

Public Employees Benefits Board Meeting

March 21, 2018

Public Employees Benefits Board

March 21, 2018

1:30 p.m. – 4:00 p.m.

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

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TAB 1

AGENDA

Public Employees Benefits Board
March 21, 2018
1:30 p.m. – 4:00 p.m.

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

Call-in Number: 1-888-407-5039

Participant PIN Code: 95587891

1:30 p.m.*	Welcome and Introductions		Sue Birch, Chair	
1:40 p.m.	Meeting Overview		Dave Iseminger, Director Employees & Retirees Benefits Division	Information
1:45 p.m.	Approve July 12, 2017 Minutes Approve July 19, 2017 Minutes Approve July 27, 2017 Minutes	TAB 3	Sue Birch, Chair	Action
1:55 p.m.	Legislative Update	TAB 4	Dave Iseminger, Director ERB Division	Information
2:15 p.m.	2018 Open Enrollment Update	TAB 5	Renee Bourbeau, Manager Benefits Accounts Section ERB Division	Information
2:30 p.m.	NW Prescription Drug Consortium	TAB 6	Ray Hanley, Director Prescription Drug Program	Information
3:15 p.m.	Report on Benefits Ideas	TAB 7	Marty Thies, PEBB Account Manager Betsy Cottle, PEBB Account Manager	Information
3:30 p.m.	Public Comment			
4:00 p.m.	Adjourn			

***All Times Approximate**

The Public Employees Benefits Board will meet Thursday, March 21, 2018, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8th Avenue SE, Olympia, WA. The Board will consider all matters on the agenda plus any items that may normally come before them.

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

Direct e-mail to: board@hca.wa.gov. Materials posted at: <http://www.pebb.hca.wa.gov/board/> no later than close of business on March 19, 2018.

PEB Board Members

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

PEB Board Members

Name	Representing
Tim Barclay 7634 NE 170 th ST Kenmore WA 98028 V 206-819-5588 timbarclay51@gmail.com	Benefits Management/Cost Containment
Yvonne Tate 1407 169 th PL NE Bellevue WA 98008 V 425-417-4416 ytate@comcast.net	Benefits Management/Cost Containment
Vacant	Benefits Management/Cost Containment
Harry Bossi* 19619 23 rd DR SE Bothell WA 98012 V 360-689-9275 udubfan93@yahoo.com	Benefits Management/Cost Containment
Legal Counsel	
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

3/16/18



Washington State Health Care Authority
Public Employees Benefits Board

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

2018 Public Employees Benefits Board Meeting Schedule

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

January 31, 2018 (Board Retreat) 9:00 a.m. – 4:00 p.m.

March 21, 2018

April 25, 2018

May 21, 2018

June 7, 2018

June 20, 2018

July 11, 2018

July 17, 2018

July 25, 2018

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

Updated 7/21/17

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: August 01, 2017

TIME: 1:51 PM

WSR 17-16-148

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

Public Employees Benefits Board
Meeting Minutes

DRAFT

July 12, 2017
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:

Lou McDermott
Mary Lindquist
Harry Bossi
Gwen Rench
Greg Devereux
Myra Johnson
Tim Barclay

Members on the Phone:

Tim Barclay (Via phone until arrival)
Yvonne Tate

Member Absent:

Marilyn Guthrie

PEB Board Counsel:

Katy Hatfield

Call to Order

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

Agenda Overview

Dave Iseminger, PEB Division Acting Director, provided an overview of the agenda.

Approval of April 12, 2017 PEBB Meeting Minutes

It was moved and seconded to approve the April 12, 2017 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

Legislative Update

Dave Iseminger, PEB Division Acting Director, provided a legislative update on House Bill 2242 and Senate Bill 5975.

House Bill 2242 is the bill that the Legislature passed as omnibus legislation related to the Supreme Court's *McCleary* decision related to K-12 education. Part of that bill contained a benefits consolidation effort for K-12 employees to move into a single state purchaser at the Health Care Authority under a new program called the School Employees Benefits Board Program, or SEBB. This bill creates a separate Board from the PEB Board that's here today. The SEB Board members will be selected by September 30, 2017. It is a nine-member Board with two individuals representing classified employees; two certificated employees; four health benefits and policy administration experts (similar to the cost containment individuals on the PEB Board), one of whom is nominated by the School Business Official's Association.

