Washington State Health Care Authority

Public Employees Benefits Board Meeting

April 15, 2015

Washington State Health Care Authority

Public Employees Benefits Board Meeting

April 15, 2015
1:30 p.m. – 3:30 p.m.

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

Table of Contents

Meeting Agenda 1-1

Member List 1-2

Meeting Schedule 2015 1-3

Board By-Laws 2-1

Meeting Minutes, July 16, 2014 3-1

Meeting Minutes, July 31, 2014 3-2

Meeting Minutes, October 22, 2014 3-3

2015 Open Enrollment Summary 4-1

SmartHealth Update 5-1

SmartHealth Policy Resolution Vote 6-1

Life Insurance Update 7-1

TAB 1

Washington State Health Care Authority

AGENDA

Public Employees Benefits Board

April 15, 2015
1:30 p.m. – 3:30 p.m.

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

Conference Call Dial In: 1-888-450-5996, Participant Passcode: 546026

1:30 p.m.*	**Welcome and Introductions**		Dorothy Teeter	
1:40 p.m.	**Approval of July 16, 2014 Minutes** **Approval of July 31, 2014 Minutes** **Approval of October 22, 2014 Minutes**	TAB 3	Dorothy Teeter	Action
1:50 p.m.	**Legislative Update** **Accountable Care Program (ACP) Update**		Lou McDermott	Information
2:00 p.m.	**2015 Open Enrollment Summary**		Renee Bourbeau	Information
2:10 p.m.	**SmartHealth Update** • **Governor's Video** • **Live Demo** • **Q1 Metrics**		Scott Pritchard Nancy Board Logan Van Meter	Information
2:55 p.m.	**SmartHealth Policy Resolution Vote**		Barbara Scott	Action
3:10 p.m.	**Life Insurance Update**		Beth Heston	Information
3:20 p.m.	**Public Comment**			
3:30 p.m.	**Adjourn**			

***All Times Approximate**

The Public Employees Benefits Board will meet Wednesday, April 15, 2015, at the Health Care Authority, Sue Crystal Rooms A & B, 626 8th Avenue SE, Olympia, WA. The Board will consider all matters on the agenda.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

Direct email to: board@hca.wa.gov

Materials posted at: http://www.pebb.hca.wa.gov/board/ no later than COB 4/13/15.

Washington State Health Care Authority

PEB Board Members

Name	Representing
Dorothy Teeter, Director Health Care Authority 626 8th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-1523 dorothy.teeter@hca.wa.gov	Chair
Greg Devereux, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 greg@wfse.org	State Employees
Myra Johnson* 6234 South Wapato Lake Drive Tacoma, WA 98408 V 253-473-0789 mjohnson@washingtonea.org	K-12
Gwen Rench 3420 E Huron Seattle WA 98122 V 206-324-2786 gwenrench@covad.net	State Retirees
Mary Lindquist 4212 Eastern AVE N Seattle WA 98103-7631 C 425-591-5698 maryklindquist@comcast.net	K-12 Retirees

PEB Board Members

Name	Representing
Marc Provence UW Administrator Fred Hutchinson/UW Cancer Consortium 850 Republican ST Seattle WA 98109 V 206-616-5423 mprov@uw.edu	Benefits Management/Cost Containment
Yvonne Tate 1407 169th PL NE Bellevue WA 98008 V 425-417-4416 ytate@comcast.net	Benefits Management/Cost Containment
Marilyn Guthrie 1640 W Beaver Lake DR SE Sammamish WA 98075 V 206-715-2760 *marilynguthrie52@gmail.com*	Benefits Management/Cost Containment
Harry Bossi* 160 E Soderberg RD J-27 Allyn WA 98524 V 360-689-9275 udubfan93@yahoo.com	Benefits Management/Cost Containment

Legal Counsel
Katy Hatfield, Assistant Attorney General
7141 Cleanwater Dr SW
PO Box 40124
Olympia WA 98504-0124
V 360-586-6561
KatyK1@atg.wa.gov

*non-voting members

4/10/15

Washington State Health Care Authority
Public Employees Benefits Board
P.O. Box 42713 • Olympia, Washington 98504-2713
360-725-0856 • TTY 711 • FAX 360-586-9551 • www.pebb.hca.wa.gov

2015 Public Employees Benefits Board Meeting Schedule

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

January 29, 2015 (Board Retreat) 9:00 a.m. – 3:00 p.m.

March 31, 2015 (10:00 a.m. – 12:00 p.m.)

April 15, 2015

May 27, 2015

June 24, 2015

July 8, 2015

July 15, 2015

July 22, 2015

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

Updated 7/15/14

TAB 2

PEB BOARD BY-LAWS

ARTICLE I
The Board and its Members

1. Board Function—The Public Employee Benefits Board (hereinafter "the PEBB" or "Board") is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB's function is to design and approve insurance benefit plans for State employees and school district employees.

2. Staff—Health Care Authority staff shall serve as staff to the Board.

3. Appointment—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.

4. Non-Voting Members—Until there are no less than twelve thousand school district employee subscribers enrolled with the authority for health care coverage, there shall be two non-voting Members of the Board. One non-voting Member shall be the Member who is appointed to represent an association of school employees. The second non-voting Member shall be designated by the Chair from the four Members appointed because of experience in health benefit management and cost containment.

5. Privileges of Non-Voting Members—Non-voting Members shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.

6. Board Compensation—Members of the Board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

ARTICLE II
Board Officers and Duties

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

2. Other Officers—*(reserved)*

ARTICLE III
Board Committees

(***RESERVED***)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.

2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.

3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.

4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.

5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 10 days prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. Minutes summarizing the significant action of the Board shall be taken by a member of the HCA staff during the Board meeting, and an audio recording (or other generally-accepted) electronic recording shall also be made. The audio recording shall be reduced to a verbatim transcript within 30 days of the meeting and shall be made available to the public. The audio tapes shall be retained for six (6) months. After six (6) months, the written record shall become the permanent record. Summary minutes shall be provided to the Board for review and adoption at the next board meeting.

6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board Members at the meeting for the minutes.

ARTICLE V
Meeting Procedures

1. Quorum— Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.

2. Order of Business—The order of business shall be determined by the agenda.

3. Teleconference Permitted— A Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, A Member may attend a meeting by telephone conference call or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at board meetings may also occur in conjunction with a public hearing or during the board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .

6. Representing the Board's Position on an Issue—No Member of the Board may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.

7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted.

8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order [RONR]. Board staff shall provide a copy of *Robert's Rules* at all Board meetings.

9. Civility—While engaged in Board duties, Board Members conduct shall demonstrate civility, respect and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

10. State Ethics Law—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW.

ARTICLE VI
Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.

2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

TAB 3

Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

D*R*A*F*T

July 16, 2014
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:
Dorothy Teeter
Mary Lindquist
Yvonne Tate
Marilyn Guthrie
Marc Provence

Members on Phone:
Greg Devereux
Gwen Rench

PEB Board Counsel:
Melissa Burke-Cain

Members Absent:
Harry Bossi

Call to Order
Dorothy Teeter, Chair, called the meeting to order at 1:30 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Approval of June 25, 2014 PEBB Meeting Minutes
It was moved and seconded to approve the June 25, 2014 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

Annual Rule Making Vote
Mary Fliss, PEB Division Deputy Director, discussed the Error Correction Policy Resolution. The proposed resolution revises the automatic three-month enrollment.

Greg Devereux: Greg wanted to clarify publicly that all this resolution does is remove the three-month period. That it does not change the potential recourse in any way.

Mary Fliss: That is correct. This policy resolution just revises the three-month automatic look back. It does not change the recourse.

Policy Resolution – Error Correction: Resolved, that if an employing agency fails to enroll an employee in benefits, medical and dental enrollment will be effective the first day of the month following the date the enrollment error is identified, unless the Health Care Authority determines additional recourse is warranted. If the enrollment error is identified on the first day of the month, enrollment is effective that day.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Dorothy Teeter: The next agenda item is the 2015 SmartHealth Program Recommendations, presented by Scott Pritchard. There will also be a demonstration of the product itself.

Scott Pritchard, PEB Health Management**:** Scott introduced the 2015 SmartHealth Program design. Smarthealth was launched this year and the design today is taking SmartHealth into 2015. Scott shared the guiding principles, the activity categories, the approach HCA is taking, how to accumulate points, types of activities the subscribers can choose from to earn points. Limeade, our vendor, will follow up with a demonstration.

There are three guiding principles. Those principles are to engage the workforce in Smarthealth, improve individual and population health, and to achieve a positive impact on the medical cost trend. In 2015, we will focus on the employee, but will include their spouses and domestic partners. The goal was to create an experience that is fun and simple to understand. We will offer and track qualifying actions for the incentive.

In 2014, members had to attest saying that they were going to do certain things. We will now offer tools that members will choose from and track for completion. We'll provide personalized Individual action plans using our new vendor platform. The Individual action plans will be relevant to the Well-being Assessment results.

Once the Well-being Assessment is completed, activities will appear that relate to the answers in the well-being report. This is your plan for yourself. We want to promote PEBB programs and benefits. We want to help members recognize and use what benefits are available to them.

We want to integrate agency-specific activities in SmartHealth, especially in the area of lifestyle change. Lifestyle is local, it's where you work and where you live. We know that the worksite is a great place to help introduce people to activities, programs, and culture around health. We will offer alternative access to those without access to the internet. We have a telephonic approach that will allow members that don't have access to the internet, or have other reasons that it doesn't work for them, to participate and create a personalized program that's right for them.

We want to promote sustainable lifestyle changes. With that in mind, in 2014 we offered an incentive and plan to offer a monetary incentive in 2015. By offering an incentive, we increase awareness and use of selected benefits. We will offer an incentive and offer programs that are valued. We created an equal incentive for eligible subscribers across all the health plans so all PEBB-insured subscribers have access.

The SmartHealth activity categories were selected to provide a comprehensive program. The activities are for the entire population. Data says that keeping healthy people healthy is one of the biggest bangs for the buck. We want to offer programs and tools to keep the healthy people healthy. We also will offer those with health risks a chance to use behavior change tools and reduce those risks. For those that have developed a chronic condition, we want to have valuable programs to help manage those conditions.

To earn the incentive, eligible subscribers must earn 2,000 points. The required Well-being Assessment will provide 800 points for completing and at least 1,200 points can be accumulated through completing activities. The activities and points are in development.

When assigning points to activities, the value will be based on activity, duration, and intensity. We want a direct correlation between the number of points and how much the person worked to earn them. With our new vendor, we will now be able to verify. We've moved from attestation to verification. The points can be verified through claims and vendor tracking tools, imported tracking applications data, and self-reporting. Tracking applications can be imported to make tracking easier. This is a strong tool for behavior change.

PEBB subscribers will need to earn 2,000 points for the incentive. The activities must start no later than June 30 and be completed within the normal timeline of the activity. Activity timelines vary. Newly eligible subscribers hired later in the year must complete the Well-being Assessment and earn sufficient points, according to the SmartHealth Program rules, within 60 days after the effective date of their PEBB medical, but no later than December 31. Most people will be completing their activities around June 30, so we are working on developing a strategy of how to keep people active through the second half of the year.

Examples of activities are an excellent tobacco cessation program, the Diabetes Prevention Program, and a Diabetes Control Program. Group Health is offering a Living Well Program. For reducing health risks, there will be points for getting a dental exam. There are stress reduction activities, health literacy, a low salt cooking class, a farmers' market recipe exchange. There will be a long list of activities to choose from.

Lora Kerns, Limeade**:** Lora provided a high-level look at the SmartHealth site. Some of the customization is still under development. What is shared today may be modified as implementation continues.

SmartHealth participants will be able to log in easily in a nice clean experience. The SmartHealth logo will be displayed. There will be some graphics with updates throughout the year. Since this is a new program, there may be some how-to tiles. Once the subscriber has their initial user name and password, navigating SmartHealth is simple. Information relevant to the subscriber will be provided based on their Well-being Assessment. It will also include information the SmartHealth administrators want them to know. Subscribers can take action and track activities they're interested in and can find out about new things that might assist in their journey.

SmartHealth also allows for agency promotions or agency-specific information to be displayed. It also displays the points you've earned to date. Subscribers know where they are with points and where they are going – what they're interested in working on. Taking the Well-being Assessment is a requirement and there will be a flag around completing it until it's done. You cannot continue until the Assessment is taken. SmartHealth also provides positive feedback.

HCA can determine what items are added to the promotion bar. It could be a letter of encouragement from the Governor or specific information we want shared with the subscribers.

SmartHealth's goal is to meet people where they're at and where their interests are at the time. The subscriber can discover activities by going to the topics area. Based on the Well-being Assessment, recommended activity tiles will appear larger and have a recommended flag. There is also an area to get personal details and to see what they're working on.

Marc Provence: How are activities chosen? Who decides what gets added to the list? Where do the ideas come from?

Lora Kerns: Limeade has about 300 ideas for various activities that span all of the different categories from emotional health and well-being, to physical, to chronic condition management, etc. We call them ideas because they need to be refined specific to the culture and the resources available at the state. That's where PEB comes in. Scott can share the approval process.

Scott Pritchard: HCA is in the midst of choosing the activities now. We want it to be data driven. We have claims data, dental data, and pharmacy data. Lifestyle data will come from our previous health assessments moving forward and well-being. We'll combine all of those to look at population health; and from that, we'll determine what we need that we currently don't have. The points will be awarded based on duration and intensity and we'll work to guide people to programs that we think are valuable, worthwhile, and serve our population. We can award more points to get people's attention. A discussion takes place with a group on the clinical side and decisions are made based on data.

Greg Devereux: Why does the points accumulation have to be done in six months? Why not nine months or a year?

Scott Pritchard: You're asking why not all year? There are two driving factors. One is operational. We need to know how much money we will be paying for the incentive since it goes into our rate build. We're hoping to give incentives to 70-80% of the eligible subscribers and that's a lot of money. The second driver is we wanted people to get started early. There is good data that says if you give people too long of a timeline, they do it toward the end. Involvement and engagement are key and we want to engage people throughout the year.

Greg Devereux: I'm not quite sure why it takes six months to operationalize things. I find in state government it either takes way too much time or too little time for operations and I'm just not sure why six months is the magic number. I do understand the psychology behind leaving it to the last minute. You could start in the prior year and extend the period. There are any number of things that could be done besides just a six-month period.

Scott Pritchard: Greg, you are absolutely right. We've had a number of those discussions going back and forth. We can take this to the State Employee Health and Wellness Steering Committee and look at different scenarios and get input. It's a good question and one that we made the decision of June 30, but we don't want to say it's that forever. That's open.

Greg Devereux: The Steering Committee would be a good place to discuss it.

Lora Kerns: To conclude this demonstration, I want to share a bit about the platform. Mobile First Design is part of this experience. We know subscribers are sometimes out and about and are not always engaged at a desktop. If you look at Limeade.com, another version of this, or the SmartHealth site on your smart phones, it scales and looks really nice in a mobile experience. I want to clarify this idea of targeted resources and content to the member. We talked about it in terms of content and what's recommended based on Assessment results. A UMP member may see a different resource than a member who has Group Health resources available to them.

