressed any concerns about either of these bills. We assume the passage of them will be a smooth update to their processes and procedures, as required by these two bills.

House Bill 1523 and Senate Bill 5526 are the “Cascade Care” bills. They are both still moving, with a lot of different action taken on them.

**Pete Cutler**: How would the last bill you mentioned, 1523, impact the ERB Programs? It deals with the individual market, which does not, on the face of it, deal with us.

**Dave Iseminger**: Pete, this agency, the public option bill has had consultation with both the Insurance Commissioner's office, the Health Benefit Exchange, and the Health Care Authority. The Health Care Authority is the primary purchaser of health care for the state, and the ERB Division in particular with expertise in the commercial market. That's the tie that has been drawn for this agency. As a health care purchaser having a significant role in a commercial market, there would be expertise here to also be leveraged and help purchase a public option that could be offered on the exchange. It's not necessarily ERB, it's really HCA. But as the ERB Division is the primary engine that has commercial impacts here in the agency, it often gets defaulted to saying there is an ERB Division impact.

**Pete Cutler**: Just to be real clear, it does not actually call for changes in the PEBB Program or the SEBB Program, but it does involve taking advantage of expertise, resources in this division or agency?

**Dave Iseminger**: That is correct.

**Cade Walker**: Slide 7 – ERB Topical Bills. A new bill came out, House Bill 2154 abolishing abortion. As it stands now, no action taken. It falls within our topics we follow, along with Senate bill 5602, which is still currently in play.

On the pharmacy side, we still have a number of bills that are still being considered and having action taken on them. We are tracking those, along with our Clinical Quality and Care Transformation (CQCT) Division.

[break]

**Policy Resolution**

**Rob Parkman**, Policy and Rules Coordinator, ERB Division. We have one policy resolution for you to take action on today, Policy Resolution SEBB 2019-08 – Terms and Conditions for RCW 41.05.740(6)(e).

This Policy Resolution establishes terms and conditions to satisfy the requirements within RCW 41.05.740(6)(e). From a policy perspective, to have as many SEB Board approved resolutions as possible be effective for this population, this resolution would allow as many resolutions as possible to be effective for this population. It would also make the administration of this part of the program easier. Changes made since introduction. The resolution number was updated from SEBB 08 to SEBB 2019-08. This reflects our current numbering process. We removed the typo, the extra "0" that was in the second line for the RCW reference. The resolution presented at the March meeting is located in the Appendix.

Stakeholder feedback. Two stakeholders provided feedback. One supported the resolution because it would ensure consistent program rules for employees granted SEBB Program eligibility under the (6)(d) and the (6)(e) eligibility rules. The other stakeholder supported it because it would make it easier for the program to be administered overall.

**Lou McDermott**: **Policy Resolution SEBB 2019-08 - Terms and Conditions for RCW 41.05.740(6)(e)**

**Resolved that,** for school employees whose eligibility is established under RCW 41.05.740(6)(e), all SEBB Program rules within chapters 182-30, 182-31, and 182-32 WAC apply except for provisions within those rules governing benefits that are not authorized in SEBB 2019-03 to be offered to RCW 41.05.740(6)(e) employees.

Dan Gossett moved and Pete Cutler seconded a motion to adopt.

Voting to Approve: 6
Voting No: 0

Absent from Vote: 3
Katy Henry
Wayne Leonard
Sean Corry

**Lou McDermott**: Policy Resolution SEBB 2019-08 passes.

**Eligibility and Enrollment Policy Development**

**Rob Parkman**, Policy and Rules Coordinator, ERB Division. I'm introducing two policy resolutions today. First, Policy Resolution SEBB 2019-09 - Error Correction Recourse, and Policy Resolution SEBB 2019-10 - Error Correction Premium Responsibilities. Both resolutions deal with SEBB Organization errors. We will run a decentralized system. With all the new SEBB Organization school employees joining the SEBB Program on January 1, 2020, there may be some employer errors that need correcting. These resolutions provide direction on how to handle those errors.

Slide 4 – Proposed Policy Resolution SEBB 2019-09 – Error Correction Recourse. If a SEBB Organization fails to provide notice of benefits eligibility, or accurately enroll a school employee or the dependents in benefits, the error will be corrected prospectively with enrollment and benefits effective the first day of the month following the date the error is identified unless the Health Care Authority determines additional recourse is warranted.

Policy considerations: SEBB Organizations must correct eligibility and enrollment errors they caused; SEBB Organizations will correct these eligibility and enrollment errors prospectively, unless the Health Care Authority determines additional recourse is warranted. Recourse may include reimbursement of dollars paid for claims, or dollars paid for other coverage by the school employee while the error was in effect. This may also include retroactive enrollment, based on the Health Care Authority's power in this resolution.

**Pete Cutler**: The language where you gave the examples of what might be included recourse, is that intended to be part of the policy resolution, or is that just comments?

**Rob Parkman**: Those are additional comments.

Proposed Policy Resolution SEBB 2019-10 - Error Correction Premium Responsibilities. If a SEBB Organization errors and enrolls a school employee or their dependents in SEBB insurance coverage when they are not eligible, and it is clear there was no fraud or intentional misrepresentation by the school employee involved, premiums and any applicable premium surcharges paid by the school employee will be refunded by the SEBB Organization to the school employee without rescinding the insurance coverage.

Policy considerations: SEBB Organizations must correct eligibility and enrollment errors. This policy addresses when a school employee or their dependents were found eligible and enrolled in coverage when not actually eligible for SEBB benefits. It requires the SEBB Organization to bear the cost of this mistake by refunding all premiums and applicable premium surcharges paid by the school employee for the coverage. The SEBB benefit coverage will not be terminated retroactively but will be terminated prospectively.

**Dave Iseminger**: That bottom piece, about not rescinding coverage, is because federal law prohibits the retroactive rescission of insurance coverage. This resolution is saying if there was a mistake, the person who bears that mistake is the employer, not the employee. I do think that we've received some feedback already and if the Board's amenable to it, it will be considered Board feedback. It would add the word "retroactively" in "without retroactively rescinding the insurance coverage." To be very clear about no retroactive rescission. In our world we often think of rescission as being retroactive, but we can be very clear that it's retroactive rescission. We'll add the word "retroactive" in the last clause.

**Pete Cutler**: I definitely approve that and I would suggest it also would be helpful to be very clear that it is permissible, however, to cancel the insurance on a prospective basis going forward if the person is not eligible. Just no doubt at all if somebody reads it. Thank you.

**Rob Parkman**: So you want that added to the resolution?

**Pete Cutler**: That's what I would suggest.

**Dave Iseminger**: I'm curious other people's thoughts about adding that to be clear that it's retroactive rescission that is prohibited, but also prospective cancellation is allowed.

**Terri House**: Could I get an example of that? Of what Pete means? Could you provide me an example of that clause?

**Pete Cutler**: I think it is actually the concept. It is generally understood that if you are discovered to not be eligible for some kind of benefit that you've been signed up for by your employer, once that mistake is discovered, this policy wants to make it clear that there will be no risk that you will have that eligibility retroactively taken away, and therefore, be subject to the cost of claims you may have incurred while you thought you were eligible. But the same time, I know from having worked with Collective Bargaining Agreements in other situations in the past, there have been some that said, "well if it's not clear, then perhaps we have a right to just continue on coverage once the employer has made a mistake. They can never basically correct it." And the idea is to say, "no, it can be corrected going forward. It just can't be corrected in any kind of retroactive manner."

**Terri House**: Thank you, Pete.

**Rob Parkman**: I will incorporate the Board feedback received. We will send that out to stakeholders. We'll conduct the same stakeholdering we have over the last 18 months. We'll bring a recommended policy resolution back to the Board to take action on at the May 16 Board meeting.

**UMP Pharmacy Benefit Proposal**

**Marcia Peterson**., Benefit Strategy and Design Section, ERB Division. **Ryan Pistoresi**, Assistant Chief Pharmacy Officer. Dr. Emily Transue, Associate Medical Director.

**Dave Iseminger**: I want to remind the Board about this journey. Last May, we had a proposal, Resolution 2018-24, about possibly changing the self-insured plan's formulary. The Board did not take action on this resolution in 2018. A similar topic has been debated by the PEB Board about changes to the pharmacy formulary components the last two or three years.

Last year, this Board wanted to know what the PEB Board did since they have spent a lot of time talking about this topic. The PEB Board had six voting members at that meeting, and split the vote 3-3. Nothing changed and we have gone back to the PEB Board with something different in 2019. There were plenty of other topics to discuss with you for the SEBB Program launch so we tabled the discussion here.