The bill eliminates the non-voting position on the PEB Board held by Myra Johnson, effective January 1, 2020 because there would be a SEB Board for K-12 active employees. There are no other changes to the composition of the PEB Board. Harry Bossi's position in cost containment stays and remains a non-voting member.

The benefits for the School Employees Benefits Board would be effective January 1, 2020. SEBB includes basic and optional benefits for school employees and it would eliminate the authority for the local school districts to be able to offer benefits. They would be limited to those benefits authorized by SEBB and administered by the Health Care Authority.

SEBB has a wide range of authority in creating its benefit structure. It can elect to piggy-back onto PEBB benefits, it can do PEBB benefits for some benefits and supplement with other benefits, or it could create separate benefits within the medical, dental, life, and long-term disability portfolio. Those will be some of the first policy decisions the SEB Board will address.

The legislation creates a third risk pool for the Health Care Authority to monitor. We currently have two risk pools; a non-Medicare risk pool and a Medicare risk pool. The new risk pool will use claims experience for the population of K-12 active employees. This legislation does not change anything related to K-12 retirees. For the time being, K-12 retirees will remain in PEBB benefits. As teachers exit their employment, they would transition from the SEBB benefits and the SEBB risk pool to the PEBB benefits and the PEBB risk pools. There is a caveat. The Health Care Authority, during this consolidation effort, is to present a report to the Legislature at the end of 2018 that describes various options related to K-12 retirees and whether they would be maintained in PEBB benefits and PEBB risk pools going forward or not. At least for the time being, the K-12 benefit for retirees stays within the PEBB portfolio.

This legislation creates a separate state level collective bargaining process for school district employees. There's currently a collective bargaining process that helps establish, at this point, the 85/15 split for the PEBB Program pool and there would be a separate state collective super coalition that negotiates with the Governor's office for school district employee benefits.

One of the questions that comes up quite a bit is what would be the resource impact for the PEB Division and the Health Care Authority. The state budget did allocate \$8M as start-up funds for creating the SEBB Program. The prior fiscal notes on SEBB consolidation, as this has been an ongoing conversation within the Legislature and the agency for many years, had start-up costs at a significantly higher amount. There will be work on a supplemental decision package and discussion with the Legislature and OFM about additional funds that will be necessary for the start-up as we go forward with implementation for January 1, 2020.

Yvonne Tate: Would this new bill have an adverse impact on the staffing for PEB?

Dave Iseminger: In the short-term, we're hoping to leverage as much as we can the current staffing in the PEBB Program to do the initial startup as we work on identifying FTE allocations to add additional resources to build up the SEBB Program.

Yvonne Tate: Thank you.

Greg Devereux: I have a follow-up to that and then a second question as well. The \$8M, is that just one-time to set-up the SEBB, or is that ongoing?

Dave Iseminger: It's an initial allocation into the PEBB fund for start-up and then there's a new SEBB account that's created that would backfill funds into the PEBB account.

Greg Devereux: Could that new SEBB account be used for staffing?

Dave Iseminger: The way the legislation is written, it appears that the account becomes active and can be utilized starting on January 1, 2020 when the benefits go live. So, in the interim, the funds are allocated into the PEBB account.

Greg Devereux: You mentioned the super coalition for collective bargaining. Is that both teachers and non-teaching staff in that coalition?

Dave Iseminger: I don't know off the top of my head. We'll follow up with that one.

Greg Devereux: Okay.

Dave Iseminger: The second piece of legislation that passed was Substitute Senate Bill 5975, which is related to paid family medical leave. I will highlight some of the

impacts that this has because it does relate to the PEBB benefits that employees enjoy. This legislation increases the maximum number of paid weeks of family medical leave for employees and increases the maximum number of weeks that employers must maintain health benefit coverage. The duration is increased from 12 weeks (under Federal FMLA) to 16 weeks, or 18 if it's related to a serious health condition with a pregnancy. Previously only five weeks were paid at a flat rate of \$250 per week. As of January 1, 2020, it will be a sliding scale that's based on the individual's average weekly wages and the statewide average weekly wages with a \$1,000 per week maximum benefit. Employees do remain responsible for their share (e.g., premium contribution) of the cost of health benefits.

One thing that relates to employee eligibility is that the threshold for this state paid leave benefit is reduced from 1,250 hours to 820 hours of work in the qualifying period; and this state paid leave benefit is available starting on January 1, 2020. This essentially extends the ability for the individual who's on this qualified leave to be able to maintain their PEBB coverage with an employer contribution for a longer period of time. We'll be working on ways to help make our communication materials adequately inform individuals about these changes as they get closer. Although the benefits go live on January 1, 2020, this is funded through a payroll tax which is funded about two thirds by the employee and one third by the employer. That payroll tax collection starts on January 1, 2019.