Marilyn Guthrie: I'm very familiar with this platform from my past experience and it looks like you have incorporated a lot of feedback that we actually gave Limeade, but I'm assuming that this will be a link from the PEBB home page for members.

Lora Kerns: Yes, it will be a dedicated URL owned by PEB or whoever owns those domains and then we'll link from any number of pages and have our stand-alone login page as opposed to a single sign-on experience.

Marilyn Guthrie: So, there will be a single sign-on?

Lora Kerns: Not at this time. It will be a stand-alone sign-in page.

Dorothy Teeter: Other questions? I see a question from the audience. We are doing this a little out of the usual here so go ahead and use the mic and introduce yourself.

Eric Faiivae: My name is Eric Faiivae and I take this is a great incentive program. I wanted to know about your 1,000 points. Can you lower it to 200 or 500?

Scott Pritchard: We can choose any point level. We chose the representation based on Limeade's experience.

Eric Faiivae: My second question, are there any therapeutic incentives in your program?

Scott Pritchard: By therapeutic I need a better, more-full description.

Eric Faiivae: By therapeutic, an employee that would like to stop smoking or prevent obesity and be involved in a massage, a clinic-type form - hands on, a feel good kind of thing to break the threshold if you will.

Scott Pritchard: We do feature therapeutic, as you described it, as the Quit for Life tobacco cessation. We have the Diabetes Prevention Program and other programs like that. You mentioned massage specifically. We haven't chosen that at this time. We are trying to do a limited selection to start, but the field is pretty open. As we start looking at our data through the years, we'll be targeting whatever works and whatever we think our population needs.

Dorothy Teeter: I have one quick question because I know it has been a concern for folks. When you enter into this, your Health Risk Assessment is private, correct?

Lora Kerns: Absolutely.

Dorothy Teeter: And then, can you as an individual, access what you have responded to, but nobody else? It's yours?

Scott Pritchard: Let me speak to the privacy issue and Lora can speak to the user experience. It's absolutely private. We are required by law to keep it private and our own internal standards also require it be kept private. This is your own information. It will be used in a de-identified manner, meaning you will be put in with everybody in an aggregate and there is no way it can be traced back to you. That is part of the HIPAA standards. You contribute to the better of the whole by contributing your data, but nobody knows it's you.

Dorothy Teeter: Thanks for that reassurance.

Lora Kerns: And as a participant, of course, once you've completed the Assessment, you can get to your results and find out where your risks were even year over year, particularly with biometric information. In 2016 when a subscriber enters their information, they'll get to see their change over time.

Dorothy Teeter: It's pretty exciting and thanks for joining the state team with your company Limeade. I think this will be something that fills out and develops over time as we get feedback from employees and other agencies on how it's going. The policy resolution you will be voting on next time is behind this tab. We will move on to our Procurement Summary, Tab 6.

Kim Wallace, PEB Procurement Manager**:** Kim shared the benefits results of the 2015 procurement process. We have some benefit changes to share with you across all of our medical plans and a couple of additional ones on other benefits as well. We will cover medical benefit changes, touch briefly on dental benefits, talk about a Long-Term Disability (LTD) Change, and also touch on Life Insurance.

First, the UMP pharmacy benefit will have an important change. The Affordable Care Act requires that member pharmacy out-of-pocket costs apply towards a maximum out-of-pocket limit, effective January 2, 2015. Currently, UMP Classic Plan members' pharmacy out-of-pocket costs that they pay don't apply to an out-of-pocket maximum. The Collective Bargaining Agreement allows for two different methods to address this ACA change. One is to increase the dollar level of the current maximum out-of-pocket and apply the pharmacy costs to that; or the second is to create a separate pharmacy maximum out-of-pocket (MOOP).

Our recommendation for the UMP Classic Plan is to institute a separate $2,000 pharmacy maximum out-of-pocket. The goal of this ACA change is to decrease the burden that people feel who have high pharmacy out-of-pocket expenses. We estimate that if we started applying the pharmacy out-of-pocket expenses to the existing current MOOP, we would experience about a 12.4 million dollar financial impact. In order to mitigate that impact, we would need to raise the level of the maximum out-of-pocket from the current $2,000 to $3,400, which would be a significant increase. By instituting a $2,000 separate pharmacy maximum out-of-pocket, we both provide direct relief to those with high pharmacy costs and are able to financially reduce that impact from $12.4 million to $1.2 million, which helps from a budget standpoint.

Marc Provence: Sorry, I'm just clarifying what the reduction would be for the $2,000? Would it be $12.4 to $1.2?

Kim Wallace: Yes, from $12.4 to $1.2 annually. In 2013, there were 1,325 non-Medicare members and 1,100 Medicare members who reached that $2,000 expense level.

There is an additional UMP pharmacy benefit for the Classic Plan. In Tier 3 we will ask to institute a Benefits Exception Policy to allow exceptions via a prior authorization process for Tier 3 non-preferred drugs to be covered at the Tier 2 preferred level when medical criteria are met. This is to assist those members that have tried all the generics and preferred brands in a class and the only option appears to be a non-preferred brand. We will develop the appropriate criteria to be applied in this decision making process.

There are six benefits in UMP for which there is a portion or a type of exclusion that we are proposing to change. They are temporomandibular joint (TMJ), Circumcision, genetic testing, orthotics, home health, and massage therapy. Circumcision is the only benefit that is not covered at all. For the others, there is some type of benefit coverage; but there is an aspect that is excluded and we're proposing to change these exclusions to be more consistent with Regence Medical Policy.

There are two changes in our Group Health benefits that are ACA driven for 2015. One change is that residential mental health treatment programs will be covered. Residential is distinct from in-patient. The second change is that there will be no cost to the member for diabetic retinal screening. Cardiac rehabilitation will also be covered.

Greg Devereux: Have you talked about the cost implications for the six changes to UMP, the new inclusions?

Kim Wallace: Yes, are you asking about the financial impact?

Greg Devereux: Yes.

Kim Wallace: Yes, we estimated that the change to the six exclusions would have approximately $231,000 of impact annually.

Greg Devereux: Thank you.

Kim Wallace: There are two Kaiser benefit changes having to do with member co-pays. They are ACA compliance oriented. Member copays for prescriptions and spinal manipulations will count toward the out-of-pocket max starting in 2015. These spinal manipulations are associated with the chiropractic benefit.

Kaiser will also eliminate the deductible carry-over, which has historically been associated with some health plans where member cost expenses paid in the last three months of the calendar year get applied to the following plan year deductible. Neither UMP nor Group Health has deductible carry-over, so this is now consistent with our other PEBB plans.

Kaiser will apply member cost-sharing for post-surgical immunosuppressive prescription drugs. The regular cost sharing that's applied to other drugs will now be applied to these particular drugs. There is a change in their surrogacy exclusion where they will seek reimbursement from a member who receives covered services as a surrogate, prenatal care, and maternity services, for which they receive payment. If they receive payment for that care, in addition to receiving covered services under the health plan, then Kaiser is being more explicit about seeking reimbursement for that.

Marc Provence: Is that essentially a coordination of benefits provision?

Kim Wallace: It's essentially a third party subrogation.

There are no Medicare benefit changes for either Kaiser or Group Health.

There are no dental benefit changes for 2015 to any of the three dental plans that we offer.

With regard to long-term disability, we are making an administrative change to eliminate the gap that exists between the end of LTD benefits at age 65 currently, and the beginning of Social Security. Not all members have a Social Security retirement age of 65. Potentially, someone who is relying on LTD benefits has them end at 65 but their Social Security has not started. This change will be provided for a nominal rate change.

There are no benefit changes to life insurance.

Dorothy Teeter: We'll be looking at these again next month. So if you have questions, check with staff in the PEBB Program.

Janice will provide an update on our 2015 premiums. Those materials are behind Tab 7.

Janice Baumgart, PEBB Financial Section Manager**:** There's a very slight chance that the rates you see today will change slightly by next week. I also wanted to share with you the good news about the procurement results. They came in very favorably for us. Before I move on, I wanted to again offer to the Board Members a PEBB Finance 101 class. It sometimes needs to be heard a few times.

Janice shared an overview of how the employee/employer contributions are calculated for state active employee and numbers related to SmartHealth participation. There will be a new component used in developing the health care premiums. It will include the entire Medicare/non-Medicare risk pool because all non-Medicare risk pool subscribers are eligible to earn the incentive, either the lower deductible or the $125 HSA payment if you're on a CDHP.

For SmartHealth, of the 128,055 eligible subscribers, 76,908 attested positively that they would be earning the incentive. That is 60%. HCA did a verification process this year. We've compared who attested that they would be participating in wellness with whether or not they filled out a health assessment. The verification process is complete for Kaiser and Group Health. For UMP, that data will be available July 20th. We have a number we're using as a proxy, which reduced the number of verified attestations to 55,000, or about 43%. It's possible that these numbers will go down somewhat after the verification process is completed for the UMP plans, and even after the rates are actually adopted next week. Other things could change, such as the participation rate for attestations done on paper that hadn't been received or if there are appeals, etc. Actual participation won't be known until 2015.

Dorothy Teeter: In reviewing your slide, the number of folks who said they were going to complete the health assessment is in the second row.

Janice Baumgardt: Yes.

Dorothy Teeter: When we actually went back to see the evidence, there was a drop in the people that actually did it and that's the difference we see?

Janice Baumgardt: Correct.

An interesting note, as we looked at who's participating, there's a higher percentage of participation in the CDHP plans, so it looks like the $125 HSA payment might be providing more incentive than the lower deductible. We've also seen higher participation among the single subscribers. Those that are not covering spouses or children seem to be participating at a higher level.

New in our procurement process for 2015 was our request to our vendors to provide us with two bids, one for the regular health plan they provide and one for a plan with a lower deductible. They provided bid rates assuming no plan design change - the same deductibles as always. A composite rate was provided using the information previously discussed regarding SmartHealth participation, using a 43% participation assumption and adding in the Limeade costs.

The composite rates are what we use in developing the employer and employee contributions. Payments to carriers will be on actual participation. In essence we'll be making payments to two different plans. But as far as calculations and when we collect premiums from our subscribers, it will be on a combined composite rate.

Slide 5 shows employee contribution calculations. The first column shows the composite rate per adult unit; the second column is the state index rate, the employer contribution, which is for state employees only. This is the 85% percent per the Collective Bargaining Agreement the employer is paying. It's the same no matter what plan you choose. That produces the third column - the proposed 2015 employee contributions for a single subscriber. The average subscriber contribution is $145.

Slide 6 is state general government and higher education active employees. State actives are a subset of the non-Medicare risk pool. The bolded items are what you'll be voting on. The first set of numbers are the percentage of subscribers in each plan. The bulk of the subscribers are in UMP Classic, then Group Health Value, and finally Group Health Classic.

The third column titled 2014 is the single subscriber contribution for 2014. The fourth column titled Proposed 2015 is the rates that you saw in the previous slide. The three columns at the end are some incremental components that are included in that proposed 2015 rate.

The column in italics is the cost of the ACA MOOP requirement. It's the cost of the ACA mandate requiring that we cover pharmacy, or apply pharmacy costs towards the maximum out of pocket. It would increase the employee premium by $1.15; and as Kim mentioned, we are proposing a separate pharmacy $2,000 MOOP that in turn reduces the premium to the employee by $1.04. So it's actually a net cost to the employee of about eleven cents per month for that added benefit. That's only on the UMP Classic Plan.

The last column is the changes to the exclusions discussed earlier that moves us towards the Regence book of business. The cost to the employee is two cents for the UMP Classic Plan and one cent on the UMP CDHP.

Slide 7 is a traditional table that shows the rates per plan and then by tiers. The first set of numbers is for the subscriber only, then subscriber and spouse, then subscriber and children, and finally a full family

Slide 8 is for another subset of the non-Medicare risk pool, the retirees. This includes state, K-12, and poly-sub retirees. They receive an implicit subsidy by being included in the risk pool along with the active employees. This table format is very similar to the state actives. These retirees are paying the entire cost of the premium so there's no reduction in the premiums. In addition, there is a monthly $6.25 administrative charge per account to cover administrative costs. Also for reference, you can see that UMP Classic looks like 71% of the subscribers, non-Medicare retirees, are in that plan. The ACA mandate would increase the premium for UMP Classic by $7.71, $6.96 of that is mitigated through adding the $2,000 pharmacy MOOP. The total cost increase to the premium is about $0.75. Approximately 15% of that is the employees' share for state actives.

There are also no changes in the HSA payments being proposed this year.

Slide 9 shows the premiums by subscriber tier. Slide 10 has the Medicare premiums which are estimated because the Group Health and Kaiser rates are subject to CMS approval. They could change between when you see them and when the feds actually give approval. These premiums are reduced by the explicit subsidy. The legislature has been providing a subsidy for retirees in the amount of $150, or 50%, of the total premium per month, whichever is less.

Gwen Rench: I'm very concerned about the high level of increase for the non-Medicare retirees and I don't recall whether there was the administrative fee before. Is the $6.25 a new fee?

Janice Baumgardt: That is not a new fee.

Gwen Rench: We're talking about a $27 per month increase for a non-Medicare retiree and that's huge.

Dorothy Teeter: Are you on Slide 9?

Gwen Rench: Page 8.

Janice Baumgardt: I didn't quite understand or hear your question on the intrigue; but the part I did here was the question about the $6.25 administrative fee. That has always been included in the non-Medicare retiree premiums. For 2014 that amount was $6.22 and it's $6.25 for 2015. Can you repeat the first question?

Gwen Rench: The other concern is on Slide 9, the huge increase in the monthly premium for the non-Medicare retirees. It's a $27 a month hit. That's huge.

Dorothy Teeter: Is the $27 a month piece on the UMP one?

Gwen Rench: UMP classic.

Janice Baumgardt: I don't have the percentages in front of me to show what the percentage of increase is, but it's the same percentage increase you would see for the state active employees.

Dorothy Teeter: Gwen, before next week, let's get back to this to see if this is the usual, the actuarial analysis based on experience. There have been no real changes here to the benefits. Lou's got the percent.

Janice Baumgardt: It's 4.9%.

Dorothy Teeter: It's a 4.9% increase which, in today's world of healthcare inflation, is not too high. But I want to make sure there's nothing beyond just normal actuarial analysis, that there's nothing unusual in those rates that could answer Gwen's question. If there is, we can take it up next time. Let's double check that.

Janice Baumgardt: I can tell you that some of the slight increase included in the 4.9% is the Limeade portal and the new pharmacy benefit at $0.75. Our actual projection was a 4.93% increase so we're right on target.

Dorothy Teeter: Gwen, we can follow-up with you before the next meeting if you have other questions.

Gwen Rench: I'd appreciate that.

Janice Baumgardt: Slide 10 has the Medicare retiree premiums. They include the $6.25 monthly administrative charge per account. The rates are rounded to the nearest dollar; but in actuality, the rates are paid to the penny. Again, Group Health and Kaiser plans are subject to federal review and approval. That second column shows the percentages of subscribers in each plan. About 61% of the Medicare retirees are in the UMP Classic Plan. As mentioned earlier, the decision to include a $2,000 pharmacy MOOP for the Medicare retiree population, even though not required by the ACA, adds $2.44 to the total premium.