We spent time in the intervening months working on a revision to the pharmacy proposal and presented this resolution to the PEB Board at their March meeting. They had fewer questions than ever before! We are asking them to take action on the resolution in the next couple of meetings.

We will bring a similar concept to you. If there's going to be a benefit change for 2020, it would have to occur for both programs at the same time. Both Boards have to agree to it. That's where we are now. So Marcia's going to present on this topic today. It's part of the reason we had Molly Christie before you the last three meetings talking about different components of pharmacy, and now we're leading into this discussion. We won't ask you to take action on this at the next Board meeting, but we will ask you to take action after the PEB Board takes action.

**Marcia Peterson**: I want to point out there is an appendix. In this appendix are definitions I'll be using throughout. You may want to pull that out and look at it while I'm talking.

Slide 2 – Considerations. If the Board wants to make this change to the UMP pharmacy benefit, it would be best if the change is made now for it to go into effect January 2020. The PEB Board is also considering this change. Moda is our pharmacy benefit manager for UMP and they are unable to administer two benefit designs for the same plan, at least in time for implementation in 2020. Both Boards would need to approve the resolution in order for the change to occur for plan year 2020. If you were to wait to make this change next year, it would be more disruptive to members because all SEBB Program members will experience a change in their benefits in 2020. It would be less disruptive to those members who choose UMP, get used to the new formulary, and then have it change in 2021 or 2022 if you were to make the change later. Also, K-12 retirees who move from UMP plans in the SEBB Program and then retiree and move to the UMP plans in the PEBB Program coverage would have continuity in their formularies, if they're both the same.

The more consistent the UMP benefit is for both populations, the less likelihood of confusion when members are looking for information on our website around cost shares, etc. You have some time to think about this and ask questions before we bring it to you for a vote. It will need to be approved by June 12 for it to be effective 2020.

Slide 3 – Proposed Policy Resolution SEBB 2019-11 – Self-insured Value Formulary. This resolution has the exact same language the PEB Board is considering. Unlike the fully insured plans, the self-insured plan we're talking about today currently has an open formulary. The main change is that it would operate more like other health plans, for instance the fully insured, with some drugs that are on a formulary and covered, and some that aren't.

SEBB 2019-11. Beginning January 1, 2020, contingent upon approval of a value formulary resolution by both the PEB Board and SEB Board, all UMP plans require the use of a value-based formulary, and:

- Nonformulary drugs are covered only when medically necessary and a formulary drugs were ineffective or are not clinically appropriate for that member, and
- Multi-source brand-name drugs, including those in refill protected classes, are covered only when medically necessary and all formulary drugs have been ineffective or are clinically inappropriate for that member, and
- Members who have been taking a non-formulary drug are required to switch to the formulary drug, unless:
  - they receive or have already gone through the exception process and been approved, or
  - their drug is within one of the refill protected drug classes which include: antipsychotics, antidepressants, antiepileptics, chemotherapy, antiretrovirals, immunosuppressives, and immunomodulatory/antiviral treatment for Hepatitis C.

Slide 5 – A high-level look at the current UMP pharmacy benefit tiers. I'm going to take you through an explanation of how it's going to work. The UMP pharmacy benefit was established in 2014. It has five tiers and an open formulary. For every covered drug class, there are drugs in one of the above tiers. In general, all drugs are covered in some way, shape, or form. The copays, which are the costs the member pays, are designed to steer members toward the lower-cost drugs. You can think of Tier 3 drugs as having similar effectiveness as those in the other tiers, but they cost more both for the plan and the member.

The Preventive Tier reflects the United States Preventive Services Task Force (USPSTF) recommendations and includes largely vaccines and contraceptives that were made a requirement for coverage within the Affordable Care Act (ACA). Those have no coinsurance or deductible in order to reduce financial barriers to their use. Value Tier has a small coinsurance amount so as not to discourage the use of these drugs and to keep them affordable for members who need them. Tier 1 includes select generic drugs at a slightly higher cost. Tier 2 includes preferred drugs that tend to be brand name drugs. Tier 3 has the highest out-of-pocket costs and includes non-preferred drugs. From the member's perspective, the drugs in these tiers might be largely interchangeable in terms of effectiveness. It's best for the member's pocketbook and for the plan's ability to hold down premium costs if the member does choose a lower cost drug.

The problem we've run into in this plan is there's a lot of volatility in drug pricing. There are some really high-priced drugs in Tier 3 non-preferred drugs where the members are responsible for paying up to 50% of the costs. Although the tiers are designed to

encourage members to choose something that may be just as effective but at a lower cost share, we found members and providers may not be aware that those less expensive drugs are available and will work for them. They get the expensive drug that was prescribed. Drug companies have introduced copay coupons, which effectively negate these member incentives. The plan still pays the cost.

Slide 6 shows the actual member costs as they currently exist for the UMP pharmacy benefit. Column one names the tiers. Column two shows the coinsurance or deductible the member pays for their drug depending on the tier it's in. Column three shows the maximum out-of-pocket costs for a member for a 30-day supply. Their annual maximum out-of-pocket is $2,000.

**Dave Iseminger**: The only thing I'm going to add is the context of this is a 30-day supply because it could be 30-day or 90-day supply. This example is a 30-day supply.

**Marcia Peterson**: Every health plan struggles to keep their drug costs down by using some sort of coinsurance mechanism. By and large it seems to work a little. Within the PEBB Program population, the use of generics is really high, about 90%. So it's working to some extent. Sometimes there's no generic available and the price of the Tier 3 drugs can be extremely high. For example, if my doctor prescribes a Tier 3 drug for me that's not a specialty drug that costs $2,000 for 30-day supply, my out-of-pocket cost is $1,000. Faced with that, it is in my best interest to try something equally as effective that costs less.

Drug manufacturers have found a work-around by offering copay coupons. In my example, if I'm able to apply my copay coupon, I might pay only $20 for that same $2,000 drug which is great for me, but the plan is still paying $1,000 to the drug company. To protect the plan, and ultimately the member premiums, from drug price increases, we would like you to consider establishing a value formulary for the Uniform Medical Plan.

Slide 7 is an illustration of copay coupons and how they contribute to increasing premium costs. The costs shown are just examples. Copay coupons may be available from your physician or found online. As a patient, you give the card to your pharmacist when you get a prescription filled. The amount of the copay may be reduced or covered entirely. The pharmaceutical company that makes the drug covers the cost of reducing your copay when you use the card. However, the health plan still pays the price of the most expensive drug, as only the consumer gets the benefit of the coupon. This is illustrated by the third column in the table, which shows that for the brand name drug costing $3,800, a copay coupon could lower the member cost from $1,900 to $0, but the plan still pays 50% of the price of the drug despite the coupon. This can lead to increased premiums for everyone because the total cost to the health system is much higher, in this case, more than 12 times higher than the generic option. While on the one hand, copay coupons can be really helpful to patients trying to afford expensive drugs. They ultimately serve to mask the true cost of the brand drug.

Slide 8 – Copay Coupons are easy to find. As I was doing research for this presentation, I was amazed to realize how easy it is to find copay coupons online. I could save hundreds of dollars by using the coupons if I really wanted to get the drug

Concerta, which is a brand name, versus the alternative. While this is great from the individual member's perspective, and we would never try to discourage anyone from trying to save money, when you multiply that by thousands of members, the plan as a whole just got more expensive for everyone. That's one of the reasons why we're proposing the formulary, to protect against that.

Slide 9 – Proposal: Pharmacy Benefit Tiers – UMP. The value formulary would essentially eliminate Tier 3, or nonpreferred drugs, from coverage. For every covered drug class, there is at least one drug in the other tiers. In the light blue box on the right, it indicates members would pay 100% for the cost of these drugs not on the formulary, or they would go through an exception process. If they can show medical necessity, those drugs would be covered.

**Dave Iseminger**: I want to highlight what Marcia said because it's such a critical piece and it can get lost in it. "For every covered drug class, there is at least one drug in the other tiers." It's not like there's a disease state or a drug class where there wouldn't be a coverage option within the pharmacy benefit. It's saying you need to try those lower cost possibly/probably equally effective drug first, before going to the one that will increase the cost for the overall plan and could impact member premiums.

**Ryan Pistoresi**: Just to kind of reiterate, we're not looking at excluding any types of drugs for certain disease states. Everyone currently taking a Tier 3 drug will have an alternative available for them, or a system in place to ensure there is access for these members to get the medically appropriate drugs.