Slide 3 shows the previously shared Governor, Senate, and House proposed operating budgets and we've added the 2017-19 Enacted budget. The agency request PEBB Program decision packages were funded, less one million dollars, related to the UMP TPA procurement. As expected, there was an administrative reduction of \$3M per year in each of the next two years of the biennium. We are hopeful that we can continue with our current staffing levels and that we don't see any negative impacts in that regard. We will be monitoring our budget closely.

There was no actuarial value reduction in the enacted budget that was in the Senate proposal. The Medicare rate explicit subsidy was again locked in at the maximum of \$150, which is the rate we've had since approximately 2012 or 2013.

Greg Devereux: The critical thing is the funding rate. My understanding is it's down approximately \$56 per member per month in the first year and \$73 in the second year. Probably enough money to cover through next year, but that's a significant decrease.

Kim Wallace: Yes, the numbers that Greg is referring to are for fiscal year 2018. The funding rate is set at \$913 per employee per month, and for fiscal year 2019 \$957. Those amounts are lower than what was in the Governor's request and in other analyses and projections that we had done prior to the budget activity. Essentially, what that means is that if claims experience in particular comes in as we anticipate, then surplus will be needed to cover those costs. The surplus is available and ample for up to a certain amount of time. Should this surplus be used and go to zero, then we would

be looking at the premium stabilization reserve amounts. Essentially, there is a tiered process of tapping available funds. We are doing a serious analysis about what the next biennium will look like; and then tracking very carefully as quarter-by-quarter unfolds during this biennium; and preparing to send forward any additional funding requests that are needed. We could be looking at an increase or request a change in the funding rate in year two. We will have to assess and track very carefully through time.

Greg Devereux: We have talked to the Governor. We've also talked to all the legislative leaders because this is a critical thing for current state workers. I guess one question I have is what triggers use of the premium stabilization reserve and/or the other surplus? Who gets to say if we get to use it?

Kim Wallace: We are in conversations with our partners at OFM regarding the various funds that are available. My understanding is that the surplus is used first and the balance must go to zero. That would trigger the use of the restricted premium stabilization reserve (PSR) which are funds held in Fund 721. The PEBB Program is funded by Fund 721.

Greg Devereux: If we don't have enough revenue coming in, then the surplus triggers automatically? If it goes to zero, is there a discussion about the premium?

Kim Wallace: Yes. A change in the funding rate itself is also a mechanism that's on the table.

Greg Devereux: Thank you.

Tim Barclay: Did you say that you haven't yet done the forecast in terms of what these funding rate levels mean to the projection of the PSR through the next biennium?

Kim Wallace: That is underway right now.

Annual Rule Making

Rob Parkman, PEB Division Policy and Rules Section. I will provide you with high level information on the more significant changes we're considering making during the 2017 annual rule making. No action is needed from the Board for this briefing.

The scope of the rule making will be to address benefit administration issues; provide clarity in areas identified by members, business partners, and staff; make some technical corrections; and implement policies adopted by the Board.

The administrative changes being considered include the following: we will amend rules to support changes in how the life insurance benefit is now being administered. We amended multiple rules to incorporate the new definition of "contracted vendor." This

definition was needed to replace the multiple different terms that represented this same idea throughout our rules.

We're considering changes to respond to requests for a greater clarity in some rules and improved readability in others. We're amending the definition of "subscriber" for clarity. During the implementation of the new life insurance contract, we realized it needed to be updated.

We've added "other legal remedy" to the error correction recourse rule to account for dollars or money received or offered from a legal settlement.

We're amending the rules that govern continuation coverage to provide a greater level of clarity regarding the first payment and enrollment. Historically, we've administered enrollment and first payment for leave without pay and retiree coverage consistent with federal COBRA requirements. The added detail explains that the first premium payment is required no later than 45 days after the election notice is received.

We need to make a couple of technical corrections. These will include: adding a timing requirement to rules for disabled dependent recertification to provide a little more time than was allowed previously for this process. We're adding greater detail to the special open enrollment provision for birth and adoption as a result of us having to add this level of detail to our contracts at the request of the Office of the Insurance Commissioner.