Marc Provence: Just a clarification to Gwen's earlier point. So the impact to the subscriber is an $11 increase after the employer contribution?

Janice Baumgardt: Yes, if you look at the $224 to $235, it's $11.

Marc Provence: **S**o from $27 total to $11 member impact, is that right?

Janice Baumgardt: Correct. Group Health, for instance, is at $145 in 2014. $145 of that is being subsidized through the retiree subsidy. But you can see that the UMP Classic was already over that total premium of $300, so that increase in premium is not being shared fifty-fifty through that explicit subsidy. It exacerbates that increase to the retiree.

Slide 11 addresses dental premiums. Per the Collective Bargaining Agreement, the employer for state actives pays 100% of the dental premiums for self-pay groups. The self-pay, like the pre-Medicare retirees and other self pays, pay the entire premium. The first column shows you the three available plans. Uniform Dental plan is our self-insured plan, similar to UMP, and the Delta Care and Willamette are two managed care plans - fully insured plan. Almost 80% of our subscribers are with the Uniform Dental Plan. The rates are increasing from $44.72 in 2014 for a single subscriber to $45.20. The Delta Care rates remain flat from 2014 to 2015. We did not go to procurement this year. In the 2014 procurement cycle we got a rate guarantee to keep it flat through 2016.

We had an offer from Willamette to have a price guarantee through 2016, but it was at an increased price. We chose not to accept that rate guarantee and took their one-year rate. That was a good call because during procurement this year, we received a 2% premium reduction, which is guaranteed through 2016.

Slide 12 addresses life insurance premiums. The basic coverage is paid by the employer at 100%. The basic life insurance that's provided for state employees is at a cost of $4.08 per month. It has remained that same since 2012. It provides $25,000 of life insurance and $5,000 of accidental death and dismemberment insurance.

Also available to employees is supplemental coverage, an employee funded coverage. The premium is based on age and tobacco usage. The premiums stayed flat from 2011 to 2014. In 2015, the rate increased from .078 to .095 per thousand for a monthly premium of $23.75. It looks like a big jump, but in actuality, there was a larger stabilization reserve held by our insurance company. In order to lower those reserves, they subsidized or lowered those rates for employees for four years. If you looked at it over the five year period, it would actually be less than a one percent increase per year.

Greg Devereux: When you say subsidized from reserves, from the reserves of the company or from PEBB premium stabilization reserve?

Janice Baumgardt: It is not from the PEBB stabilization reserves. Those are kept for the UMP and UDP claims. The company we contract with keeps a reserve for the employee coverage. Those reserves belong to the employees and they had a higher amount in reserves due to some good experience in the past and the decision was made.

Greg Devereux: Did you say that those reserves belong to the employees?

Janice Baumgardt: We keep track of our reserves with our vendor. For the employee supplemental coverage those are tracked separately from the employer funded basic insurance. Because of good experience, the reserves that they're holding for us were higher than we felt there was a need, so the rates were reduced for those four years.

Greg Devereux: So are the reserves only held for supplemental or are they held for basic as well?

Janice Baumgardt: I think they're also held for basic. I'll double check on that. In any event, they are kept separately. Supplemental, optional coverage is paid 100% by the employee.

Greg Devereux: We did have a little lawsuit about those reserves awhile back.

Janice Baumgardt: Ok, I'll check into that and get back with you.

Greg Devereux: Ok.

Janice Baumgardt: Slide 13 addresses long-term disability insurance premiums. Again the basic coverage is covered 100% for state employees by the employer. The rate is increasing from 2014 to 2015 by $0.10, from $2.00 to $2.10. The coverage has a ninety-day waiting period or when sick leave runs out, whichever is longer. There's a $50 minimum monthly payment received and a maximum of $240 per month. Currently the coverage ends at age sixty-five. In 2015, benefits will end when the subscriber reaches Social Security Normal Retirement Age. The optional employee coverage is also increasing for the same reason and the rates are dependent on the retirement plan of the subscriber, as well as the waiting period that is selected.

You can get coverage up to about 60% of your adjusted salary - up to $6,000 per month. In 2015, this new rate will end whenever your Social Security Normal Retirement Age is met.

Next Wednesday you'll be asked to vote on the proposed 2015 medical plan benefit recommendations, 2015 active employee premiums, and the 2015 explicit employer Medicare contribution.

Dorothy Teeter: Behind the goldenrod sheet in this section, you'll see the resolutions that we will be voting on at our next meeting. Questions?

Greg Devereux: I don't have a question. I do have a concern way back on page two regarding the wellness web portal costs. I don't want to take up time today. I'll address it with staff offline before the meeting on Wednesday.

Dorothy Teeter: Okay, I'm not finding it on page two.

Janice Baumgardt: Are you talking about the flow chart?

Dorothy Teeter: So Greg, your question is just that piece of it and how it works with the overall rates, correct?

Greg Devereux: That's correct. I'll talk to staff before the meeting next week.

Dorothy Teeter: Awesome. As usual, if you have other questions, please be sure to get in touch with Lou and Janice and others on the team. We''ll make sure questions are answered before the next meeting.

Melissa will take us through a HIPAA training, which is behind Tab 8.

Melissa Burke-Cain: This is actually our first formal training for this group. This will be a high level discussion. Our goals for today are: to ensure that members of the Board have a minimum amount of basic information on privacy and security, to gain awareness around what to do and how to recognize when you have protected health information that may come to you as a member of the Board, or may come to you in another capacity which you would not want to bleed over into your work on the Board; and what to do when those kinds of things happen.

Information on how to reach me is at the front of the book. Connie is someone you can always call and she can find assistance for you. Don't hesitate to call us if you have specific questions around information that you may have at hand.

This is the very, very basic parts of HIPAA. There are covered entities that are responsible to protect personally identified information. Those include health plans, providers who bill electronically. Through the hi-tech law, business associates who are essentially performing functions under a contract with health plans are also directly responsible for privacy and security. There is another category called clearinghouses. They have a job to translate one form of data into another to allow for electronic billing.

Regarding HIPAA, the Health Care Authority has multiple hats it wears within its duties. It's very important that the part of the Health Care Authority and the state that are employing an employer are kept separate and sequestered from the plan functions because we cannot mix

HR and decisions that we made in the course of employment with anything having to do with health information that comes from a covered entity like your health plan. If you don't remember anything else from this training, remember that within the scope of our Health Care Authority, there are multiple functions going within the same work unit, and they have to be very careful to keep those separations in place.

So the Health Care Authority, especially for purposes of our Uniform Medical Plan which is a self-funded plan, is both an employer sponsor and a plan and that creates some challenges for us. One of the things that we do typically is analyze questions along functional lines. What function is being performed, and then based on that function, what is the permitted use of information and the permitted disclosure information. There are three components to protected health information - it's identifiable to an individual; it's received from a covered entity so that for example, if an employee self-identifies, then that is not a HIPAA-covered disclosure because they have made the disclosure to the Health Care Authority. What we have to be careful about then is what you do with the information that you have as far as re-disclosure and limitations based on the use of it. It can be any form: written, electronic, hallway conversation, discussion in a restaurant. It can be in any media form and it has to relate to either past, present, or future physical or mental health, and it could also be related to healthcare being provided, or payment for healthcare received.

Those are the three parts that it applies to, and then the identification is whether it could reasonably identify the person. Sometimes information can be modified in a way that makes it useful as individual demographic information, but it's masked so that no one can match that up to a specific person and identify their health conditions from that, and that's called limited data set. Examples of PHI would be, in addition to healthcare records, demographic information like name, address, birthdate, age, telephone number when it's associated with a health record, medical records, claims records, referral records, incident reports, explanations of benefits, and then there's a category that has some limited disclosability and that involves research records that have individual identification potential with them. Those can be from public health purposes, they could be for health policy purposes, or they could be from hard bench research about outcomes or about treatment.

It is possible with the correct redactions, and also with approval for example from an IRB, to use data sets and to do that kind of analysis and research. More and more the Health Care Authority is being charged with some responsibilities to look at quality of care, outcomes of care, and cost effectiveness of care. All of that could be in the realm of research, but that's an area we have to take care when making those disclosures, especially when that work is being done internally at the Health Care Authority. Why is that important to you? Because the Health Care Authority staff serves as your staff. They do work and analysis that would allow you to make the decisions that you have to make so we want to make sure that the work that they do to support your work complies in all respects with federal and state law.

There are general categories of use and disclosure. Some are exempt from needing an individual authorization, for example, treatment, provider to provider; payment, plan to provider; plan operations, things like auditing that might be done at the plan utilization review and similar activities that go to the functions of the plan. One thing that's important to remember is that even if it's exempt from authorization for treatment, or payment, or operations, you still use the minimum necessary information to do the job - no extra information. You still keep in mind that it is better to use limited data sets that give you only what you need to accomplish the task or the job responsibility that you've been given.

There are a number of permissive disclosures. They're all outlined in federal law that plans or other covered providers may disclose; and there are disclosures that are legally required. Generally those fall under the public safety, law enforcement categories. Sometimes they also fall under public health, for example, epidemiological work which we use in some requirements to get that information. We're careful in those situations to look at whether you can individually identify limited data sets that are generally used there. You can also have a patient give written authorization and there are rules about how long that lasts, what they have to do, what it has to contain, and what kind of notice you have to give them in order for them to authorize use of their health information. Then there can be incidental disclosures such as I come into my doctor's office and sign in. My name is there and it's associated with some healthcare of some type, unless I'm perhaps representing a drug company or something similar in the doctor's office and I sign in. The bottom line is just do and use information only to the extent that is required for the duty that you have in your hand.

The next one has to do with what happens when use or disclosure is unauthorized. There are federal responsibilities for coming after unauthorized disclosures that occur and what we do in our office. It's pretty universal here at the Health Care Authority that we treat whatever PHI we have and as if it's our own PHI and use it only as if you'd want your own information used. Places where that may be difficult and present some challenges are things like public places, what you leave on the table if you bring other work to do and you go out for a break; stolen data from stolen laptops in your trunk. We've got a pretty good track record of some of the things that individual health covered entities have been hit with from somebody being curious about a coworker's medical records and having being able to access that, or somebody working on claims information on the subway and leaving those documents on the subway by mistake, dropping their jump drive with their data. There are two things to consider – first, is the security of the device that you're using or the source of the data being maintained, and then is privacy being maintained. They work together. You have to think about both. For example, if you're using a flash drive, in order to comply with the security requirements it must be encrypted; and if it is lost it can't be readily accessed as far as the information on it. So think about how secure the storage is.

We used to take home a disc with health information printed on it preparing for a trial for the next day and I'd be wandering around with it in my car. We don't' do that anymore. We make sure that all the data is physically secure, in addition to being kept private. We do that in a number of different ways. For example, we have limited access to work sites so you have to have a badge to get in, people are taken up to offices with somebody accompanying them, password-protecting the printers, encrypting email, all of these things are being done here at the Health Care Authority. The chances that you will encounter this are small but they're not zero and that's why we have to make this information known.

There's a presumption of a breach if there's any unauthorized access, use, or transmission of PHI. Then there are mitigating factors that apply to decide how badly you're going to be impacted by the breach. The four factors are: the kind of information it is, how much information there is about an individual; who is responsible for the error, was it a theft versus a hacking by an employee versus an untrained employee; was it an email that was misdirected, was is opened or not; theoretical versus actual use; and how quickly and effectively you mitigated that disclosure.

So any time you have a question, the sooner you call the Health Care Authority or myself, the better off you are because we jump on those things as quickly as possible. We try to reduce

the scope of any damage for individuals. Don't share your passwords, don't forward or reply all, be very cautious about how you respond to those kinds of emails.

What is your role and how does the PEB Board interact with the Health Care Authority? The Health Care Authority has multiple components/responsibilities that are covered. Under statute, in 41.05.055, the Public Employees Benefits Board is created within the authority. That means you're a part of the Health Care Authority rather than an external group. This is language that was put in place in 1988 when the agency was created. It's been changed over time with the first round of state health reforms in 1993; and now instead of having the function that is identified here in 41.05.055(1), which is design and approve insurance benefit plans, establish eligibility criteria, and participation requirements for insurance benefits, now we have some limitations around that. In 1993 we had 27 different plans offered for employees and they didn't have the same benefits plan to plan to plan. Some had better vision, some had better hearing, some had better dental. The world has changed. Our statute has changed in some respects, but there's also a lot of artifact language still left in which makes it more of an art than a science to try and interpret how HIPAA privacy and security applies to our work.

One of the things that you're required to do is study matters connected with provision of healthcare coverage for employees. The standard for which you exercise your discretion is the best basis possible with relation to the welfare of the employees and to the state. So the Health Care Authority is essentially the administrative arm and carries out the operations of these benefits and provides staff and analysis for you to do this work of exercising your collective wisdom, collective discretion to make decisions around benefits that are in the best interest of the employees and of the state. Sometimes that can be a conflicting situation to be in. There has been quite an evolution in what the Board does compared with what other pieces of state government do. Your environment for decision-making involves legislation, OFM, different entities, the business environment for plans and providers, and it's all against the larger context of what's been happening in the way of health care reforms over time.

It's a complex mix and sometimes it's difficult to see, to tease out where your responsibility begins and ends compared with other pieces of state government. But there is a list of considerations that you're expected to use and this is some of the mixed language that you would find in your statute. In the past there was a lot of emphasis on cost containment. More recently that's been married up to the concept of quality in health care and improved outcomes; population-based health concepts. At the beginning we were just an arm of purchasing care and coverage. Now we're looking not only for state employees but also for the state as a whole, as a benchmark towards improved quality of care. It's the value-based purchasing concept that you work with now. Wellness incentives have been added. Utilization review was and is still there. All of these things go into the mix of the analysis that staff does for you; but at the end of the day, you apply your knowledge and your consensus to that information.

One very important piece of information in the statute that remains from 1993 is the requirement to maintain the comprehensive nature of employee healthcare benefits. Benefits provided to employees shall be substantially equivalent to the state employee health benefits plan in effect on January 1, 1993. That was a very important addition because the PEBB benefits were being used as a benchmark for other employer-based coverage and for other delivery systems. There was a real need for state employees to know that the good and comprehensive benefits that they had were going to continue to be comprehensive and they wouldn't have an erosion of their benefits.

More recently there've been a lot of collaborative activities that have been added to the Health Care Authority's jobs and the work of this Board is part of the mix of data and analysis that goes into the larger work of the collaborative efforts - the Bree Collaborative, purchasing issues, the health technology assessment work that we do to find out whether particular covered services are cost-effective and safe. The Board approves the employees' share of the cost of coverage. It's not a blank check for the PEBB to decide what employees do or don't pay.

Some of the additional limitations have to do with collective bargaining and the labor relations work that's done at the Governor's Office, and that's broad language in the statute. Not all of it is being implemented at this time. We have to be very cautious around making sure that this work doesn't get in conflict with work being done on the labor relations side, although we have broad language that says that you can as long as their benefits are a substantial equivalent to what was done in 1993. Figuring out what that was now so many years later is an almost impossible task. But in addition, we have specific legislation that says eligibility criteria doesn't have to be the same, but scope of coverage, especially in the nature of hospitalization - the major components of the covered and scope of benefits, has to be equivalent to what was done in 1993.