**Pete Cutler**: Is there some analysis done of the efficacy of the options that are provided in Tiers 1 or 2, or the value because I could see somebody saying “for whatever class of drugs I'm taking, you give me an option, but it's not nearly as effective as what you're preventing me from getting in Tier 3.”

**Ryan Pistoresi**: Every drug on the UMP formulary does go through a review process through the pharmacy and therapeutics committee. There are certain drug classes that go through the Washington State Pharmacy and Therapeutics Committee, which meets every two months. They review the most current safety and efficacy data and comparative effectiveness data so they can make that comparison. Then we go through a cost analysis process at HCA and select a lot of the drugs that way. For all the other drugs not on the Washington preferred drug list, they go through Moda's P&T Committee. They have a Board of physicians and pharmacists that review the safety and efficacy of those drugs. They provide us the recommendation so that we have a chance to review and either approve them, which mostly we do, or if they're a Washington P&T drug class, then we'll look at some reconciliation that we can do for those drugs. Every drug does have a P&T review to ensure there is comparable safety and efficacy. Moda does provide the recommendations of how these drugs should be structured on our preferred drug list.

**Emily Transue**, Associate Medical Director. The one thing I would add is if for an individual one drug was more effective, if the drug on Tier 2 didn't work, they would be able to go through the exception process. As a rule, there should be comparable efficacy, but individual circumstances do vary.

**Pete Cutler**: So it's both. Once something's considered equally effective available in the higher tier, or lower tier number, but for a given individual, there is a process if for that individual the doctor or whomever doesn't believe that option is effective, then they can seek access to a drug that's not in the formulary. Thank you.

**Marcia Peterson**: Those are good questions and we have struggled to understand those as well. It's important to shift our mindsets. I had to do this myself. As a layperson, I watch tv and see advertisements. I'm excited about these drugs that are advertised and it's embedded in my mind that "this is the best drug." I've had to learn to think about this, in this process as a member, I begin my medications for a medical condition with a most-preferred drug therapy. I only go to those other therapies if necessary. Most fully insured plans usually have formularies. We are proposing one as well. Why would you pay more for a drug that's no more effective than a lower cost drug?

Slide 10 is an example of why that's actually a better option for our members. I'll use the drug Lyrica as an example. Lyrica treats nerve pain and commonly used to treat fibromyalgia. It's a Tier 3 drug and costs the member $214 for a 30-day supply. We chose Lyrica because it's one of the most requested exceptions in the PEBB Program. Gabapentin is a generic alternative, also used to treat nerve pain and fibromyalgia. It's a Tier 1 drug and costs the member $1.78 for a 30-day supply.

Slide 11 is an example of what we're worried about happening and we want to avoid by setting up this value formulary. The example shows two members, Don and Dave, who are both prescribed Lyrica for fibromyalgia. They both try gabapentin, but as can happen for a few people, it doesn't work for either of them. Don is aware of the exception process and his doctor and plan determine there's medical necessity for him to take Lyrica. He pays the Tier 2 price and gets Lyrica at that price. Dave is not aware of the exception process and goes through the whole thing, ends up paying the Tier 3 price. He has not gone through the exception process. He can still get Lyrica, but he's paying $214 for a 30-day supply.

We asked ourselves if we could address this issue with better education, but with 150,000 subscribers and all of their dependents, there are going to be people who fall through the cracks. That's what's happening now. It creates inequity for people. By eliminating Tier 3, it basically requires people to go through the exception process so they don't get stuck paying those higher prices.

**Ryan Pistoresi**: We put the exception process in place because there were people that needed to progress to Tier 3 drugs because they did try the lower cost alternatives, but because there were no lower cost alternatives, we didn't want there to be a barrier in terms of the costs. We wanted to make sure they're taking the medication that is medically appropriate for them, and the one that works. Not everyone in the plan knows about this process. There are a lot of people who could benefit from this, take their drug currently and they do meet this process, but they're not paying the Tier 2 cost share. We believe this would benefit the members.

**Dave Iseminger**: I saw a puzzled look for a minute. I will say it again in a slightly different way. When we described the current UMP formulary earlier in the

presentation, we drove home that point that every drug and drug class has something within all the formulas. It ties to Pete's question that for most people, the lower cost drug is effective for them and for some, they didn't win the genetic lottery. They got the bad lottery ticket and the drug that works for most people doesn't work for them. In that instance, they have a drug in Tier 3 and are paying that higher rate. We came up with the exception process. Just because I got the bad genetic lottery ticket, I'm not penalized for that. I tried all the things that work for everybody but didn't work for me. Now we would eliminate the Tier 3 category. Instead, everybody goes through the exception process. You won't go through the exception process if you're part of the majority who the drug works for. Everyone starts with the preferred drug.

**Patty Estes**: The question that keeps rattling through my mind is how is this going to work for open enrollment and that giant switch that's going to be flipped.

**Ryan Pistoresi**: We are working on a transition plan. Regardless of the action on this resolution, we are working on a transition plan for all new members that would be going through open enrollment and potentially joining the UMP Plan for 2020. We are looking at how we can identify what medications the members are currently using so they can continue to use it, especially around specialty medications. We are working on a transition process that could incorporate the value formulary should both Boards approve it.

**Patty Estes**: I have several friends on medication. They've been on that same medication for years. Having them go through the exception process where they have to try another drug could be potentially dangerous medically. That would be a concern of mine, of someone not informed on the process. Hearing that they have to now go through this process might scare people a bit.

**Dave Iseminger**: There are a couple of safeguards in place. Even if the Board doesn't pass this resolution, we would always be very sensitive with those categories of anti-psychotics and the list of seven refill drug-protected class.

**Patty Estes**: Refill-protected classes?

**Dave Iseminger**: Whether or not the resolution passes both Boards, there will be a lot of careful sensitivity with those particular disease states. There are a lot of delicate medication transitions that have happened. That is one piece that has a special bubble around it to protect it. The second piece, when someone is getting to the drug that is now working for them and had previously tried different drugs along the way, they would get credit for that. They wouldn't have to retry a drug they had already tried in a previous step therapy under another insurance plan. I want to make sure there is an acknowledgement of that piece. You don't have to repeat your homework if you've already done it.

**Patty Estes**: With that, the question would be how do they prove they've already tried that. Do they have to provide medical records? What does that process look like?

**Ryan Pistoresi**: There is going to be a transition period and process for the Uniform Medical Plan. When people first join the plan, they'll be able to fill the medications.

Moda will be able to gather data and better understand what medications members are on. We will also be able to provide information on open enrollment. If your friends know what medications they're on and they're asking questions, they could be able to reach out to Moda or to the other SEBB plans and ask how are these medications covered? Is there anything else I should know about? What is my potential cost share for a 30-day supply? There will be information available. Hopefully we can answer a lot of these questions during open enrollment for a smooth transition for January 1, 2020, and have a system in place to allow PEBB Program members to fill their medications and not be interrupted, even for drugs that have prior authorization or step therapy, etc.

**Emily Transue**: One of the important points that you raised is what if it's dangerous for them to change. There's a real distinction between when it's dangerous to change, and when it's really what someone is used to. If someone has been taking the blood pressure medication Lisinopril, even if it's been for 20 years and it's working for them, and there's another one called Benazepril that's basically the same and works the same for 95-99% of people, there would be an expectation that there would be a change since that's a low risk situation. There's no reason to think they'd do poorly on Benazepril.

The creation of those protected classes really was specifically around those areas where there can be a danger to changing. There also would be an awareness in other situations if the clinician explained that this patient has a set of conditions and it's not safe for them to change, that would be taken into account in the exception process, in addition to the other standard components.

The question of the evidence standard for showing if you are on something before. I think we'll probably have to go back and look that up. I know different Pharmacy Benefit Managers (PBMs) handle that differently and I'm just not sure about Moda.

**Dave Iseminger**: We'll follow up on that at our next meeting.

**Ryan Pistoresi**: Typically that information is between the provider and the PBM. There will be a lot of communication. It's not really on the member to be able to generate pharmacy records or pharmacy claims to show what drug they took on what date. It'll mainly be between the provider and the PBM, and potentially the pharmacy in case they need to have some communication there to ensure the patient is able to get the right medication.

**Patty Estes**: I think that answered almost everything. So, follow up. Thank you.

**Dan Gossett**: I'm trying to think about how to word these questions. I guess in a pre-SEBB world, that's what we've been talking about. You tried the generic, there's been a problem with it. The way the language here says you've done all formulary drugs under it. Maybe with your provider at that point you hadn't tried all of them. Are you going to have to go back and work with other generics that you hadn't tried?