Slide 7 lists the resolutions that Barb Scott briefed the Board on at our last meeting. These resolutions will be voted on following this briefing. If approved by the Board today, these resolutions will be included in the annual rule making.

Slide 8 lists the next steps for rule making. We plan to file draft rules in August so they're available for public comment and will conduct a public meeting and adopt the final rules in September. Any new or amended rule will be effective January 1, 2018.

2018 Policy Resolutions

Dave Iseminger, PEB Division Acting Director, read each proposed resolution before the Chair asked for comments from the public and Board members, and before the Board vote.

Policy Resolution 1 – Season concerns the definition of "season." It helps to clarify the current interpretation and administration of a rule and will memorialize the historical practice. It addresses a question that is periodically raised from agencies that have higher seasonal employees.

Lou McDermott:

Policy Resolution 1 - Season: Resolved, that "Season" means any recurring annual period of work at a specific time of year that lasts three to eleven consecutive months.

Greg Devereux: I trust Barb with my life, but we have a lot of seasonal members and I believe her comment at the last Board meeting was that this simply codifies what is actually done. I will be voting for this, but it's based on that it does no harm to any existing, current employees.

Lou McDermott: It's my understanding, Greg, that this policy is reflective of the current practice.

Dave Iseminger: I would agree with that.

Greg Devereux: Thank you.

Moved. Seconded. Approved.

Voting to Approve: 6

Voting No: 0

Lou McDermott: Policy Resolution 1 - Season passes.

Dave Iseminger: Policy Resolution 2 – Surviving dependent eligibility. At last month's meeting this was introduced as a policy proposal that helps clarify challenges with some of the higher education retirement plans that pay out as annuities, which raised a concern as to whether a surviving spouse in that situation was satisfying the eligibility requirement to immediately receive a pension benefit. These annuity payments are paid out on a prospective basis, whereas many of the other DRS administered plans are retroactive to a certain date. This resolution would clarify that.

Lou McDermott:

Policy Resolution 2 – Surviving dependent eligibility

Resolved, that the surviving dependent of an employee who receives a monthly retirement benefit no later than one hundred and twenty days from the date of death of the employee satisfies the requirement to immediately receive a monthly retirement benefit.

Moved. Seconded. Approved.

Voting to Approve: 6

Voting No: 0

Lou McDermott: Policy Resolution 2 – Surviving dependent eligibility passes.

Dave Iseminger: Policy Resolution 3 – Retiree insurance coverage eligibility for statewide elected officials and appointed officials. This policy proposal helps clarify the current interpretation and administration of a rule and memorializing historical practices. It clarifies that the eligibility for retiree coverage is on the same basis as outgoing

legislators who are eligible under statute, and it provides a clear description for PEBB Division staff to use.

Lou McDermott:

Policy Resolution Number 3 – Retiree insurance coverage eligibility for statewide elected officials and appointed officials

Resolved, that the following employees are eligible to continue enrollment or defer enrollment in PEBB insurance coverage under the same terms as outgoing legislators when they voluntarily or involuntarily leave public office.

- (1) A statewide elected official of the executive branch;
- (2) An executive appointed directly by the Governor as the single head of an executive branch agency; or
- (3) An official appointed directly by a state legislative committee as the single head of a legislative branch agency or an official appointed as the Secretary of the Senate or as the Chief Clerk of the House of Representatives.

Moved. Seconded. Approved.

Voting to Approve: 6

Voting No: 0

Lou McDermott: Policy Resolution 3 – Retiree insurance coverage eligibility for statewide elected officials and appointed officials passes.

Dave Iseminger: Policy Resolution 4 – SmartHealth concerns an additional SmartHealth wellness incentive. This policy proposal is necessary to establish an eligibility framework for a gift card incentive negotiated in the collective bargaining agreements that have since been ratified. I do want to make sure that the Board and record are clear in understanding that this incentive does not replace the current \$125 deductible or HSA deposit incentive. This is a separate, additional incentive that could be earned.

Lou McDermott:

Policy Resolution Number 4 – SmartHealth

Resolved, that effective January 1, 2018, all SmartHealth eligible subscribers will receive a separate PEBB wellness incentive after completing their SmartHealth well-being assessment on or before December 31 of the current plan year. This separate PEBB wellness incentive may be earned only once per plan year.

Moved. Seconded. Approved.

Voting to Approve: 6

Voting No: 0

Lou McDermott: Policy Resolution 4 – SmartHealth passes.