PEB Board decisions also affect others. Succinctly said, there are employer groups that are local government and K-12, that's why we have K-12 representation on the Board, that purchase through the Health Care Authority. We act as the broker essentially for that care and coverage; and so your decisions will indirectly affect those additional groups that buy through PEBB. In the future there may be more that buy through PEBB. There can always be less too; it depends on what the legislature decides to do.

There are other state laws that we are required by law to train you about and we'll be doing that. They are the Open Public Meetings Act, you participate in them so you might as well know about them; review of Roberts Rules of Order to try to make sure that we are in compliance with the rules of open public meetings; and the public records law where we try to do the work of this Board as transparently and publicly as possible, and with as much information available as possible; ethics in Public Service because in the work that you do for the Board, you are state officers; and finally, the attorney/client privilege.

Any time you're doing work on the Board, consider which hat you're wearing and where you are. All of you have a reason why you're on this Board, whether it's because you have policy background because you represent a constituency or whether you come from a state government position that gives you a place on the Board. And up to this point, and I have no reason to think it would ever change, the members of this Board have been very good at making sure what hat they have on. For example, we go into executive session and you get information about lawsuits, and sometimes they're individual cases, and sometimes they involve individual health information. This Board is very cautious and deserves credit for not taking that information and using it in other ways for other purposes. That's something we're always on the lookout for.

Here's the bottom line for today. I'd like to make sure that you have an awareness of what kinds of information might need to be protected, which is almost any form - electronic, paper, or spoken. It involves information that can be reasonably identified to an individual so that their health status, health treatment, and their identity aren't connected in a way that would allow someone to identify who they are with their records. We do have all of the requirements of HIPAA in place for the agency. That protects you as well because you're part of the agency.

We do have a privacy officer, George Taylor, and a security officer, Bill Brush. We maintain all of the documents, records, and procedures. One thing that we have learned by watching the bad experiences of other entities who get hit because they've had a breach of HIPAA privacy is that the full weight of the Office of Civil Rights comes down on anyone who has a breach. They look at every single piece of HIPAA required protections. They look at your documentations, your training records, your logging of disclosures. All of those things will be put on the table if we have a breach and that's why we're so cautious about wanting to make sure that we have maintained all the formalities when that happens.

Lou McDermott is responsible. He's your first point of contact, which probably means you'll talk to Connie. Connie will find Lou, me, or someone else at the Health Care Authority to help you. If that occurs and we're talking about potential disclosures or how did I get this information and what am I supposed to do with it, then you can expect we'll have a conversation around how you received the information, who sent it to you, why it was sent to you, whether there is a real business purpose for its use, is it part of a function that you have as a non-PEBB member or did it come to you as part of your role in PEBB. For example, was it as a subscriber, perhaps a retired or active teacher, did they contact you with information? Then we go through the analysis, is it really protected health information, did it come from a covered entity? We tease out all of these requirements and come up with a nice logical flow of information, how it came, can we have it, can we use it, who can we give it to, and how do we need to protect it if we hold onto it.

When I say to err on the side of caution, that doesn't mean to err on the side of not providing public information when public information is supposed to be provided. We do have an obligation to make sure that we comply with public records. We do our work in the open. If there's any doubt about an individual's health records, that should be a stop sign to you, to wait and try to make sure that you're not going to do anything to violate privacy rights of individuals. We have to maintain the faith that our covered folks have, that we will secure their data; and when folks start participating in things like wellness, or claims appeals, they really do rely on us to make sure that their rights are protected.

The final thing is that just as quickly as you might find out about a problem, contact us because the quicker we act the better it is. Sometimes it takes a bunch of people locked in together to figure out what to do. If it's more financial related information, there's one strategy for mitigation; if it's similar to what has happened to other entities, like 100,000 people affected versus three, there are different strategies we use to mitigate; but the quicker that we act the better it is for everyone.

Dorothy Teeter: Thank you for this really succinct and organized presentation. It is good to remind us of this, so thanks for the training.

Dorothy Teeter: Any questions for Melissa?

Yvonne Tate: Just a comment. For me I think the riskiest thing we do is when we receive letters from subscribers. Usually they come through the Board and not to us directly so you all have an opportunity to look at it, red flag it, and let us know that it's personal information.

Melissa Burke-Cain: I agree with you and you never know when that's going to happen. I've been in meetings for other things. I've been at Health Benefit Exchange meetings and had somebody come up, tap me on the shoulder, and say "I see you work with the Health Care

Authority. I need to ask you some questions about my healthcare, my sister's healthcare, my neighbor's healthcare, my ex-wife's healthcare." It can happen and so the more you have in your mind what you need to do, the easier it's going to be to react. The first time that happened to me I froze and went "Holy cow, what am I going to do with this?" Generally the person is a little agitated, probably certainly a little bit irritated with the state, so you want to try to address the need in the best way you can.

Dorothy Teeter: Thank you very much. I think you said to call Connie.

Our next agenda item will Dan Lessler. He will give us an update on transgender health care. Information is behind Tab 9.

Dan Lessler, HCA Chief Medical Officer: Today I will follow up on the conversation from a previous Board meeting about transgender care. At that time, I provided you with clinical background on the care of people with gender dysphoria. I indicated that it was appropriate to move forward with creating a benefit for people with gender dysphoria and the Board agreed. The plan was to come back with a proposed timeline on how to move forward. After considerable thought and internal discussion on this topic, Slide 9 is our proposal on how best to proceed. I realize that for many, we can't go fast enough.

On the other hand, my responsibility as the Chief Medical Officer is to ultimately ensure members in need of transgender care get the best care possible. This requires designing a benefit which takes time in terms of thinking through what is included in the benefit and how it's provided. For example, do we use centers of excellence for ailments of transgender surgery?

With that in mind, Slide 2 is how we propose moving forward, effective January 1, 2015, to implement a mental health and hormonal therapy benefit for people with gender dysphoria. We would continue to develop a full benefit that includes surgical care for people with gender dysphoria effective January 1, 2016. This is a clinically appropriate way to move towards a full benefit.

Marc Provence: I don't know if there is such a thing as a typical progression of care, but with respect to the mental health and hormonal therapy benefit, could you describe to me how an individual might access those benefits? Would it typically be through a primary care provider or would it be self-referred? Or could it be anything?

Dan Lessler: It would much more likely be through an endocrinologist with expertise in terms of the hormonal benefit.

Marilyn Guthrie: Just a comment. I want to give credit to you and the rest of the staff for addressing what I think we all discussed last time. This essentially addresses some of the exclusions that are currently in the benefit plan design and gets us moving forward. I really want to give credit to the thoughtful way in which you've addressed this.

Dan Lessler: Thank you.

Dorothy Teeter: Thank you, Dan. This topic will be back to us as we do the benefit design, but I appreciate the clinical perspective on this.

Dorothy Teeter: Next up is our public comment. Kathryn Mahan, David Ward, and Danielle Askini will come up together.

Dorothy Teeter: Okay. If you still want to make a public comment and didn't sign up, just let Connie know.

Kathryn Mahan: Good afternoon. My name is Kathryn Mahan and I live in Puyallup. I am a subscriber and I want to thank you for the work that you've done up until now. I don't want what I'm about to say to sound ungrateful. It's just that some of us have been waiting a long time. So I know I got about two minutes and that's really not long enough for my life story and I'm sure that's kind of a relief to all of you. If I did have time I could describe how it feels to be excluded for a lifetime. I could tell you how it feels to be ridiculed. I could tell you how it feels to be beaten and worse. I could tell you how it feels to stand in a shower and hold a razor to your genitals and start to cut and wonder if you can make it all the way through before you chicken out or pass out. I could tell you how it feels to drive down I-5 and look at the bridge abutments and the power poles and wonder which ones would be the right one to drive into. I could tell you all these things and this is something that a lot of my brothers and sisters experience quite often.

I've worked in state and local government for 25 years now. I've paid into the insurance pool that covers all of the members and I've received pretty good medical care, all the members' legitimate medical needs, except for the one most important need to me. I can tell you how it feels to be specifically excluded, to have my most important medical issue specifically excluded. It feels unfair. I'm a single parent of nine teenagers, eight of them are at home and I earn $60,000 as a budget coordinator for state government. Some people would say, "well, pay for it yourself." Gender reassignment surgery costs about $20,000. I have to pay for my kid's food, their clothes, their lodging. I have to pay for their medical needs. I buy their ASB cards. I buy their sports equipment, their art supplies. It's like the list is endless, right? Christmas presents, birthday presents, school outings.

It would take me a third of my annual budget to do this thing, something that I deal with every day of my life. I can't set aside a third of my annual budget so I just limp along the best I can. I don't want to sound ungrateful. I've been in state government for a long time. I've followed legislative processes for a long time. I don't mean to question anybody's sincerity, but when I see somebody in the front of the room say, "we're going to study this for a year," what I hear is that it's going to the boneyard. I've had this happen too many times and it just feels kind of helpless. So that's what I have to say.

Dorothy Teeter: Thank you.

David Ward: Thank you folks. My name is David Ward and I'm an attorney at Legal Voice and I'm happy to be here again speaking about the same issue about removing transgender health exclusions. It's been a lot of progress since we first appeared before you at the April meeting and we're very appreciative at the swift movement towards removing exclusions. At the same time, we still do want to push for swifter action for the reason that Kathryn just outlined. There is urgency to this issue for folks and we are behind other states on this issue.

California's CALPERS covers these services without exclusions. Oregon's PEBB covers these without exclusions. And I'm not familiar with the process that went into necessarily all of those designs, but in Oregon they did it as a result to a law suit and they fixed it by a pretty simple settlement agreement that took out exclusions. There wasn't a long period of time to design a benefit and I think a similar step could be taken here, obviously a well-designed benefit package I think everyone would agree with. I also think that there are ways that other states have addressed this issue; and CALPERS for instance, under some plans, they just mandate

the coverage be provided for sex reassignment surgery consistent with the standards of care that are put up by the World Professional Association for Transgender Health, which provides a baseline for measuring medical necessity and determining these things without having to go through an extensive benefit design process and provides immediate relief. So I guess what I'm saying is we really do appreciate all of your work and your commitment on this issue, but we'd like you to move faster, and we do think that lives are at stake as a result.

Danielle Askini: Great, thank you. My name is Danielle Askini and I'm the advocacy lead for Gender Justice League and a member of the Coalition for Inclusive Health Care with David. I've provided you with some written testimony here and I just want to reiterate the points that both David and Kathryn have made. And I think for me, the most important highlight is that last month we lost a young transgender activist in Seattle, Son Kim, who we memorialized at Trans Pride, who committed suicide. This is a regular occurrence in the transgender community and lack of access to these benefits is certainly one of the primary motivating factors for people to commit suicide in our community. Various studies have shown that suicide rates are between 30 and 45 percent and that those drop down to about 1 to 2 percent when people have access to this care.

I want to reiterate what David has said and I've included United Health Care's gender identity disorder, gender dysphoria treatment here from the CALPERS plan. And so there are currently benefit plans that exist. Group Health also already offers a benefit plan to its own employees in the city of Seattle. There are designs that are out there and while I definitely understand the need for ensuring that people are able to access this care with good surgeons, there are a very limited number of surgeons who perform these genital surgeries. It's not willy-nilly. It's not any surgeon that can perform these surgeries. There's a very small number, they're highly regulated, very scrutinized. Few hospitals will actually even allow doctors to perform these surgeries in their hospital facilities. And so there is a very small number, unlike other surgeries, that may be done by general surgeons. There is a very small number and so the community is very familiar with all these surgeons. Folks have been accessing these surgeries for the last 30 years from a very small group of people so it's not something that I think people are going to generally just be able to access. And we know that on a case by case basis, all of these surgeries will be reviewed most likely on any plan that's created through a prior approval process, which I believe is a sufficient opportunity to address any concerns that the UMP would have in terms of appropriateness of candidates, have folks follow the World Professional Association of Transgender Health Standards of Care. Are the surgeons licensed and experienced?

I also want to point out that recently since we lost Matt, the Office of Insurance Commissioner issued a letter which I included for you, stipulating that private health insurance companies in Washington State can no longer include these exclusions, categorical exclusions, in health plans and that it is a violation of the Washington law against discrimination. And also Medicare removed these categorical exclusions in all of their plans very recently and Medicare is the largest health insurance provider in the country and they did so by simply extracting the exclusions and not going through a complex comprehensive 18-month long design benefit plan. So I think that there - Just to summarize my key points, there are a number of designs that are currently out there and available including in Washington State. This is a very urgent need and we certainly see people who have committed suicide even since we've met. We've lost a transgender person in Seattle to suicide. And I don't know that an 18-month period to remove something that is categorically wrong, that is discriminatory, is appropriate for the PEBB to be doing so. I would urge you all to consider a resolution at your next meeting to include these benefits and to remove these exclusions for the 2015 year. Thank you so much.

Dorothy Teeter: Does anyone on the Board have any questions? I want to express our collective appreciation for the work that you're doing to keep us educated and to continue to press this issue. We really deeply appreciate it. So thank you very much.

Greg Devereux: I don't have a question but I do want to add my voice to the call for expediting this issue and I appreciate very much what the Health Care Authority has done to date. I do appreciate Dr. Lessler's comments today. When a DOT worker is working on a project, they have a work plan that outlines almost every hour of the day for the next two years. I haven't seen that in this case. I think it probably would be impossible to do this by January 1, 2015, but it might not be impossible to do it quicker than 2016. The urgency could not be greater. Danielle already outlined it. I think anything we can do to speed this up would be an incredible benefit for everyone in the community.

Dorothy Teeter: Thanks, Greg, for that perspective. Anyone else have other comments for today? The last item on our agenda is informational and is behind Tab 10. It's a list of proposed meeting dates for the 2015.

Meeting adjourned at 4:00 p.m.

Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

D*R*A*F*T

July 31, 2014
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
10:00 a.m. – 11:30 a.m.

Members Present:
Dorothy Teeter
Yvonne Tate
Marilyn Guthrie
Mary Lindquist
Marc Provence
Gwen Rench
Greg Devereux
Harry Bossi
Melissa Burke-Cain

Call to Order

Dorothy Teeter, Chair, called the meeting to order at 10:00 a.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Dorothy Teeter: This is a day of voting. Today is a culmination of many, many meetings of preparation, briefings, and comment. I appreciate not only the Board, but those that are here today and others that have contributed to the policies that we're going to be voting on today.

Janice will first share a premium overview update and clarify the life insurance benefit in response to a question from the last meeting. Those materials are behind Tab 3.

Janice Baumgardt, PEB Finance Manager**:** At our last meeting, Greg Devereux had a question on the Life Insurance Premium Stabilization Reserves (PSR). I indicated the reserves Voya has for the employee contributions are owned by the employees. I want to clarify that the reserves are actually owned by our vendor. However, to Greg's point that there was a lawsuit - at one time the employer and the employee PSR's were co-mingled, and those are now separate.

Greg Devereux: Thank you.