**Ryan Pistoresi**: Is this for a new start?

**Dan Gossett**: Already been on something.

**Ryan Pistoresi**: I think we have examples of that in future slides.

**Dan Gossett**: Okay.

**Marcia Peterson**: Slide 12 is a summary of the issues we've talked about for the current design that we want to fix with a value formulary. The current design is open, has tiered pricing, and has an exception process, if you know about it.

The challenges are that the members might or might not be aware of the less expensive alternatives that they could actually use. Tiered pricing doesn't always work to steer members to lower cost alternatives that are just as effective. Copay coupons negate the impact of that shared pricing and cost the plan. Members who are prescribed Tier 3 drugs might not be aware that the exception process exists.

Slide 13 – Uniform Medical Plan Proposed Value Formulary. When we use the term value, we're referring to the fact the drugs have the same level of effectiveness as lower cost drugs, but are higher cost and not included in the formulary. The medications can change all the time. There are always new drugs coming on that are being evaluated.

**Pete Cutler**: I have a comment about where does value come from? My understanding is if these medicines are, for a given drug class, expected to be of equal efficacy and safety, that understates it, should be that but are not expected to work better than. This makes it sound like you may get lucky. What we're offering may be worse, where in fact, it's the assumption I've done research and it's expected that the ones that drop more will probably not work better than the option they do have.

Getting to the point you made about how the formularies could change. If I were a member, I'd be concerned about how much risk is there that something that I've been approved for that's, say, in Tier 1 or 2, or whatever, would get dropped. I'd find myself mid-plan year, when I can't make a change, finding that I no longer can take that drug. How much turnover, and how much notice, is there for turnover on the formulary?

**Emily Transue**: Drugs typically jump to being less expensive rather than more expensive, although there are some exceptions. Most of the changes that are happening to the formulary are things shifting to lower on the tier structure and being added in as a lower cost drug. There are rare occasions where there is a frame shift. You've probably read in the papers about a few older, generic drugs who were picked up by a new manufacturer and the price was increased 200 - 300 fold. There would be the potential in that kind of situation if there was an equivalent, much cheaper drug, that someone would be asked to change. But that would be a relatively rare situation.

**Pete Cutler**: Thank you.

**Marcia Peterson**: Slide 14 has examples of how the value formulary will work from a member's perspective. In this first example, a member who's notified that the drug that she was previously taking, Lyrica, that was previously covered, is no longer on the formulary and is now not covered. Unless she has already gone through the exception process, or if she's using a drug from one of the refill-protected drug classes, which Lyrica is not as far as I know, she has three choices. She can continue using Lyrica,

but would have to pay the full cost in order to continue using it. Or she could try Gabapentin. In this case, that's on the formulary, and she could pay the applicable copay. Or she can request an exception for medical necessity, and go through the process with her physician and the plan. If she's approved, she can continue using Lyrica. Maybe there's some reason why that's the only thing that will work for her. And pay the applicable copay, at the Tier 2 level in this case. If she's not approved, she can go ahead and pay the full cost, or she can use the covered drug and pay the lower copay. In talking with our clinicians, it's very likely other health plans have a similar process that your members are going to go through.

Slide 15 is the example of somebody newly prescribed a non-formulary drug. Again, we're going to use Lyrica. We have a member who goes to see his doctor. He's newly prescribed Lyrica, a Tier 3 drug not on the formulary. He goes through a similar process. He can use Lyrica and pay the full cost. He can use Gabapentin. He needs to try that and pay the applicable copay. Or, in using that, and requesting the exception he can go through that process. Again, his physician and plan work together to determine if there's medical necessity for him to use Lyrica. He has similar choices. If he's approved, he goes ahead and gets Lyrica at the Tier 2 copay. If he's not approved, he can still use Lyrica if he really wants to but he's paying 100%. Or he can go ahead and use Gabapentin, or whatever the formulary drug is. So that's how the exception process would work.

Slide 16 shows the refill protected drug classes. If the formulary changed to exclude a drug in one of these classes, the member would not be required to switch to the formulary drug. I think that addresses your comment, Patty. That is a concern we've all heard from friends, family members with chronic conditions, and life threatening diseases. They've spent years trying to find exactly the right drug that works for them. In these cases, you can see antipsychotics, antidepressants, and so on. They would not be asked to switch.

**Ryan Pistoresi**: Going back to the last slide where we went through the example. A lot of members who are going towards these non-formulary drugs usually do try the lower cost alternatives first. But this is a way for us, if someone is stepping into some of these higher-cost drugs, to tell them about this formulary version that is safe, effective, and a much lower cost to the member and would you be able to try that instead? If they have already done that, there is the exception process. It's not very frequent that a member will start with one of these non-formulary drugs without having tried some of the other alternatives. They may already have tried two or three of them. If they still want to continue, there's still a few other formulary alternatives that are not only lower cost to the member but lower cost to the plan.

**Alison Poulsen**: On that point, I'm curious about the process from my doctor prescribing me Lyrica. I assume the pharmacy and the pharmacist is now saying, "gosh, it's going to cost you this amount based on the tier. But you could try this." And so, if I agree, I want to try the lower cost one because it's better for my pocketbook, how does that information then get back to the provider? Or does the pharmacist have to consult with the provider, and has the provider made a decision to prescribe Lyrica because of it being Lyrica versus the type of medicine? Could you just talk about the process part of that?

**Emily Transue**: Yeah, I can talk about it from the physician side and then Ryan can talk about it from the pharmacy side. Typically, that's a phone call while you're in the pharmacy. Or it could be a fax if you get there at seven o'clock on a Saturday. And there would always be a check with the doctor. I shouldn't say "always." There would typically be a check with the doctor to make sure. “There’s something that's much cheaper. Is this something that you think would be appropriate for your patient?” And the doctor would say yes or no.

There are rare exceptions to that. There's a substitution process for some things that are very nearly equivalent where if the doctor signs up to say, “it's okay for you to substitute within these groups unless I sign on a different line, to say it's got to be what I said exactly.” But typically that would be a communication cycle back and forth. That's really normal.

One thing that I would really want to express in all of this. I graduated from medical school in 1996, and back then, we were not that concerned about prices and you just wrote whatever you wrote. If someone came in and said, “I want this one -- we write for that one.” Over the last 10 or 15 years, it has become very much the norm of what we all do to try to figure out how to get people what they need within a set of cost constraints that are going to be reasonable. People really try to pick the lower cost and formulary things in general, when they can. People have the expectation that there will be times when you're going to be having that back and forth with the pharmacy. For me, the horrifying thing is when you don't have it and someone comes back holding an inhaler saying, “I spent three hundred dollars on this because they said there was a different one, but I figured you probably gave me the best one.” And I'm thinking, “the $40 one is exactly the same, but I didn't know that your insurance company was going to view them differently.” Those discussions are part of the world that we expect to live in as docs and having that happen as seamlessly at the pharmacy as possible is certainly what you expect to try to do as a doc.

**Lou McDermott**: When we have the discussions internally, it's always about trying to steer folks to the most cost-effective medication that work for them. There's always exceptions, and those are always built into the framework. But what happens is the world sort of changes their practice. So, originally, when the tiering system was built, the use of coupons for members wasn't widely used. And so the Tier 3 was a disincentive to use that medication. There was a little known exception process, that you could get the Tier 2 pricing for the Tier 3, but you'd have to know that. There's a portion of the population who was disadvantaged because of that. They didn't know, they didn't have the information. But at the end of the day, you know when the drug companies started realizing, “hey, if we just waive the employee's copay then we're still going to get the big hit on the employer.” It has become less and less effective as a tool.

The theme you heard around the old system and the new system is still getting medication that works to the patient, and making sure it's the most cost effective way -- and always allowing an exception, because we're dealing with people. And people are all different. And there are unique circumstances. Anytime we transition, like we're transitioning from what folks are in today to what they're going to be in tomorrow, lots of thought goes into how to make that transition. So on the PEBB Program side, the

thought is, how do we implement this new program the best way possible? Is it going to be like the cold shower and everyone's going to right on January 1, or is it going to be the, we grandfather people in to the medications they're already in and then there's lots of discussion on how to do that.