2018 Procurement Overview

Beth Heston, PEB Division Procurement Manager, presented this year's PEB procurement results. There are some changes to the new Kaiser Permanente of Washington plans collectively. They are formerly known as Group Health. A network change is being put in place to the consumer directed health plan (CDHP). Coverage services are now going to be limited to the core HMO. Formerly, CDHP members had access to care through a wider ranging PPO network. They will now be restricted to the core HMO. However, there is some offset. They're adding access to the consulting nurse helpline, care clinics at Bartell Drugs at select Seattle area locations, or Kaiser Permanente online visits for routine issues.

Tim Barclay: In this particular case, is there any sort of grandfathering that goes on if somebody is in the middle of a treatment plan and using someone in the broader network? What happens to that person?

Beth Heston: I would assume that there would be coverage for continuity of care if they were seeing someone and they were in the midst of care. Kaiser determined there are approximately 4,500 people impacted. Under 100 people had providers they will no longer be able to see. Kaiser will do a direct outreach to them. We don't foresee any problems.

Tim Barclay: Thank you.

Lou McDermott: Beth, have we confirmed that there will be an exception made for continuity of care issues? Do we know that for a fact?

Beth Heston: We do not know that for a fact. I will check and bring that information back to confirm.

Lou McDermott: Thank you.

Beth Heston: Plan design changes are going to sound very repetitive. I will go through them by plan because they've made some decisions about adding a pharmacy deductible and maximum out-of-pocket.

SoundChoice includes some reductions to those numbers. The new out-of-pocket maximum for members will be \$2,000 per person and \$4,000 for family. That's down from \$3,000 for individuals and \$6,000 for family. They will also add a \$100 per person, \$300 per family prescription drug deductible. The deductible will be waived on value and Tier one drugs. They also added a \$2,000 per person prescription drug maximum out-of-pocket, and reduced the co-insurances on several benefits from 20% to 15%.

For the Value plan, under Kaiser Permanente of Washington, we had the addition of the pharmacy deductible and out-of-pocket.

Greg Devereux: To go back to SoundChoice, the third bullet, add \$2,000 per person prescription drug out-of-pocket limit? Is that a change?

Beth Heston: Yes. That is a change. They didn't have a deductible or a maximum out-of-pocket before.

Greg Devereux: Okay, thank you.

Myra Johnson: So that's per person? Is there a family rate on that as well?

Beth Heston: No, it's per person. There's no family rate. Each person in the family will have to meet the \$2,000 deductible. The Value plan also added the \$100 and \$300 deductible, and the \$2,000 maximum out-of-pocket.

Lou McDermott: One clarification, the \$2,000 wasn't the deductible but it's the maximum out-of-pocket.

Beth Heston: Yes, maximum out of pocket.

Lou McDermott: I just wanted to make sure it's not a deductible, it's a maximum; and before, there was no maximum.

Beth Heston: Right. Lastly, the Classic plan, Kaiser lowered the medical deductible on the Classic plan from \$250 to \$175; and they lowered the family from \$750 to \$525. There's a typo on your handout. The \$250 in the first bullet should be \$525.

David Iseminger: So, that first line would read, "lower medical deductible to \$175 per person and \$525 per family?" That's changing from what?

Beth Heston: From \$250 per person and \$750 per family. And like the other plans, they're adding the \$100 and \$300 deductible for prescriptions and the \$2,000 prescription drug maximum out-of-pocket.

I understood that you were asking for the comparison chart that Kim provided in previous years. I will have this available for you at the July 19 meeting so you can see the whole, not just Group Health, but Kaiser Northwest and the UMP plans as well.

Tim Barclay: I have a question on the first two, the Sound Choice and the Kaiser Plan. There are benefit improvements and benefit takeaways both happening at the same time. Do we know what the composite impact is? Is it a net takeaway? Is it a net enhancement? Is it a wash? The Value plan clearly is a takeaway. We're just adding cost-sharing.

Beth Heston: Right.

Tim Barclay: But for the other two, do we know what the composite impact is?

Dave Iseminger: Kim will cover that.

Tim Barclay: Thank you.

Greg Devereux: Beth, the \$100 per person and \$300 family prescription drug deductible I assume is a takeaway.

Beth Heston: Yes. They did not have one before. We have had one in UMP for several years and they've added that as well.

Greg Devereux: Thanks.