Janice Baumgardt: As an example, the reserves for the Uniform Medical Plan (UMP) and the Uniform Dental Plan (UDP), a self-insured product, are owned by PEBB Program.

However, our life insurance is actually a fully-insured product, so the vendor owns those reserves.

Greg Devereux: Thank you.

Janice Baumgardt: Another question came up at the last meeting regarding the administrative fee I had pointed out in the Medicare and the non-Medicare retiree premiums. Although this is not a new fee, I pointed out the $6.25 monthly administrative fee per account in the tables I shared. This fee has always been in the premiums. It's not in the chart that shows the employee premiums because for the employer pays the admin fee for state active employees. Every subscriber is assessed a $6.25 administrative fee for 2015. This fee funds PEBB Program Administration.

Greg Devereux: **H**as that always been true? Has there been an administrative fee in the past?

Janice Baumgardt: Yes, that's how the PEBB Program is funded. There might have been some confusion in the past when COBRA retirees we were charged an additional 2% fee on top of the admin fee. We no longer charge that.

Greg Devereux: Is the administrative fee for all administration? Does it cover all aspects of the administration or HCA?

Janice Baumgardt: It covers everything that's not directly related to a health plan. It covers staffing, except for those staff working directly with UMP. Those would be part of the UMP Rate Build, part of the premium. It covers all of the overhead and administrative costs,

Greg Devereux: Does PEBB get any dedicated funds, any dedicated appropriations from the legislature?

Janice Baumgardt: We work out of several accounts. One of those is appropriated, that's fund 418, and the $6.25 monthly fee is what makes up the appropriation.

Greg Devereux: There is no other direct funding besides that?

Janice Baumgardt: No. It all comes in via the funding rate for state agencies or the premiums that are paid for the self-pay groups.

Greg Devereux: To go back to the life insurance issue regarding the lawsuit. Did you indicate that when the lawsuit happened before, that both employee and employer put some portion in?

Janice Baumgardt: I wasn't here then, but my understanding is this. There is our basic insurance that the employer pays 100% of and there is supplemental insurance that employees can buy into. My understanding is that our vendor had mingled the reserves. There was a lawsuit, and as a result of that lawsuit, our vendor now keeps those reserves that are attributable to the premiums paid by employees separate from those reserves paid by the employer.

Greg Devereux: Thank you.

Janice Baumgardt: I mentioned at the last Board meeting that there might be changes to the premiums. A few changes have been made to the premiums. One of the reasons for changes to the premiums is SmartHealth participation. Our initial thought was to say people eligible for the incentive would be those that we had validated - they had filled out the attestation and they would be participating in the SmartHealth Program. We would then validate that through the Health Assessment to make sure it was completed. It turns out that not all subscribers were notified of this validation process. We've also learned that there were different technical problems for different subscribers, depending on the plan, on getting those Health Assessments completed. So the decision was made to include all those that attested to SmartHealth. The threshold has changed so more people will be eligible for the incentive. That changes the premiums slightly. Sixty percent have now attested positive across the plans. Those are the assumptions that are going into the rate build.

Greg Devereux: Do you know what the impact on the rate is?

Janice Baumgardt: The impact is less than $1.

The other change impacting the change is due to adding transgender benefits. The proposal you will see indicates that as of January 1, 2015, non-surgical transgender benefits will be included and effective July 1, 2015, the surgical transgender benefits would be added. Those two combined, in some instances, increase the premiums by $1. The state index rate and the employee premiums are always rounded to the nearest dollar, so the rates you see in some instances will be exactly what you saw previously, depending on how they rounded. Some will be $1 more than what you saw previously.

Slide 4 of the presentation shows the employee contributions that will be voted on for state employees general government and higher Education. Slide 5 is the non-Medicare retirees. It includes the $6.25 admin fee, where on the previous slide doesn't because it's paid by the employer. The state is covering that $6.25 for the employee.

Gwen Rench: I would just like to go on record as being concerned about the large level of increase for the retirees. Retirees aren't getting increases in income, just increases in expenses and I noticed that it has even gone up another dollar from the last meeting.

Janice Baumgardt: That was due to the benefit changes and the SmartHealth change.

I also wanted to point out changes in the Medicare plans. The transgender surgery benefit is also being added effective July 1. You don't vote on the premiums. You are voting on the subsidy of $150, or half of the monthly premium, whichever is less. There is no premium change for UMP on the UMP Medicare rates. For Group Health, it is less than $1 to add that benefit; and Kaiser is waiting further direction from CMS.

PEBB 2015 Procurement Vote

Eleven Procurement Resolutions were presented for a vote before the Board. All resolutions were approved.

Procurement Resolution 1: Resolved, that the Uniform Medical Plan Classic (non-Medicare and Medicare) will administer a separate annual out-of-pocket maximum of $2,000 for members' prescription drug costs.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Procurement Resolution 2: Resolved, that the Uniform Medical Plan Classic (non-Medicare and Medicare) will administer a benefit exceptions policy whereby Tier 3 non-preferred drugs that do not have a generic equivalent may be covered at the Tier 2 coinsurance level when medical criteria are met.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Procurement Resolution 3: Resolved, that the Uniform Medical Plan Classic (non-Medicare and Medicare) and the UMP Consumer Driven Health Plan will change coverage to be more consistent with Regence Medical Policy for the following services:

- **Temporomandibular Joint (TMJ)**
- **Home Health Services**
- **Circumcision**
- **Genetic testing**
- **Orthotics to prevent complications associated with diabetes**
- **Massage Therapy visits to exceed one hour when medical criteria are met**

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Discussion:

Greg Devereux: I support all of this. I wonder what the financial impact is.

Lou McDermott: These changes will about $236,000 annually.

Greg Devereux: Do you have any idea the cost per member?

Janice Baumgardt: I believe it's one cent employee premium for non-Medicare and UMP CDHP and two cents for UMP Classic, if I remember correctly.

Procurement Resolution 4: Resolved, that all PEBB medical plans (non-Medicare and Medicare), including the Uniform Medical Plan Classic, the UMP Consumer Driven Health Plan, and all the fully-insured Group Health and Kaiser medical plans, will administer the following benefits assuming the FY 2016 funding rate supports them:

- **Effective January 1, 2015, will include benefits for covered non-surgical health care services and prescriptions for the treatment of gender dysphoria, and**
- **Effective July 1, 2015, will include benefits for covered surgical services for the treatment of gender dysphoria.**

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Discussion:

Greg Devereux: I just want to thank the Health Care Authority. A lot of work has gone into this. We've had multiple meetings and a lot of discussion. I really do appreciate that the date has been moved up and that it is voted today by this Board and not next year. I really appreciate the effort that went into that.

Dorothy Teeter: Thanks, and on behalf of the whole PEB team, I know that there was a tremendous amount of work that went into this.

Procurement Resolution 5: Resolved, that the Kaiser Classic Plan will not apply members' out-of-pocket costs in the last quarter of the year toward the next year's deductible.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Procurement Resolution 6: Resolved, that SmartHealth Program requirements are:

- **Complete the Well-being Assessment**
- **Earn the required number of points according to the Smarthealth Program completion rules.**

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Procurement Resolution 7: Resolved, that the PEB Board endorses the Group Health employee premiums.

Moved. Seconded. Approved.

Voting to Approve: 5
Marc Provence
Yvonne Tate
Mary Lindquist
Marilyn Guthrie
Dorothy Teeter

Voting No: 2
Greg Devereux
Gwen Rench

Discussion:

Greg Devereux: This is a tough one for me. I will be voting no, not because I don't think the Health Care Authority and PEB staff have done a fantastic job of negotiating the rates, especially Group Health Classic being reduced, but Group Health Value has gone up. I'll be voting against a number of others too, just because I understand that what drives it is utilization and inflation, which means providers get an increase, but state employees haven't

gotten anything for six years. In fact, they have had their wages reduced six percent over that period and their money goes to pay for these. I think providers and other folk should also take a hit in that regard. So, again, I appreciate very much what the staff has done to get it to the level where it is, but I reluctantly will be voting against.

Procurement Resolution 8: Resolved, that the PEB Board endorses the Kaiser employee premiums.

Moved. Seconded. Approved.

Voting to Approve: 5
Marc Provence
Yvonne Tate
Mary Lindquist
Marilyn Guthrie
Dorothy Teeter

Voting No: 2
Greg Devereux
Gwen Rench

Procurement Resolution 9: Resolved, that the PEB Board endorses the Uniform Medical Plan employee premiums.

Moved. Seconded. Approved.

Voting to Approve: 5
Marc Provence
Yvonne Tate
Mary Lindquist
Marilyn Guthrie
Dorothy Teeter

Voting No: 2
Greg Devereux
Gwen Rench

Discussion:

Greg Devereux: For the same reasons that I stated earlier, I will be voting no.

Procurement Resolution 10: Resolved, that the PEB Board endorses the maximum $150 employer Medicare Contribution, not to exceed 50% of plan premium, set forth in the legislative budget appropriation.

Moved. Seconded. Approved.
Voting to Approve: 7
Voting No: 0

Procurement Resolution 11: Resolved that the PEB Board ratifies the minimum Spousal Surcharge amount required by the legislature, which is $50 per month, for implementation by the Health Care Authority.

Moved. Seconded. Approved.

Voting to Approve: 6
Gwen Rench
Marc Provence
Yvonne Tate
Mary Lindquist
Marilyn Guthrie
Dorothy Teeter

Voting No: 1
Greg Devereux

Discussion:

Greg Devereux: It was not too long ago we were doing coordination of benefits, and now we are penalizing folks for having benefits, their spouses having benefits elsewhere. I think this is punitive. I think it's another way for the legislature to fund things when they have alternatives, so I will be voting no.

Dorothy Teeter: Again, thank you all very much. This was the culmination of a lot of work from lots of people in the audience, on the phone, and around this table to get this done.

Lou McDermott: Behind Tab 5 is the 2015 PEB Board meeting schedule we will be filing with the Code Reviser.

Dorothy Teeter: It's time for public comment. Kathryn Mahan and Tobi Hill-Meyer have signed up to comment.

Kathryn Mahan: Thank you. I'm not used to coming down to Olympia being hopeful and this is just really an amazing day. Our people, we're not used to receiving this kind of formal support. So, I don't do this usually when I testify, I want you to know that. I just want to recognize the compassion that you're showing right now and the courage. It means a lot to a lot of us. Thank you.

Dorothy Teeter: Thank you for the time you've put in to helping us learn.

Tobi Hill-Meyer: I'm Tobi Hill-Meyer with the Gender Justice League and I would just like to say thank you. I know this has been a long process and we've had to do a lot of work around it and we really appreciate everything that you've done. This is a move that is going to bring things in line with state non-discrimination laws, and is something that we are seeing mirrored by many states all over. Just yesterday, I forgot which one, but I got an announcement of another state that had their Insurance Commissioner come to the same conclusion of our Insurance Commissioner, that these forms of exclusionary practices are illegal discrimination. By removing them it has a significant benefit to many people's lives and we really appreciate

that. We are going to continue to be available for support in implementation and further down the road. Again, thank you.

Dorothy Teeter: Thank you for that offer of continued work with us.

Meeting was adjourned at 11:30 a.m.

Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

D*R*A*F*T

October 22, 2014
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
12:00 p.m. – 12:16 p.m.

Members Present:
Dorothy Teeter
Melissa Burke-Cain
Greg Devereux

Members on Phone:
Marilyn Guthrie
Marc Provence
Yvonne Tate
Mary Lindquist
Harry Bossi

Call to Order

Dorothy Teeter, Chair, called the meeting to order at 12:06 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Dorothy Teeter: This is a special meeting of the Public Employees Benefits Board. There is one item before the Board today. Lou McDermott will bring us up-to-date on the proposed changes to Resolution 4 that was approved on July 31, 2014. Materials are behind Tab 3.

Lou McDermott: Basically, during the Board season there was a lot of interest in the transgender benefit and having that available to our members. We went through the Board season working with our clinical staff, our program, with Regence, Group Health, and Kaiser. We determined what we felt could be done for 2015 – mental health visits and medications would be authorized for treatment of Gender Dysphoria, effective 1-1-15 and the surgical treatment would be authorized in July.

During the Board season there was a letter from the Office of the Insurance Commissioner that was sent to all the carriers indicating that, basically, they felt it was not appropriate to discriminate against folks with Gender Dysphoria and that they should make treatment available. That took time to get through all the legal departments and committees of the carriers. Based on our conversations with the carriers, we felt we had the most aggressive timetable we could offer. The carriers have since changed their position. Group Health,

Kaiser, and Regence are all going to be implementing the full benefit effective 1/1/15. They have been working closely with our clinical staff. We feel that the criteria are appropriate, the timeline is appropriate, the carriers will be ready; therefore, we are asking the Board to change the July 1 start date for the surgical benefit to January 1 to be in sync with the carriers.

Greg Devereux: I would just say that I really appreciate that everyone looked at it very closely and that it is moved up six months. I think that's great and I really do appreciate that we're doing this.

Dorothy Teeter: Thanks, Greg. Hearing no other comments from the Board, I am going to read the proposed amended resolution and then ask for questions or comments before we vote on the item.

Amended Procurement Resolution 4: Resolved, Resolution #4 from the PEBB's July 31, 2014 meeting is amended to state the following:

Resolved, that effective January 1, 2015, all PEBB medical plans (non-Medicare and Medicare), including the Uniform Medical Plan Classic, the UMP Consumer Driven Health Plan, and all the fully-insured Group Health and Kaiser medical plans, will administer and include benefits for covered non-surgical health care services, covered prescriptions, and covered surgical services for the treatment of gender dysphoria.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0

Dorothy Teeter: That's a unanimous vote for making this change. Thank you all.
We have one person, Kathryn Mahan, signed up to speak.

Kathryn Mahan: Thank you, Madame Chair. On behalf of the group of people who worked so hard on this, I want to say thank you up front so that I don't forget to do that. I've been a subscriber for a long time. I've been a Group Health customer for twenty-six years and I really like that coverage. It works very well for my family. I don't always get everything that I want, but it's been very good for us. And it's been a very large part, being as I am a parent of a whole lot of kids, it's been a very large part of my decision to stay in government service.

What I want to say is, first off, I really appreciate what you've done because this is going to help me personally. Group Health has already been working with me and I am going to be using these services next year. And it's something I never thought I'd be able to do, so that's important. You probably already know this because you work in this field, but some people don't think about this. I have a lot of kids and how well I care for them is based upon my own mental and physical health. And by helping me, you are actually helping ten of us and I'm just very pleased with what you've done. Thank you.

Dorothy Teeter: Thank you very much for your comments and that's a very inspiring thought to take forward with us as a reminder that as we make positive impacts on some people's lives, they have ripple effects for many others, so thank you for that.

Meeting adjourned at 12:16 p.m.