In this program, there is the same discussion but a little bit different because we're picking people up from all different kinds of insurance and now trying to incorporate them in ours with that bottom line of making sure that they get the medication they need, that it is as seamless as possible. But that's sort of the theme. It's not a tactic to try and take medications away from people. It's to try and get them to the right medication. The format we used before, the pharmaceutical company has outsmarted us. That's why they get paid billions of dollars. They found a way around our structure. So this is now to combat that. And in a few years, we'll be back with, “oh, guess what now.” So, just some thoughts.

**Patty Estes**: I actually did work in a pharmacy for a few years, so I understand that process where we would call, “is this one okay? Does it interact?” So I get that process. My question is more about the exception process. How long does that typically take? Is it back and forth? I know you guys said the member typically doesn't have a lot to do with that. It's more in between the providers and the insurance companies. So how does that process work, and what does that look like for a new member switching over to a UMP that wasn't on a UMP before?

**Ryan Pistoresi**: The current process usually will take a couple of days. Usually what happens is you get the exchange between the pharmacy, they bill it, it comes back with a reject message, and says “must try the formulary alternative” or like a typical prior authorization wherein the pharmacy contacts the provider's office and says this is now a prior authorization. The physician will then call the plan and say, “what information do you need, and how do I submit it?” Once they get the information that they're able to get from the chart notes or from the pharmacy records, they will submit that to Moda. And there is a clinician at Moda that will then be able to review that and determine if the information is sufficient to grant the exception, if there is more information that's needed, if they need to make a call, or if there is not enough information, if they don't meet the criteria, then that denial. And then that gets communicated back to the pharmacy and they are either able to adjudicate the claim and get the medication to the patient, or they'll be able to provide an alternative that's based off of the formulary exception. If someone is denied, they can point them towards an appropriate alternative that would be approved.

For new members, though, that point would be similar but it may be a bit more of a challenge since they will be new to the plan. They won't necessarily have a lot of that claims history and so there may be more information that needs to come from the provider's office. But it should only take a couple of days to get the information into the Pharmacy Benefit Manager (PBM) for them to review, and then make a determination.

**Dan Gossett**: It's difficult to have data for the SEBB population, because we're dealing with all these different groups. But we should have data for the PEBB population and so the question -- a couple questions is what's the percentage of the people in the PEBB Program that this would impact? Right now, under the PEBB Program, what's the percentage of medications that are generic that are taken?

**Marcia Peterson**: I think that's 90% within the PEBB population.

**Emily Transue**: And there are also brand name medications in Tier 2, so the number would be less than 10% who would be in the exception process.

**Patty Estes**: Another number that I would be curious to get is the percentage of denials in the exception process, and maybe why.

**Ryan Pistoresi**: The denial number for the most recent quarter that we got a report from Moda is about 70%. And the reason it is about 70% is that a lot of patients that are trying to go through this process usually go after trying maybe one alternative or none. People try to see if they are able to go through that process. So most of the time when we get these medication requests for the exception process, it's denied because there are still other alternatives. We're able to provide that list and say, “here are one or two other alternatives that you would need to try first before getting this exception.” If you look at the case, then the member has the decision to try those or they can continue to pay at the Tier 3 cost share or try the alternatives.

**Pete Cutler**: Am I correct that the Health Care Authority would have access to which drugs are covered in the formularies for at least several of the larger carriers that are currently covering school employees, such as Kaiser, Premera, or Aetna? Is that publicly available or accessible information for the Health Care Authority?

**Ryan Pistoresi**: If I can clarify your question. So you're looking for a few high-profile disease states like diabetes, hypertension -- and seeing how the different formularies compare?

**Pete Cutler**: Actually, just which drugs they will cover under which tiers. My daughter just signed up for a large group employer plan in Florida. We were able to print off an amazing number of pages of details. They were in various tiers and had various footnotes. Some were more complicated to access than others. But if that information is available, it would seem one place we could start where it would be helpful if there are resources available, would be to look at what these other carriers do because in the school area, last I checked, a huge amount of the coverage is with insured plans. It's not self-insured. If you have access for those carriers and what they include in their formulary, it should be possible, hopefully, to do a check off, to see where don't we align if we eliminate Tier 3. That would, without getting into an individual person-by-person SEBB Program member interaction, be a way to try to predict how many different drugs would we expect to have some kind of discrepancy in terms of what they could access under the value-based formulary versus what they're currently getting access to.

**Dave Iseminger**: We won’t answer that question off the fly right here, but we'll take a look at that request for basically formulary-by-formulary comparison with the proposed UMP formulary to elucidate the types of drugs that would be the most likely candidates for people to be navigating, or impacted by this.

**Pete Cutler**: Thank you.

**Dave Iseminger**: There are two pieces I want to add. The Health Care Authority keeps talking about these as real issues that are happening in the PEBB Program. And by you taking the opportunity to switch to this formulary at the same time the SEBB Program is launched, you avoid creating these problems in your population. While we're using very active verbs now, it's because we have a population that has these issues and I wanted to acknowledge that verb tense. In reality, by passing this at the same time as the PEB Board, you would avoid some of the very problems that exist, that are prompting the agency to recommend this to the PEB Board.

The second piece is Slide 16. It is an important piece about these refill protected classes and why the generic therapeutic definitions are on it. It is true that under existing state law that if there is a generic drug created that covers one of the drugs in one of these disease states, there is already a requirement to switch to that generic drug because, by definition, a generic is same dose, same form, same safety, same strength, etc. It is essentially identical. State law requires that switch to generic drug. That is not the case if it's a therapeutic drug. It's got something just a little different so it's not a generic. Where there is a true generic, there would be a requirement to switch to a refill protected class, even in a refill protected setting because of existing state law.

**Marcia Peterson**: Slide 17 – Proposed Changes. This slide summarizes what we've already talked about. Why are we proposing this? We feel it's simpler and more consistent with other plans that our SEBB Program members will encounter. It offers more value, addresses equity issues by allowing for that lower copay if the member goes through the exception process. It could save members money at the pharmacy when there's a less expensive alternative and could protect the plan from some of the extreme volatility in drug pricing that we've seen the last few years. It allows members already taking drugs in refill protected drug classes to remain on their drugs. It could help control the trend in premium prices, keep the drug spend at a manageable level for our SEBB population. We feel this is the best time for this change to avoid member disruption a year from now. It addresses the continuity issue for K-12 employees who then move into the PEBB Program when they retire.

**Lou McDermott**: Are we going to talk about the significance of the impact to the retirees? It will have a positive impact on the retirees and their premiums? Because of the way the retirees' premiums are established, the significant increase in pharmaceutical cost is picked up by them. They're feeling the entirety of that increase. While on SEBB and PEBB, with the 85% - 15% split, we're feeling a portion of that increase, but the retirees feel most of it. They have been impacted significantly. When we have an increase in premium, let's say by $10, maybe $7 or $8 of it is pharmacy, $2 or $3 is medical and other, whereas, the retirees are experiencing the whole $10. It's really been hard on them and they've had some double digit increases.

**Dave Iseminger**: That is why we've been on a multi-year journey with the PEB Board about this issue. It stems from the fact that once you're in Medicare, Medicare pays primary for medical. But under the UMP, Medicare pays secondary on pharmacy. And so, when you're the primary payer for pharmacy under UMP, your pharmacy costs heavily drive the ultimate premiums that are paid. That's fundamentally the structure that exists on the PEBB retiree portfolio. With UMP as primary payer for drugs, those costs do get borne more on the member. That's why we've been on this journey.

Although retirees aren't in your risk pool, at least for today and probably not tomorrow, but maybe one day.

**Marcia Peterson**: Slide 19 – Proposed Policy Resolution SEBB 2019-11- Self-Insured Value Formulary.

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

- Nonformulary drugs are covered only when medically necessary and all formulary drugs were ineffective or are not clinically appropriate for that member, and
- Multi-source brand-name drugs, including those in refill protected classes, are covered only when medically necessary and all formulary drugs have been ineffective or are clinically inappropriate for that member, and
- Members who have been taking a non-formulary drug are required to switch to the formulary drug, unless:
  - they receive or have already gone through the exception process and been approved, or
  - their drug is within one of the refill protected drug classes which include: antipsychotics, antidepressants, antiepileptics, chemotherapy, antiretrovirals, immunosuppressives, and immunomodulatory/antiviral treatment for Hepatitis C.

**Marcia Peterson**: Slide 21. What will happen if either Board chooses not to adopt the value formulary this year? If that happens, the existing tier benefit design will remain unchanged for both programs. It could result in inequities, exposes the plan to more risk from some of the pricing volatility, and it would be harder to implement in following years because of changes for members two years in a row.

**Lou McDermott**: Marcia, who is voting first? Just out of curiosity.

**Dave Iseminger**: The PEB Board will vote first. As I said, we recognized last year there was intent interest as to what the PEB Board would do since they've had many more years focused on this issue. That is why we presented this resolution to the PEB Board at the end of March. Because we started that way, the cadence is always that there is a PEB Board Meeting before a SEB Board Meeting. There will always be an opportunity to have the SEB Board vote after the PEB Board. The drop dead date for each Board to make its decision is June 5 for the PEB Board and June 12 for the SEB Board. By design, the calendar and how we have scheduled it with the meetings, there would absolutely be an answer to whether the PEB Board said yes or no before the drop dead date for this Board.

**Lou McDermott**: So the PEBB resolution, is it contingent on SEBB saying yes? Is that how that works?

**Dave Iseminger**: It's the literal same resolution, though I do think the title's different. I think we added the word "self-insured" in this title. But the words of the entire resolution are identical.

**Pete Cutler**: First of all, I will admit there's been some question about what if this body for some reason wanted to move on this and adopt this resolution today? Is there anything from a legal point of view that would prevent us from acting before the PEB Board?

**Lou McDermott**: I don't think there would be. It would be contingent upon the PEB Board saying "yes" as well.

**Pete Cutler**: I understand that.

**Lou McDermott**: But I don't think there's a reason, although our historic practice is to introduce the resolution and then take action at the next Board meeting.

**Pete Cutler**: And, generally, that is my preference as well, just to have time to think about it and stew on it. A second question, on the resolution. On the second bullet on Slide 19 it says, "multi-source brand-name drugs are covered only when medically necessary and all formulary drugs have been ineffective," which implies you can't be a multi-source brand-name drug and also be a formulary drug. I guess I don't understand, what falls in the class of a multi-source brand -ame drug that excludes it from being a formulary drug?

**Ryan Pistoresi**: Multi-source brand-name drugs are like originator drugs that have generic alternatives. As we talked about earlier in today's presentation, the generic alternatives are available at lower tiers and state law directs the members to the lower cost alternatives. If they tried the generic and the generic doesn't work, there are still multi-source brands. If there is some clinical rationale, and this is very few and far between, but we've seen experience with it, that a multi-source brand works when a generic doesn't, that's talking about that. Really the multi-source brands and why that's a separate bullet point from the non-formulary drugs is that these are non-formulary drugs with generic alternatives that are on the formulary.

**Dave Iseminger**: Pete, if you go to Slide 25 in your definitions, that might also help. A multi-source brand by definition is a brand name drug that is no longer under patent protection, and has one or more generics available. For example, back in the day Allegra was the primary allergy seasonal medication that many people took. It was on patent for 20 years. In the last four or five years, it went off patent and they made Allegra-D, which was slightly different so they could get another patent. The point being, then you started seeing in your grocery stores the grocery store version of an antihistamine. It was exactly the same chemical active ingredients and same percentages as if you picked up the Allegra box. And so Allegra, the multi-source brand, would not be covered unless everything else wasn't effective.

**Pete Cutler**: So by definition, if you have a multi-source brand-name drug, that drug has a generic alternative, and by definition the generic alternative would presumably be in the formulary somewhere and 100% of those cases where it is a generic in the formulary, then the brand name drug is excluded from the formulary? So it is a subset of nonformulary.

**Dave Iseminger**: It's almost like reading statutes. You have to go back to the definitions to understand.

**Pete Cutler**: And that's a good reminder. But it was not self-evident to me that if a drug had a generic, then automatically that meant any brand-name version of that would be excluded from the formulary. That was implied in the definition.

**Ryan Pistoresi**: Currently, for UMP and what we've been doing since 2014 is whenever a brand-name drug has a generic in the market, that brand-name drug automatically moves to Tier 3. If it's a Tier 2 drug, it automatically will move to Tier 3 and then the generic will be covered at a lower tier.

**Pete Cutler**: That was a piece of information I needed. Thank you.

**Marcia Peterson**: Slide 22 is when the UMP value formulary will go into effect for the SEBB Program population, by January 1, 2020. The SEB Board needs to vote no later than June 12. We can vote earlier and the PEB Board has to vote, too.

**Dave Iseminger**: So for purposes of this presentation, we know there are a couple of questions that we need to follow up on. I want to make sure I've captured those. We will bring this back in May to talk about the follow ups of what's the evidentiary standard that's used, which was Patty's question, and the percent of PEBB Program people we believe will be impacted, which was Dan's question, and then whatever we can do with the publicly available formulary comparison that Pete brought up. We'll bring back those questions, as well as any insights that are new from the PEB Board Meeting in two weeks and if they vote in two weeks, the results of any vote.

**Lou McDermott**: On the "how many people are impacted," if I remember right, from the original PEB Board presentation, the answer is "it depends" on how you implement it.

**Dave Iseminger**: We're going to figure out how to best answer the Board's question, Chair McDermott, without committing right now what that's going to be. We'll bring back stakeholder feedback, of course. We could always, in anticipation, schedule that you take action on it.

**Pete Cutler**: I think the underlying policy has been carefully thought out and I think it really would be hard for me to imagine what new information would come up that would lead me to not support adopting it. But at the same time, I would also, if it wouldn't be too much work, appreciate a confirmation of what we know about how many of the plans the school district employers are coming from, do in fact have closed formularies, because that's a big thing. If in fact 90% are moving from one closed formulary to another, then I think that's a different messaging situation than if many of them are coming from some variation on an open formula, for whom this will be perceived as a takeaway. So that would be helpful, if it's possible to get that information.

**Dave Iseminger**: We'll do our best.

**2020 Final Benefits Design Refinements**

**Dave Iseminger** and **Marcia Peterson**. I've talked a lot about your work being a novel broken into various chapters. We're about to enter the last major chapter of the Board's work before the Program launch. I told the Board, depending on how closely you read the October/November/December minutes, that 90% of your work was before the

legislative session and setting a preliminary suite of benefit designs. That was really the culmination of, I believe, 18 votes in the November meeting.

After the Legislature answers the final funding question, there would be the opportunity for refining the benefits in any way you wanted to. We are about to enter that stage. It is, unfortunately, a chapter with a relatively narrow timeline. It has to begin after the Legislature has done its operating budget, but before we can go into the final rate-setting piece, to be able to have the benefit design locked in enough to create and bring you employee premium contributions.

The window we're looking at is discussion and ideas at this meeting, information that we can present and have you vote on in the May meeting, and then action taken by the June 12 meeting. So aligned with the pharmacy deadline of June 12, any benefit for refinement for the 2020 program launch would need to be locked in at that June 12 meeting. After the June 12 meeting, we'll go back to the fully insured carriers and do the final rate negotiations and bring you employee premiums in the month of July. You can't make a benefit change and expect the same premium contributions to come out in the same meeting. That sets the timeline for this refinement period being the June 12 meeting.

We want to talk with you and get a sense if there are things you are interested in us preparing for May. You can also think about this between now and May, and ask us in May. But if you do ask us for specific ideas in May, we would be bringing that analysis and any potential resolutions without stakeholder review at the June 12 meeting. That would go against the principle that we've had of trying to present things, go through a month's stakeholder process, and bring them back to you. So if there are things that you want, we could prepare accompanying resolutions that could go through stakeholder review between the May and June meetings, it would be informative for the agency to know what type of things you want us to review.

I want remind you of some things we've presented in the past and will bring back in May. There was a lot of concern around the basic Long-Term Disability Benefit (LTD). The $400 employer-sponsored benefit. We previously presented a couple of potential horse trades, as I've always called them. One of them being the life insurance benefit. You could reduce that basic benefit from $35,000 to $25,000 in order to have an uptick on the basic LTD benefit. Some Board members asked that we present information about capping the dental orthodontia benefit in the fully insured plans. We presented information if you eliminated the orthodontia benefit from being in the dental plans.

Those are, I believe, the three primary pieces of information shown to the Board. We also presented information about the chiropractic, acupuncture, massage benefits, and the combined physical therapy/occupational therapy/speech therapy/neurodevelopmental therapy (PT/OT/ST/NDT) limits, and you took action to refine those upward in the November meeting.
If there are other areas you are looking to that are on par with that or equally important to try to improve, any guidance on that would be appreciated because right now our lens has been what are things that we can present to you to horse trade up the LTD basic benefit.