TAB 4

Washington State
Health Care Authority

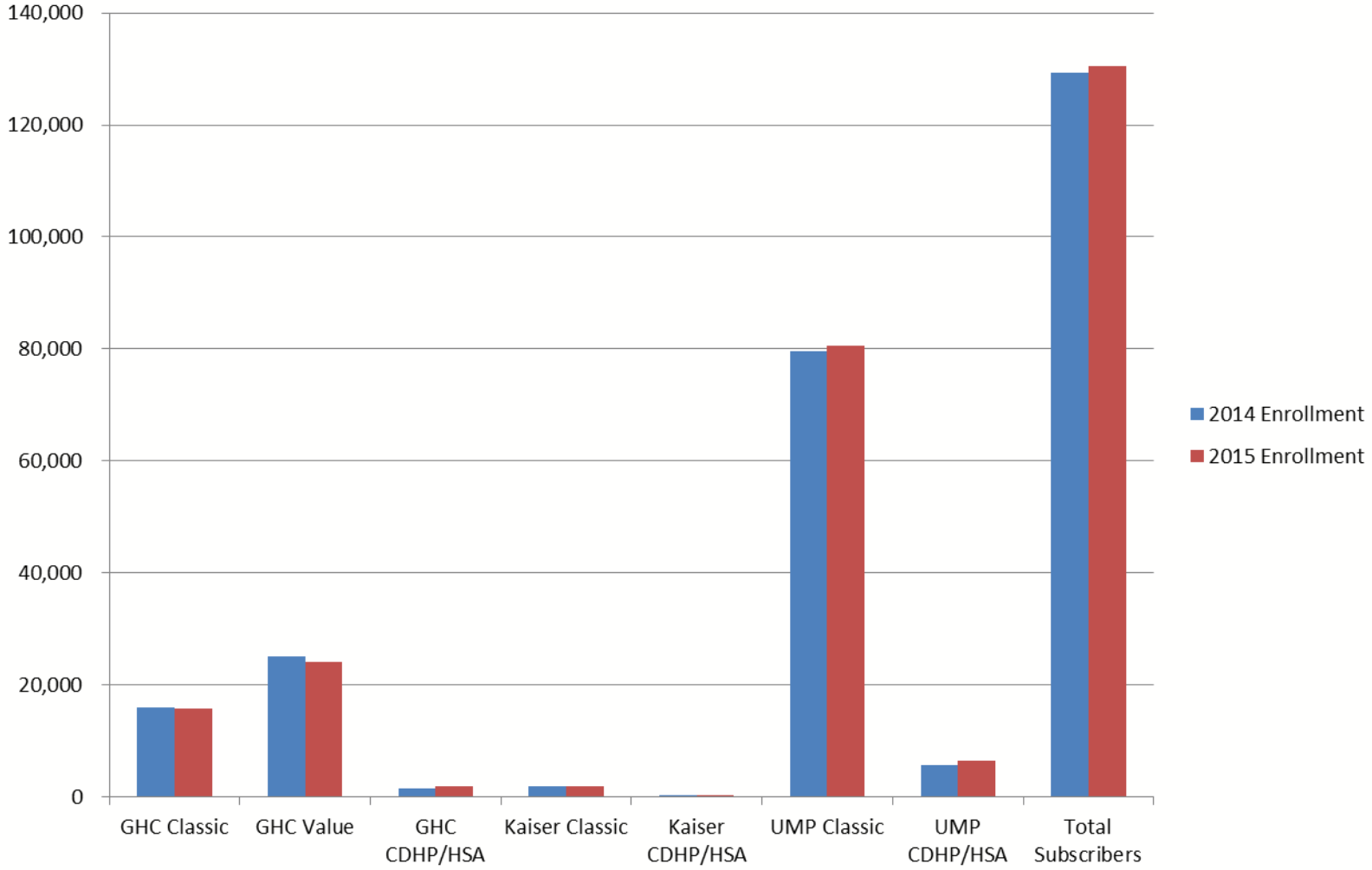
2015 Open Enrollment Summary

Renee Bourbeau
Benefits Accounts Manager
Public Employees Benefits Division
April 15, 2015

Open Enrollment 2015 Initiatives

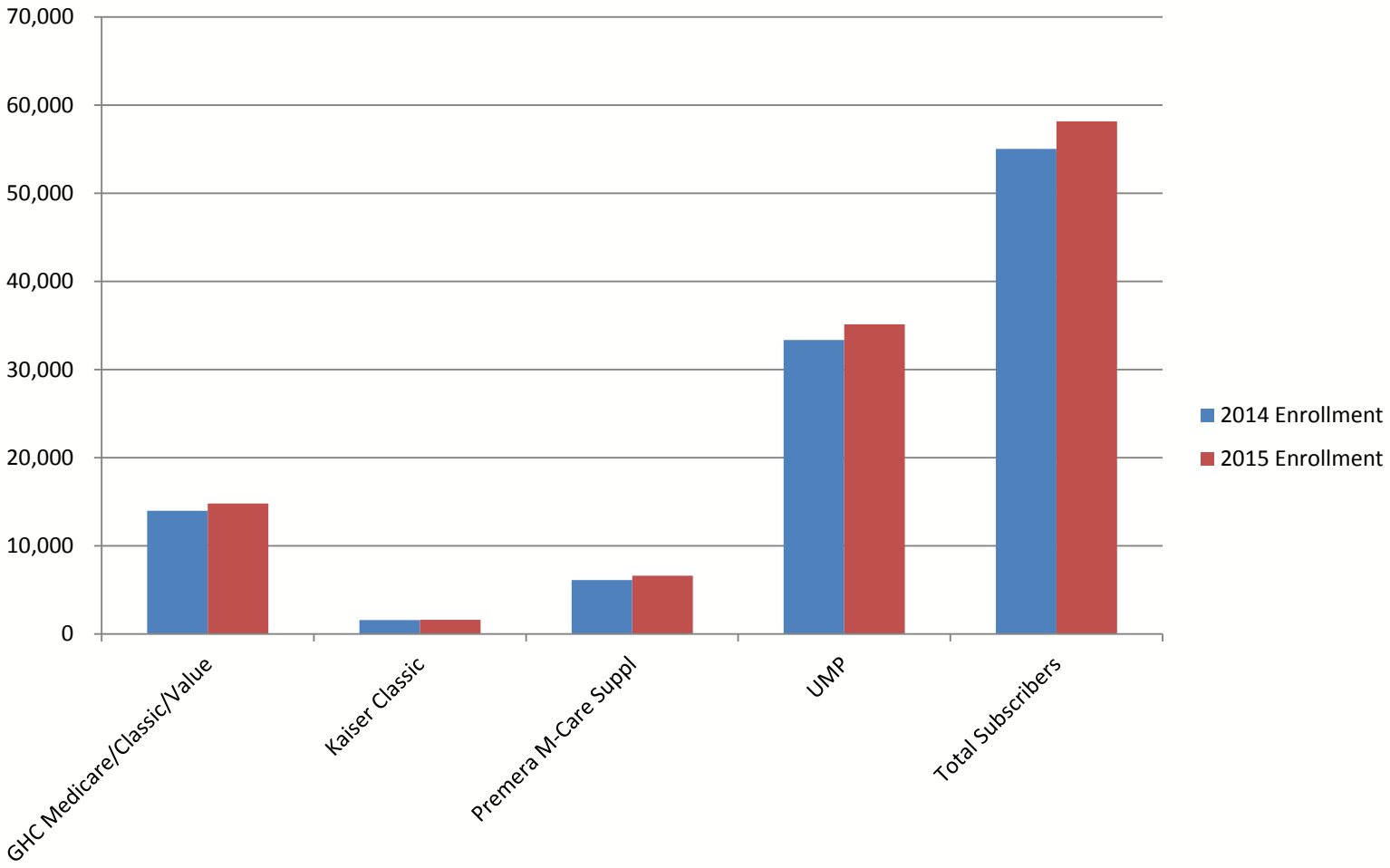
- Spousal re-attestation
- PEBB Program website
- Benefits Fairs and messaging
- Wellness activities

Employees and non-Medicare Retirees (subscriber count)



Washington State Health Care Authority

Medicare-enrolled Retirees (subscriber count)



Washington State Health Care Authority

	PEBB Enrollment Changes 2014 to 2015					
	Health Plan	Feb-14	Feb-15	Change		Percent of Total Subscribers
				No. of Subscribers	% Changed	
Employees/Non-Medicare Retirees	GHC Classic	15,857	15,822	(35)	0%	12%
	GHC Value	24,961	24,164	(797)	-3%	19%
	GHC CDHP/HSA	1,419	1,831	412	29%	1%
	Kaiser Classic	1,882	1,803	(79)	-4%	1%
	Kaiser CDHP/HSA	138	63	(75)	-54%	0%
	UMP Classic	79,493	80,514	1,021	1%	62%
	UMP CDHP/HSA	5,596	6,344	748	13%	5%
	Total Subscribers	129,346	130,541	1,195	1%	100%
Medicare Retirees	GHC Medicare/Classic/Value	13,979	14,804	825	6%	25%
	Kaiser Classic	1,565	1,608	43	3%	3%
	Premera M-Care Suppl	6,124	6,624	500	8%	11%
	UMP	33,346	35,122	1,776	5%	60%
	Total Subscribers	55,014	58,158	3,144	6%	100%

Questions?

Renee Bourbeau, Benefits Accounts Manager
Public Employees Benefits Division
Renee.bourbeau@hca.wa.gov
Tel: 360-725-0823

TAB 5

Washington State
Health Care Authority

2015 SmartHealth Presentation for PEB Board Meeting

Scott Pritchard, HCA/PEBB
Nancy Board & Lora Kerns, Limeade
April 15, 2015

Program Goals

- ✓ **Engage** the workforce in SmartHealth
- ✓ **Improve** individual and population health
- ✓ Achieve a **positive impact** on the medical cost trend

SmartHealth Program

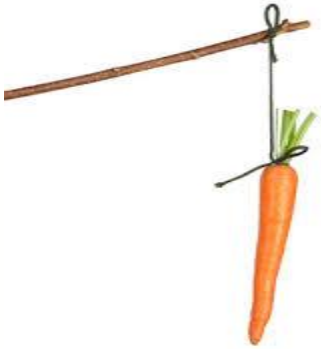
PEBB Program Wellness

SmartHealth

Washington State Health Care Authority

Incentive

- ✓Incentives are intended to get a person's **attention** and to **direct** them to something of value
- ✓Create **equal incentives** for eligible subscribers across all Health Plans



How to Earn your $125

- Take the Well-being Assessment (worth 800 points, plus 100 bonus points if you complete it by March 31, 2015, to be awarded on April 8, 2015)
- Earn additional points by participating in Activities of your choice
- When you earn 2,000 total points by June 30, 2015, you'll qualify to receive $125 off your PEBB medical plan deductible in 2016 (if you meet PEBB Program eligibility requirements in January 2016)

Member Experience

SmartHealth

SmartHealth supports you on your journey to greater health.

YOU EARNED IT!
2000 pts
$125 Subscriber Incentive

KEEP GOING!
2500 pts
You're on Your Way

YOU ARRIVED
3000 pts
You're a SmartHealth Champion!

Member Experience

SmartHealth Learn more

SmartHealth supports you on your journey to greater health.

Earn It $125 Subscriber Incentive	0 100	**2,000**pts	✓
Keep Going You're on Your Way!	2,001	**2,500**pts	✓
You Arrived You're a SmartHealth Champion	2,501	**3,000**pts	✓

Sign-In Page

SmartHealth

SmartHealth supports you on your journey to greater health.

EARN IT
2000 pts
$125 Subscriber Incentive

KEEP GOING
2500 pts
You're on Your Way

YOU ARRIVED
3000 pts
You're a SmartHealth Champion!

Earn rewards.
Be healthy.
Have fun!

New to SmartHealth?

If you have not signed in before, click below to activate your account.

Get started

Sign in

Sign in name or email

Password

Remember me for 2 weeks

Sign in

Trouble signing in?

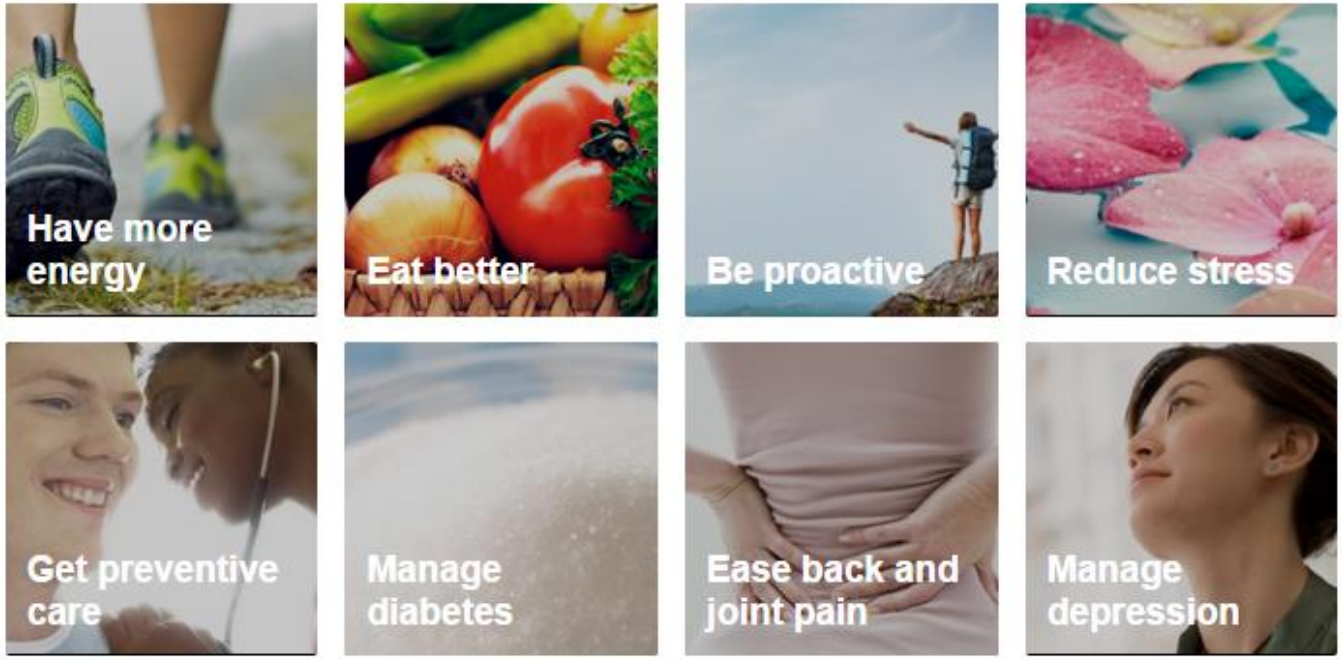
© 2015 Limeade | Customer Service **855-750-8866** | Get Started Guide (PDF) | FAQ | Terms of Service | Privacy Policy

Vision Page

Sample

Smart Health

What would you like to achieve? Select one.



Home Page

SmartHealth

Home | My Results | Topics | My Points

Take your Well-being Assessment

How to earn your $125

SmartHealth Learn more

SmartHealth supports you on your journey to greater health.

Earn It $125 Subscriber Incentive *(see How to earn your $125 for details)*	1	870	2,000 pts
Keep Going You're on Your Way	2,001		2,500 pts
You Arrived You're a SmartHealth Champion	2,501		3,000 pts

Hide levels

Results

Smart[Health]

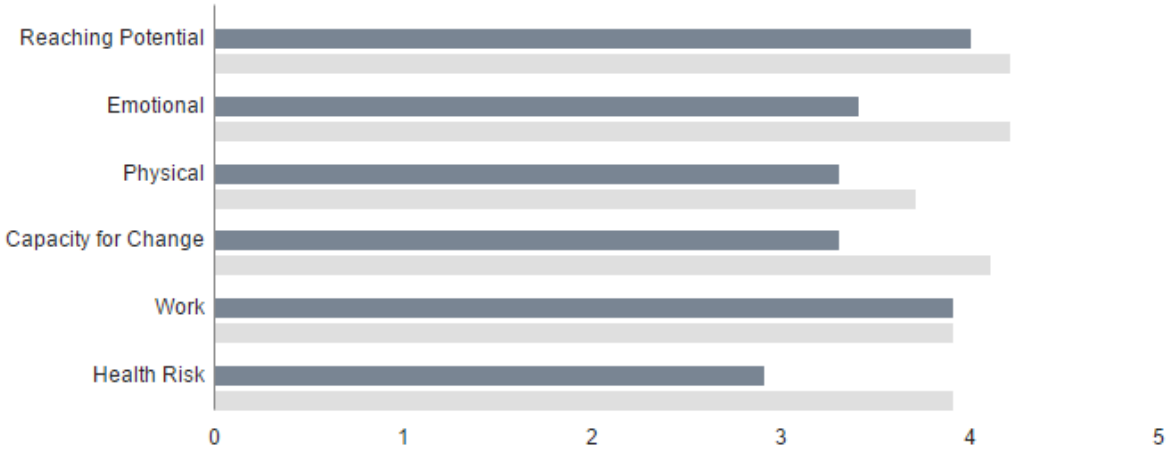
Home | **My Results** | Topics | My Points

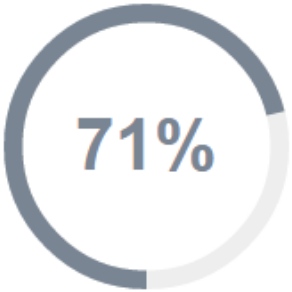
Summary | Reaching Potential | Emotional | Physical | Capacity for Change | Work | Health Risk

Life Areas Summary

Here's where you stand when it comes to the key life areas that make up your overall health and well-being. You'll likely find you're above average in some

Read more





Overall results score

What does this mean?

YOU OTHERS' AVG

Recommendations

Top 3 things to improve

We all have things that require special attention or a bit more effort. In your case, these are the three dimensions where you can most improve. "Get started now" and find activities to add to My Plan.

Smoke-Free Living

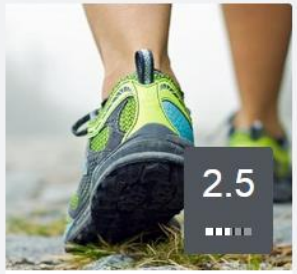
Get started now

Learn more

Back Health

Get started now

Learn more



Energy Level

Get started now

Learn more

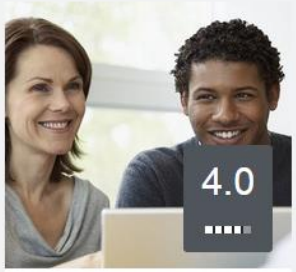
Top 3 strengths

You're really doing great it in these three dimensions - congrats! Make your strengths even stronger and "Explore" to find out how.

Appreciating Life

Explore

Learn more



Belief in Company

Explore

Learn more

Concern for Others

Explore

Learn more

Topics

Emotional

Self-Leadership

Managing Depression

Managing Stress & Anxiety

Positive Relationships

Self-Acceptance

Examples of topics

SmartHealth Activities

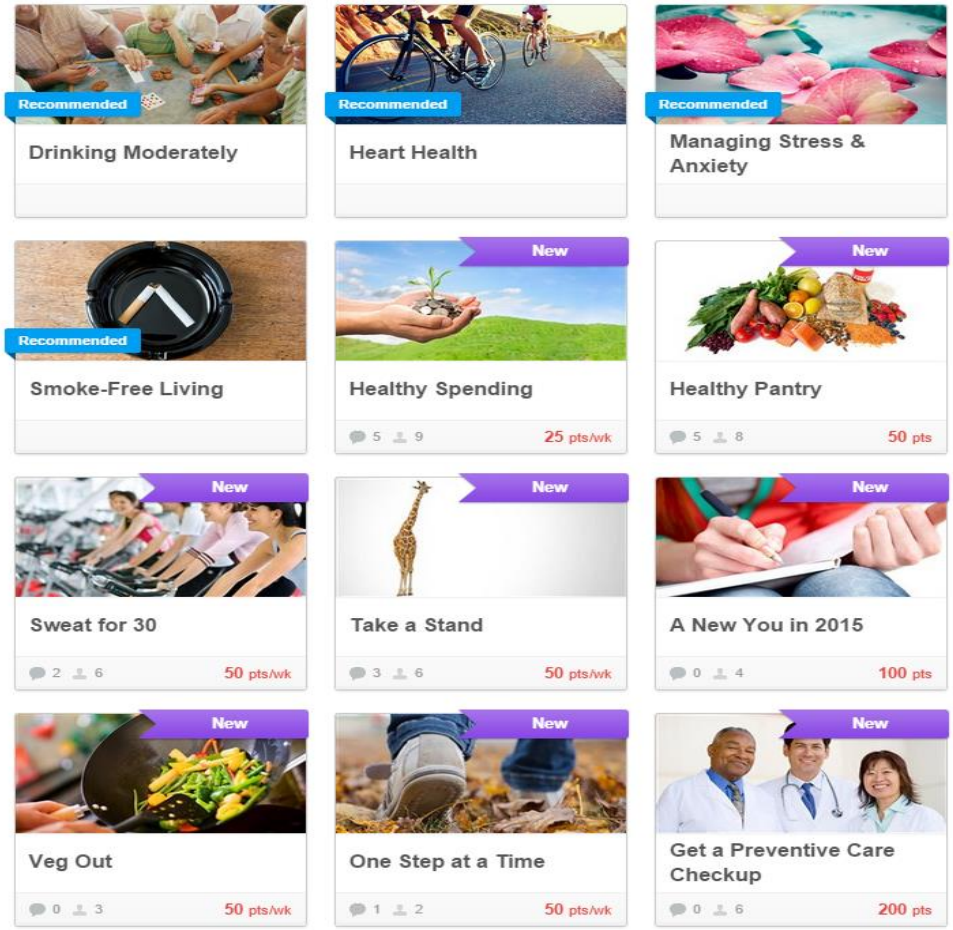
- Activities are organized to provide choice and variety over time
  - 8+ activities to choose from at any time
  - Something new each month
  - 100 activity choices throughout the year
  - Always opportunities to track healthy behaviors like exercise and nutrition
  - Balanced offerings at all times: Nutrition, Exercise, Work-Life Balance, Emotional Well-being

Sample Activities

- Pre-built Calendar of Activities to help engage year round
- Members have a personalized experience
- Choice is key – lots of ways to earn the financial incentive

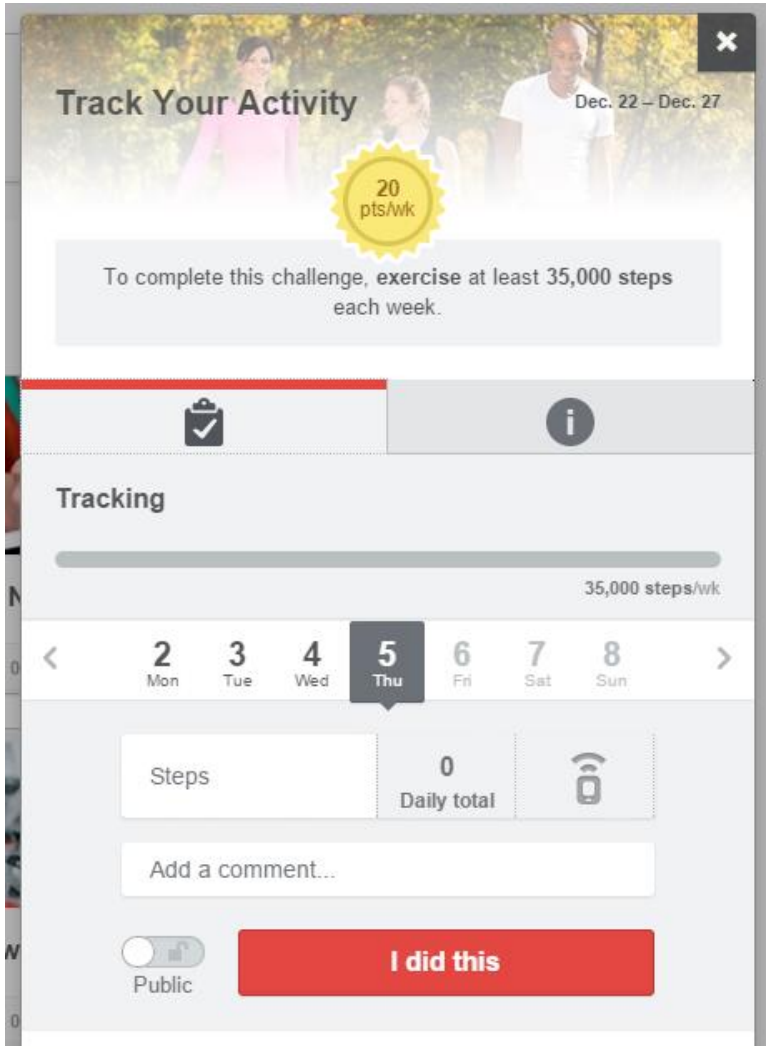
Examples of Activity Tiles

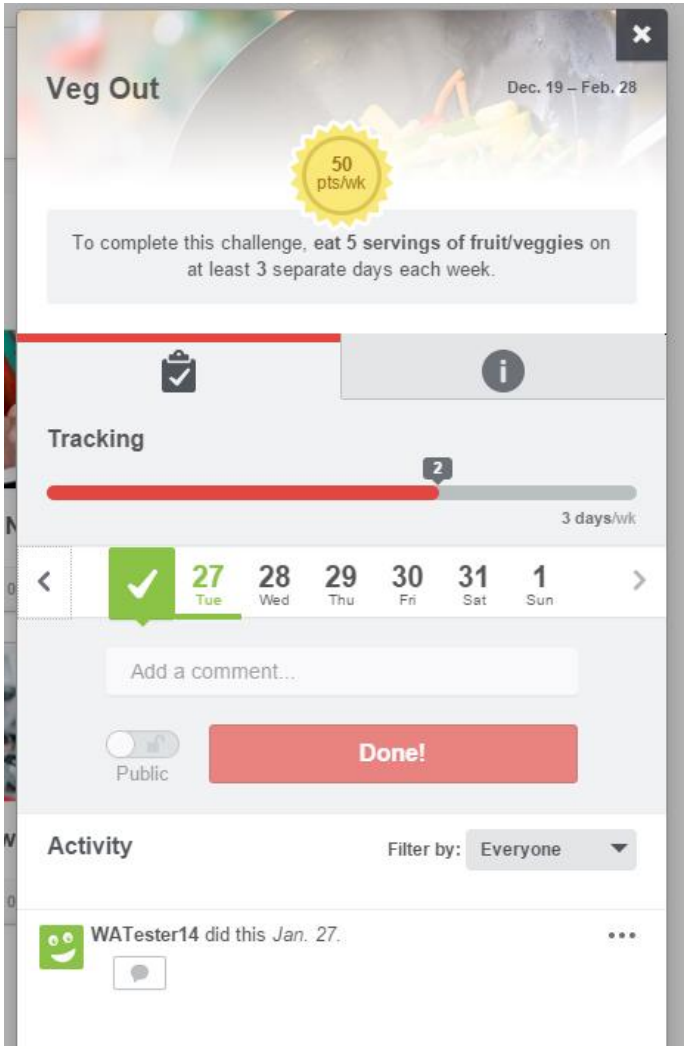
Other things to do



Home Page

Activity Examples





Take a Stand

Studies show that sitting for long periods — even if you exercise regularly — is bad news for your health. Your defense: simply get up out of your chair every 1-2 hours. Move around, stretch, or at the very least, stand for a minute. It's good for your body and will help you stay focused.

Did you know?
Pass this message on to the next generation, too. In 2010, kids ages 8-18 spent an average of 7.5 hours a day in front of a computer, TV, or video game screen.

Reports

What we report on:

- Participation & Activity aggregate data to drive decisions on what to keep doing and what to stop doing

To Whom?

- PEBB Program Administrators
- SEH&WSC

What you won't see:

- Individual information of any kind

Is My Privacy Protected?

- Any information retained in the SmartHealth Program is protected under federal and state privacy laws
- Will not be used or disclosed except as permitted by those laws
- Data is only provided in aggregate form
- Only provided to those with special access for review (e.g., medical claims, pharmacy claims)

Engagement Metrics

	Baseline Goal (of eligibles)	Stretch Goal (of eligibles)
Subscribers Registered On Site	70%	80%
Incentive Earned	60%	70%
Assessment Completion	65%	70%
Challenge/Activity Participation	60%	70%
2-Week Engagement (avg): incentive period / Q3 and Q4	25% / 15%	30% / 20%

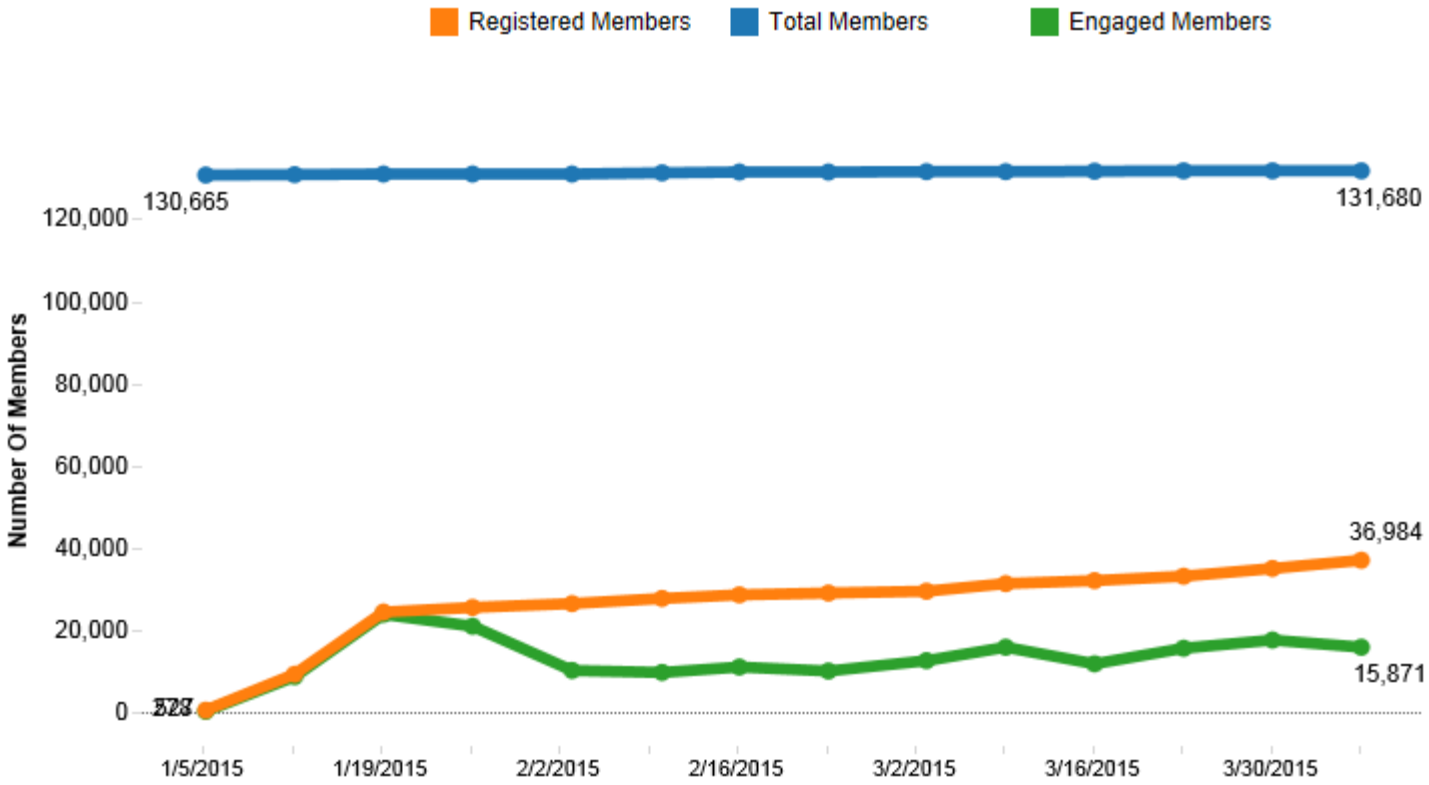
2-week engagement is defined as having participated in an activity (e.g., tracked progress) within 2 weeks.