Our first question is are there things you're interested in refining other than the LTD basic benefit in an improvement direction. The second question is, are there other parts of the portfolio, upon further reflection, that you can identify that would generate enough claims projection savings to alter the LTD benefit?

I want to set up the timeline. We will bring back information we provided before for LTD benefits. And then, if there's other things you're interested in us preparing over the next month for May, we would love to hear your ideas. Otherwise, November 2018 votes are the current status quo. No further action leaves those prior actions in place.

When we bring information in May about those prior horse trades that we've highlighted about LTD, we'll also talk about the long-term strategy of putting forward a decision package in the next supplemental budget process to possibly have the Legislature take an incremental step. That's the “ask for more money” option, which doesn't exist for 2020, but it could exist for plan year 2021. We will talk about that long-term strategy if there is no trade that a majority of the Board is willing to make in the short term. We'll talk about some of the strategy the agency was going to pursue for the long term.

**Pete Cutler**: Not to further beat a dead horse that I've been beating for quite a while, but I feel very strongly that the state should offer both for public employees/state employees, and for school employees a more robust long-term disability coverage plan. At this point, given how far we are and how tight the funding levels are, already below what the Health Care Authority has indicated it believes necessary to fund what we have already adopted, I personally am a fan of the "ask for more money.” Provide all the analysis and presumably tie that to the collective bargaining cycle and process since it's really ultimately up to the employee organizations to discuss with the state what that priority should be given to that benefit. I personally won't be coming in asking for ways to shoehorn in some incremental change before we go live with the program next year.

**Dave Iseminger**: Thanks for those comments, Pete. And I will say that we already know that you couldn't eliminate the basic AD&D benefit to be able to increase the LTD. I know, you don't like the basic AD&D benefit. But we already know the analysis that the AD&D claims don’t provide enough to improve the Basic LTD benefit at all. That is not something that would help. I just wanted to throw that out in a tongue in cheek moment.

**Public Comment**

**Fred Yancey**, Washington Association of School Administrators. Again, I thank you for all your work and expertise. It's way beyond mine, but I'm trying to play catch up. I'm going to go backwards in terms of most current to what you discussed earlier. First of all, I'm concerned, as I think Patty is, the issue of drug use and the fact that you have to try all possible generics before you can move to something that might be more effective. I'm just concerned at a humane level. I went on your health care site to see how easy it was to find the waiver process and it's not easy. Which, you know, so that would be my one suggestion along that line. Although I did find a statement, I didn't bring my phone, that says you only have to try two generics in order to qualify for your other. And that's different than “all,” which is what you're discussing here today. So I'm just not sure. I could show you that site, I just didn't bring my phone up. But it says very clearly, "two." I think I'm clearer now, but it would be nice to see it, just a nice little one-two-three, this

is how the exception process works. Terms like "PBM" don't mean a lot to me. They may mean a lot to you, but I hear it a lot. I would just like to see that.

And then of course the data that has been suggested, in terms of formulary, I think what I heard Pete ask, and I think it would be my concern, is do the health plans currently in use in this state by K-12 employees use the tier system? And are the drugs that they place in the tiers similar to what UMP drugs are? Or do you suddenly have a common Tier 2 drug that's in my current plan that suddenly would be a three in UMP Plan? I think that's what I heard you ask, and I think that would be good information to have.

Now going to what you said earlier, and I think, Patty again, and I would call you Mrs. Whatever but I don't , Mrs. Estes, okay, I see the last name here, to not presume familiarity. And correct me if I'm wrong. But earlier on the discussion it seems like the SEB Board believes that their mission is to operate by legislative directive. And so, which is certainly true, no question on that. But here's my question. Let's assume the Legislature concludes by the May 10 meeting, and I'll take bets on that, but that's a separate issue, okay? And let's assume they only allocate $1,000 or $900. Let's assume they choose a figure less than what the Senate chooses. Then I think, in my opinion, it's incumbent on the Board to look at the designs of the plan to bring the premium rates down to meet that $900. To sit there and design a plan and you don't know the premiums, all of these unknowns in this. But if you end up with a host of plans you have to offer and the cost is $1,200, then look at the difference you're inflicting on districts, in addition to their already burdened to cover unformulated appropriated funded staff. So I think it's incumbent upon you to consider that. That's not a legislative directive. But if you're met with two sets of figures, then I think it's incumbent on you to alter the designs to bring the cost under the figure that's funded. That's my two cents. Thank you for your time.

**Rachel Smith**: Good afternoon. I am Rachel Smith and I am an educator. And I am a grieving parent who is coming before you because I was a citizen sponsor of a bill that was recently signed Wednesday of last week by Governor Inslee. Engrossed Senate Bill House Bill 1099, which is about network adequacy and transparency. I come before you because this document was given to me by OEBB when I was an educator in Oregon, for the one year that I took off to go take care of my son when he disclosed to me that he was struggling with depression and a possible addiction to cocaine. I was able to get renters into my home here in Federal Way, transfer my job as an assistant principal down to Portland, Oregon, land a job as an assistant principal, find a home to stay in, all within three weeks' time. No parent is able to do that. I've pulled it off, and told my spouse, "Don't work, just stay with Brennen. We're going to get him the help he needs."

So I'm used to moving mountains for my students. I needed to move it for my own child. I did it. When I signed up through OEBB, the Oregon version of you, I was given this document. And emblazoned across the top is "The care you need when you need it." Never has there been more false advertising than this document. In this document, which I am sure you are creating one for my fellow educators and state employees here, it lists out-of-pocket premiums, copays, maximum out-of-pocket for individual, what you pay for your generic versus your name brand prescriptions, and it also specifies here "mental health inpatient and residential services, chemical dependency,

inpatient and outpatient residential mental health office visits." And I actually sat there with my son and went through this document and highlighted it. I said, "Don't worry, son," when he said, "Mom, rehab is so expensive and I don't want to break the bank on the family." I said, "Don't worry. I have bought the Cadillac of insurance policies that were offered to me as an educator. I've got you. The other options were 80% coverage. I've got 100% coverage. The other ones had high copays, I've got a zero copay. All we have to do is activate this care."

And my kid had hope. My kid believed. I believed. I was a Kaiser Permanente baby. I had all my children there. I was born there. My cousin's an ER doctor for Kaiser. Never had any issues. I've always received timely appropriate care. Why would this be different? Especially since I bought the Cadillac version as a school administrator. My son did a 20-, no, I'm sorry, a 51-minute intake that day with Kaiser over the phone. He was, unbeknownst to us, mis-triaged as routine care. There was nothing routine about what my son disclosed. I heard it through the door. I'm a nosy mom. Made sure he wasn't hiding the ball. He said, “I need a mental health care appointment. I'm struggling. I need chemical dependency inpatient. I'm struggling. And I've never been on antidepressants or antianxiety, but right now I need something.” That's three different kinds of appointments my son was asking for very specifically. And they said you can have an appointment in 29 days. 29 days. So he comes out. And my son who moved mountains, and testified before congress, and was a page, and was keynote speaker for his high school, who is my kid, who speaks like I do, all right? Came out and said “29 days,” and I said, “well, you did your job, kid but now it's time for some parental freak out -- because 29 days when you're suffering is too long.”

So I got his permission for his dad and I to call. And so we called and they said, nope he's 20 years old, you need to get a release. No problem, next day, opening of business, the doors open, there was my family, signing the release. And so we started calling and advocating for Brennen every single day. I had somebody with him. Every. Single. Day. We were told, “have a go bag, we're going to have a cancellation, we're going to get him in.” Every. Single. Day. When I was told, “well, can't we go anywhere else? I was told, no, it's a closed network. You won't have any coverage. Don't worry, we're going to get you in.” Every. Single. Day. Four days before my son's appointment, he was struggling, he had his hopes dashed, he had relapsed, and within five minutes my son legally purchased a 12-gauge shotgun in a pawnshop. He walked across the street and for $5.99, the cost of a Happy Meal nowadays, my son bought the ammunition and within an hour, my son lay dead.

My fierce, low-hanging fruit, ready to receive help, begging for help kid isn't here today because I didn't know something. And that is the network adequacy number for Kaiser Permanente was 43%. 43% of the time did you get the timely access to care -- urgent, emergent, or routine. Less than a 50-50 shot. So every time I called in, they were lying to me. There was no doctor for my kid. Didn't matter what kind of coverage. Didn't matter that I paid top dollar for it. There were no doctors. There was no network adequacy. My kid didn't get seen. He had no hope of it. I should have known that as a consumer. It doesn't say "network adequacy" anywhere. House Bill 1099, which is now law of the land as of last week, says that you must convey that to me as a consumer on documents like these.