Challenge participation is participated in at least one activity.

21

SmartHealth Program Update

- Overall Participation



Data current as of 4/6/2015

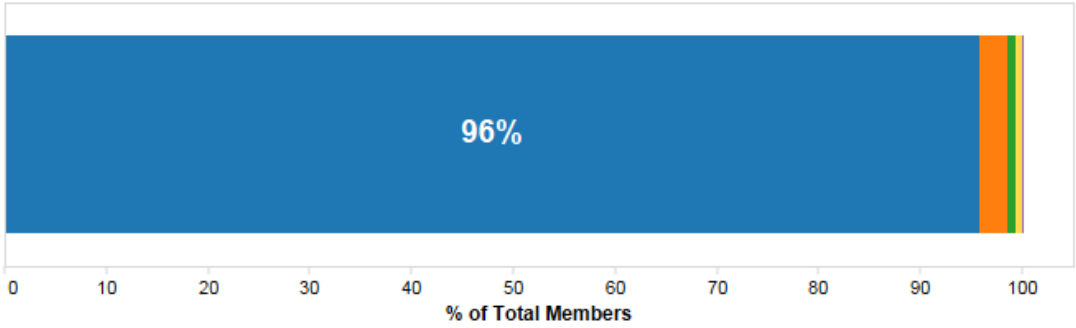
SmartHealth Program Update

- Well-being Assessment Completion

Completed Assessments:	**35,461**
Completed IVR Assessments:	**40**
Assessment Completion Rate:	**27%**
IVR Assessment Completion Rate:	**0%**

Incentive Levels Summary :

No Level	Level 1 Completed	Level 2 Completed	Level 3 Completed
126,090	3,697	999	894



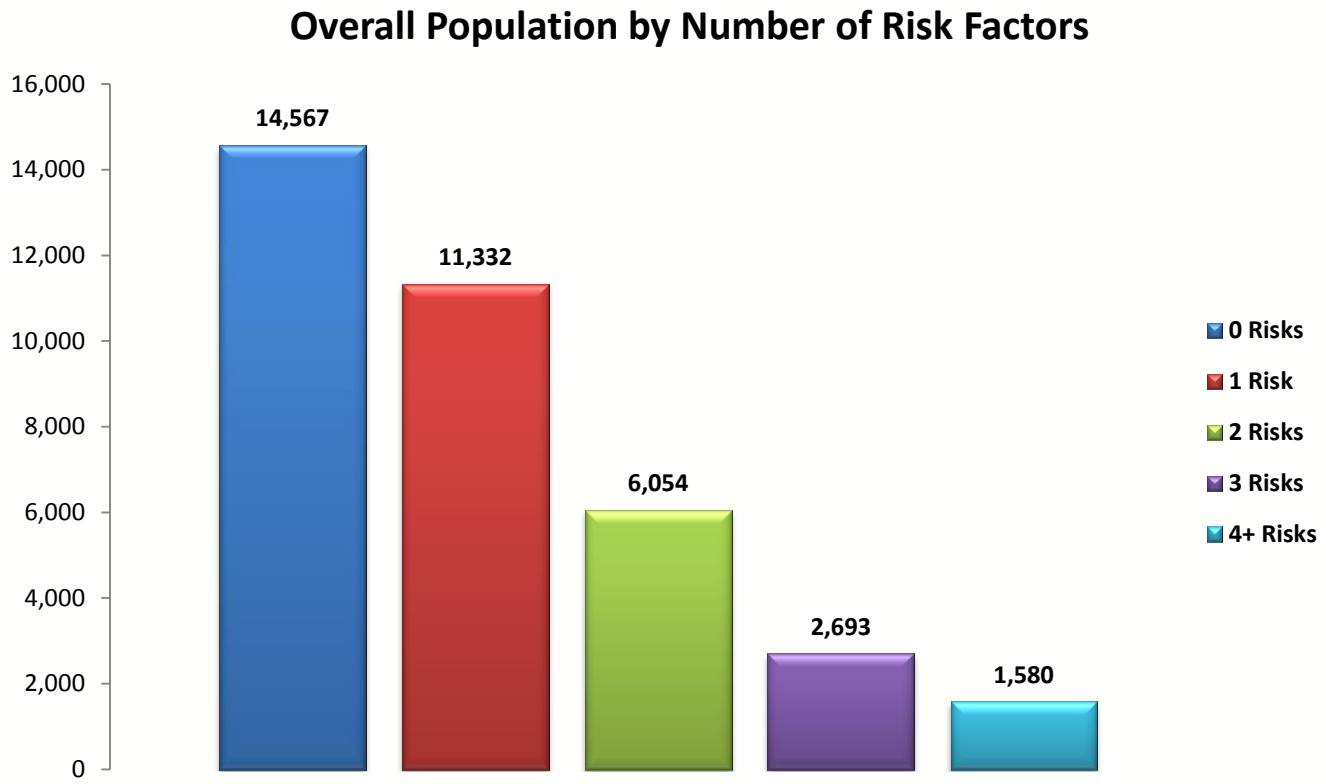
Data current as of 4/6/2015

SmartHealth

Washington State Health Care Authority

SmartHealth Program Update

- Overall Population by Number of Risk Factors

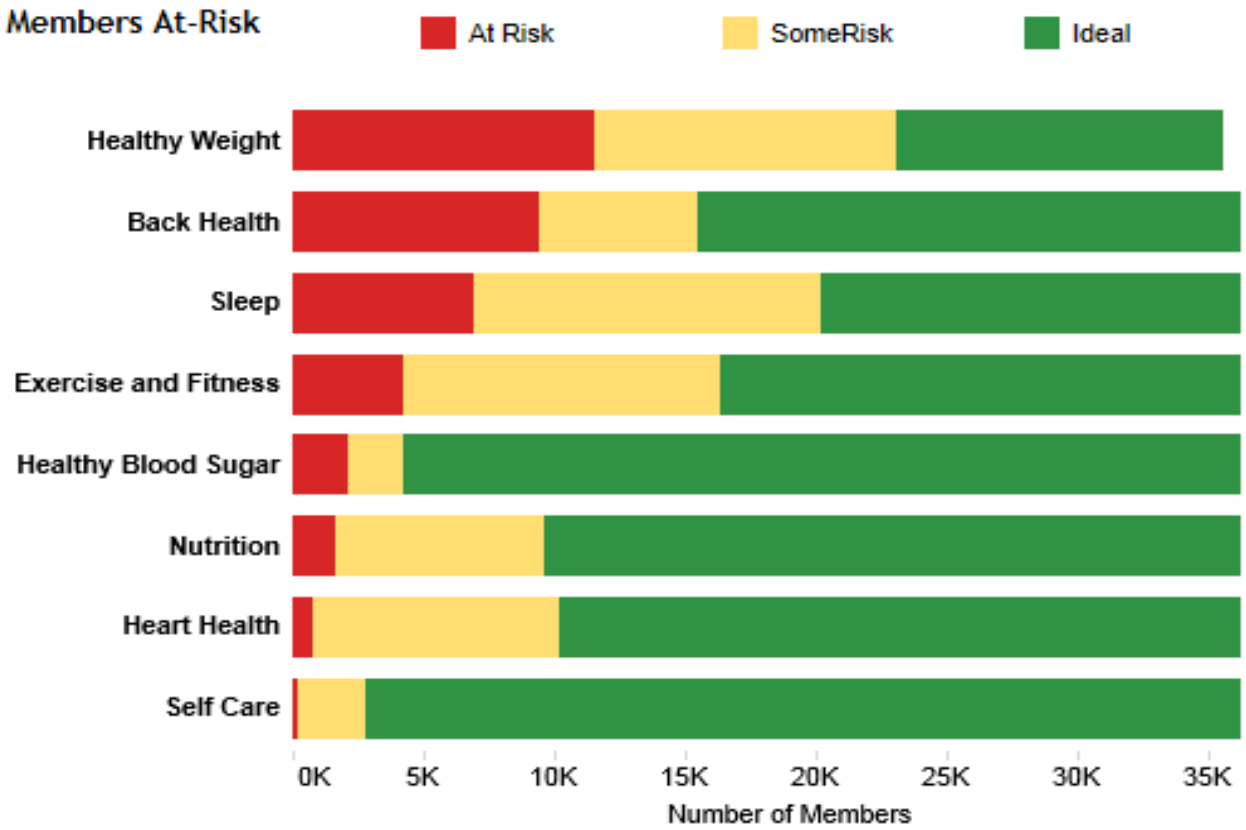


NOTE: Graphs apply to members with recorded biometric risk values and not the entire member population.

Data current as of 4/6/2015

SmartHealth Program Update

- Risk in Population



NOTE: Graphs apply to members with recorded biometric risk values and not the entire member population.

Data current as of 4/6/2015

Sample Comments & Feedback from Members

Feels great! I should be doing this more often and this challenge will help. Think I'll add a 5th time today. ☺

Fui al gymnasio anoche con dos de mis hijos. Quiero que el ejercicio sea un valor de la familia.

I went to the gym last night with two of my children. I want exercise to be a family value.

While I don't have a device that will "connect" I am using a pedometer that measures steps and distance…

I am going to walk more on my breaks.

…Amazing how little things can make a huge difference. Proud of myself!!!

I love using my pedometer…reminds me to get moving!

A coworker gave me a journal as a gift – I am thankful for friendships like these.

I use Run Keeper, but there's also a very important app missing here – Zombie Run!

Wow…didn't realize how much outdated stuff I had in my pantry! Now there's lots of space to store more healthy options. Grocery shopping this week with new motivation.

Installed Map My Walk. Don't like the forced ads, though.

I can only walk a little each day, so I am starting small and will work up to something more in the coming months.

Good for you! Every little bit counts…keep up the good work!

SmartHealth Program Update

Current Status

- Strong start
- Robust Reporting Capabilities
- Meeting Participation / Engagement Goals Will Require Value for User and Innovative Marketing
- Long-term Focus is Individual and Population Health Improvement Based on 2015 and Ongoing Data

Questions?

TAB 6

Washington State Health Care Authority

Wellness Program Policy Resolution

April 15, 2015

Barb Scott
Policy and Rules Manager
PEB Division

Purpose of Briefing

- Board Action: Vote on an eligibility policy related to the SmartHealth wellness program

Policy Resolution

Resolved, that to receive a PEBB Program Wellness Incentive in the following plan year, eligible subscribers must complete Wellness Incentive Program requirements by the following deadline:

- For subscribers continuing medical enrollment and subscribers enrolling in medical with an effective date in January, February, or March, the deadline is June 30
- For subscribers with a medical effective date in April, May, June, July, or August, the deadline is **120 days** from the subscriber's medical effective date
- For subscribers with a medical effective date in September, October, November, or December, the deadline is December 31

Next Steps

- The PEBB Program will administer benefits under this policy resolution effective immediately.
- The HCA will amend the current rule to align to this policy during the upcoming PEBB Program annual rule making.

Questions?

Barbara Scott, Policy and Rules Manager
PEB Division
Barbara.Scott@HCA.WA.GOV
Tel: 360-725-0830

Policy resolution adopted by the Board in January 2014:

Resolved, that to receive a PEBB Wellness Incentive in the following plan year, eligible subscribers must complete the PEBB Wellness Incentive Program requirements by the latest date below:

- June 30, or
- Within sixty days after the effective date of their PEBB medical, but no later than December 31

Policy resolution for action by the Board today:

Resolved, that to receive a PEBB Program Wellness Incentive in the following plan year, eligible subscribers must complete Wellness Incentive Program requirements by the following deadline:

- For subscribers continuing medical enrollment and subscribers enrolling in medical with an effective date in January, February, or March, the deadline is June 30
- For subscribers with a medical effective date in April, May, June, July, or August, the deadline is **120 days** from the subscriber's medical effective date
- For subscribers with a medical effective date in September, October, November, or December, the deadline is December 31

TAB 7

Washington State
Health Care Authority

Life Insurance Benefit Reprocurement

April 15, 2015

Beth Heston, Contract Manager
Portfolio Management
Public Employees Benefits Division

History of Life Benefit

- Purchased in 1977 by State Employees Insurance Board (SEIB)
- Attempted reprocurement in 1993 for matching benefits and system requirements
- "Simplified" plan design and re-enrolled members in 2012

Current Benefits

Insurance Type	Current Employer Paid Plans
Employee Basic Life	$25,000
Employee Accidental Death & Dismemberment (AD&D)	$5,000
	Employee Supplemental Plans
Employee Supplemental Life (Increments of $10,000)	Guaranteed Issue $250,000 Up to $750,000 with EOI
Spousal Life (Increments of $5,000)	Up to 50% of Employee's Supplemental (with EOI when required)
Dependent (includes Spouses) Basic Life	$2,500
Retiree Life Pre-65 Age 65-69 Age 70 and over	 $3,000 $2,100 $1,800
Employee, Spouse, & Dependent Supplemental AD&D	Up to $250,000 for Employee 40% for Spouse; 5% or 10% for Dependents

Goals of Reprocurement

- Align benefit with Results Washington and Procurement Reform law
- Explore more modern, efficient, and cost effective options for benefit administration
- Improve benefit design and cost
- Bring the benefit current with Life Insurance industry standards and practices

Questions?

Beth Heston, Contract Manager
Portfolio Management
Public Employees Benefits Division
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Tel: 360-725-0865