So I'm here today to help with that process. To share my story, and to help you make sure that these documents have the transparency, the accountability, and so that my para-educators in my school who can't choose anything but the cheapest plan, and probably are dealing with low network adequacy, at least they know that. So that when their kid needs help, they can go use social services. They can call on their church. They can do what they need to do. Because they'll at least know they've got a crappy plan. So that's what House bill, now Engrossed Senate Bill 1099, that the Governor just signed, did. So that no one else doesn't know the way that I didn't know. So I'll share with you, this is the plaque that is up in Kaiser Permanente's corporate office now, and it says, "Timely access to quality mental health care and addiction services is just as important as timely access to quality physical health care." Kaiser Permanent must never forget this, just as we will never forget our son, brother, and friend Brennen, who left us too soon at the tender age of 20. And you'll note the date on here. My kid was supposed to turn 24 tomorrow.

So please help us, as consumers, as educators, as state employees who are going to be reading this document, know what we are getting. Please hold the insurers accountable to delivering on the promise because if I only paid 43% of my premium they'd drop me in a heartbeat. If this were a car that you were selling, and the airbags only deployed 43% of the time in an accident, that car would be recalled and the industry wouldn't be allowed to sell it. This is about truth in advertising, transparency, accountability, and frankly it's the same thing I had OEBB do, which is I said, have anyone who wants to have you to peddle their product show you the network adequacy numbers up front and convey that to us so you aren't holding a deadly secret, and that information is clearly communicated to us as the consumer, so that when we need to access the care when you need it, it actually is the truth. Thank you for listening to me.

**Lou McDermott**: Thank you very much.

**Pete Cutler**: Thank you for coming and testifying. My heart goes out to you for your loss. I have not had nearly the extreme situation you did, but I can say I have had personal experience within my family, almost identical dynamics. Incredibly frustrating to have the illusion of access to behavioral health support services and behavior addiction support services and to instead find that the organization's idea of prompt care is four weeks, six weeks, something that's totally unrealistic. So anyway, I'm very glad to hear the bill's been signed and I hope it applies to the state plans.

**Rachel Smith**: It does.

**Dave Iseminger**: It does.

**Pete Cutler**: And I look forward to seeing what the Health Care Authority -- I think we should have very robust focus on providing information about network adequacy, and especially in behavioral health. I think it is a particularly problem area. But that has long been a problem of whether, like you say, you always know what your benefit is for going to the doctor for a regular visit, or a specialist, or whatever. But this has been an area in which trying to get information has been very difficult for patients and for potential persons when they're looking to sign up for a plan. I think it's great that you helped move this along and I'm looking forward to hearing what the Health Care Authority will be doing to implement it with the SEBB Program. So thank you.

**Lou McDermott**: Other comments from the Board? Ms. Smith, could you stay after for a few minutes?

**Rachel Smith**: Yes.

**Troy Andrews**, President of Laborers 252 in Tacoma. I was here before and we spoke about this change in medical, and how it affects my members' medical when they retire. Again, I represent the members of Laborers Union 252. They are employed at Tacoma School District. My members are currently covered by a Collective Bargaining Agreement that clearly shows the responsibility of the school district to pay into my union trust funds for health care. This puts us in an expensive situation to the taxpayers of Washington State because of the definition of what an employee is. The definition of an employee is a person who works 630 hours per year and is employed by the Tacoma School District. This has been verified by Mr. Rob Parkman of the Washington Health Care Authority, to apply to my members. The extra cost to the taxpayers, due to the fact that the district is contractually obligated through the Collective Bargaining Agreement to make union trust payments and provide medical coverage to these employees based on the new SEBB requirements, which would in effect cost taxpayer for coverage and it cannot be exempted from without action taken by the Board. I've got some handouts I'd like to hand out to go with this, if I may. Thank you very much. These are RCWs that are essentially in the SEBB law, I guess I'll call it. Once everybody gets them, I'll move on.

Under RCW 41.05.740, School Employees Benefits Board, it states the following in section one: “The School Employees Benefits Board is created within the authority. The function of the School Employees Benefits Board is to design and approve insurance benefit plans for school employees and to establish eligibility criteria for participation in insurance benefits plans.” This essentially outlines the responsibility and scope of the Board. Section two, number two -- section seven, if you look on this handout, which is on the second page at the bottom, I highlighted it -- it states the following: “School employees shall choose participation in one of the health care benefit plans developed by the School Employees Benefits Board. Individual school employees eligible for benefits under subsection (6)(d),” which again is highlighted on the first page, it says School Employees Benefits Board and on the second page (d) is highlighted and states the following: this section may be permitted to waive coverage under terms and conditions established by the School Employees Benefit Board.”

Article Six states, “the School Employees Benefits Board shall,” subject indeed “determine the terms and conditions of school employee and dependent eligibility criteria, enrollment policies, and scope of coverage.”

When I came before, I asked if there is a waiver, a process to where my people covered by a Collective Bargaining Agreement, which my people feel is clearly covered regardless of whether you implement this one or not, is still going to have to be paid in due to a trust agreement that I have through the school district through a Collective Bargaining Agreement. We're going to be paying for two sets of insurance, one that is obligated by contract and one that's obligated by this new law that's being passed.

While my people meet the definition of 630 hours, which is an employee, and work for a state agency or a school district, it doesn't relieve the process of them having to pay into my trust agreement, because they have a trust agreement with our health trust.

Mr. McDermott and the Board, it appears that the Board has the authority to grant a waiver by definition in RCW 41.05.740. I feel it also appears, due to the burden it will add to taxpayers of Washington State, you have an obligation to be the steward of the taxes paying for this medical plan to make sure a waiver is created so funds are not being paid on benefits that are already provided by the Laborers Union. While these authorities are written in law, the obligation to make a person's life better is written in morality. If no action is taken to fulfill the responsibility, hardworking men and women of the Laborers Union in the state of Washington will be adversely affected due to the loss of access to their union-provided retiree medical.

I just want to say, will you please examine this? I feel from what I'm being told, and my legal teams have looked at things, you have the authority to set waivers in place based on this language. My members are going to go from, again, being able to get retiree medical as low as $150 a month, like I will have when I retire. If they're pulled out of that and don't have effective coverage the day before they retire and they're in the new medical plan, the cost could be $600 - $1,200, accordingly. Myself, I have 57,000 hours as a laborer. I joined the Laborers in 1982. That 57,000 hours has been paid into a retirement fund so when I retire we have access to that retirement to buy down this. Now I'm a worker, maybe I'm going to walk away three, four, five thousand dollars and all of a sudden my medical goes to twelve, fourteen hundred because of a change in a law and a waiver that's not allowed to keep me on my medical plan. That worker can't afford to retire any more. That's just reality. I mean, it's expensive to live. And that's what's going to eliminate this for them.

I have 15 people at the school district. From what I understand, this affects people at the Seattle School District as well because they're having trouble with retention due to the temporary employees up there. As soon as they no longer become temporary and no longer needed, they go back to the union hall and their medical drops off and they have no way of carrying it back with them, to carry it on to their next employer, so they will have a break in coverage. So, again, you guys are very professional, very diligent, this is your 16 meeting from what I understand. And from looking at the packets, this is not a small undertaking. I get it. But these are human lives whose lives are going to be affected by this so I really, really request that you look at this, if you have the authority -- which I feel this law says you do. Please work with me to make the adjustments we need to, to look out for these working men and women. And thank you for your time. Happy to answer any questions if you have any.

**Lou McDermott**: We will look into it.

**Troy Andrews**: Thank you, I appreciate it.

**Next Meeting**

May 16, 2019
9:00 a.m. – 4:00 p.m.

**Preview of May 16, 2019 SEB Board Meeting**

**Dave Iseminger,** Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the May 16, 2019 Board Meeting.

**Lou McDermott**: Dave, thank you and thank you to your staff. I appreciate the public comments. Mrs. Smith, I appreciate your story. When we sit here and do this function, we're talking a lot about numbers. And we talk about the cost and we talk about eligibility, who's in and who's out. And away from this Board, as we administer the PEBB Program, we have the other side, which is the members, the people. And this Board has been insulated from that because you don't have any members yet. You will. You'll have members in January and stories like this and others will come before the Board. They are very emotional, but they do guide our actions and they are important to hear. And I hear them all the time regarding a variety of topics. And so I appreciate you coming today and sharing your story. I hope everybody has a good evening.

Meeting adjourned at 4:15 p.m.