2018 Non-Medicare Rates

Kim Wallace: Before I review the results of the 2018 procurement for non-Medicare plan rates, I will speak to Tim's question with regard to the actuarial value and the richness of the Kaiser Washington plans.

The analysis that we have done using the federal actuarial value (AV) calculator, which is a standardized tool that allows us to assess the value to members of various plan design features, specifically regarding their cost share. When I share some figures with you, you can think of this in terms of how much a typical plan member will have covered for them under their plan. It's not true for any particular individual; but on the whole, a typical policy holder can expect to have this level of coverage from their plan. When we did this analysis specifically with respect to Kaiser Washington, we found for 2018 that the actuarial value of the Classic plan is going down by about one percent and the AV on the Value plan is also going down by about one percent. Interestingly, the AVs on SoundChoice and the CDHP are going up, each by about one percent.

Kim Wallace: There are many different factors that go into the calculation and I couldn't begin to describe all of them to you; but suffice it to say this is a standardized tool. I will also mention that for UMP and the Kaiser Northwest Plans, the AVs are staying stable.

All of the PEBB medical plans are in the 80%-90% range. We are offering plans with AVs that range from 83% to 89%. Most of our plans are considered platinum metal tier plans in terms of the ACA metal band tiers, platinum, gold, silver, bronze. We have platinum plans and we have gold plans. Does that address your question?

Tim Barclay: It does.

Kim Wallace: I will be speaking to rates and premiums for state active employees and for non-Medicare retirees; and then I will walk through what's happening with dental, life, and long-term disability.

Slide 4. State active employees. Running down the left-hand side of the table, you see the names of the plans. They are in alphabetical order. We have the Kaiser Northwest plans that have the smallest enrollment with us. The first column is the 2018 proposed employee contribution. That's the single subscriber premium. Column two is the state index rate, which is the employer contribution. When you add those two columns together, you get the total, which is column three.

Slide 5 starts to compare 2017 to 2018. For example, starting at the top of the table, Kaiser Northwest Classic is going from an employee contribution of \$131 to \$137; and you can follow along down the column to see the changes by plan. If you move to the last column on the right, you'll see a percent change in the subscriber rate. This is not the percent change in the bid rate, this is a percent change in what the subscribers in each plan will be experiencing this year.

Dave Iseminger: Kim, do you mean at the subscriber only level?

Kim Wallace: Yes. Actually the tiers are aligned.

In the far right column you will see a negative 31.8%. That means that the UMP Plus employee contribution is indeed going down quite a bit. It's going down from \$66 in 2017 to \$45 in 2018. It is the only plan that has a contribution that's going down. That's primarily due to two things. First, this year is the first time that we have the benefit of a full year of claims experience on the UMP Plus population. We did our best last year at this time using a limited data set of claims experience; and we relied on the UMP enrollment claims experience to assess what would be happening with those individuals who picked UMP Plus.

This year, in our analysis and projections using the full year of 2016 claims experience, we could see that it was reasonable to set the bid rate at a more modest level of growth. The bid rate for UMP Plus actually stayed essentially flat from 2017 to 2018.

The other factor is somewhat complex. The relative increase in the bid rate for any one of these plans compared to the rate of the increase in bid rates for all of the plans together, affects the employee contribution amount. For plans whose bid rate went up by a small amount, the employees who choose that plan will have a lower increase in their contribution, or in the case of UMP Plus, even negative. There is no cross subsidization between the UMP Plus plans. We're not taking from members in another plan to help UMP Plus. This is the result of the experience we are seeing in UMP Plus.

Lou McDermott: Kim, are you seeing that the population signing up for UMP Plus is inherently healthier and lower risk scores overall than the population in Classic?

Kim Wallace: We do see that. The bid rates are risk adjusted to accommodate that kind of difference. The risk adjustment factor isn't perfect, so we could also be seeing an effect of the relatively younger, relatively healthier people, going into UMP Plus.

Tim Barclay: Did Group Health not experience - Kaiser Washington, not experience the same thing in SoundChoice that is a similar mix of people who chose that plan? I thought that those two were supposed to be parallel, much like the CDHP plans are parallel. Did they experience the same thing?

Kim Wallace: I don't know specifically. I would be happy to check with them and look for what factors and assumptions did affect their projections and their rates for this year, if you'd like.

Tim Barclay: I think that'd be interesting. It's interesting that the two programs that are supposed to be parallel – ones that we have such dramatic differences in - what's happening in their prospective rates.

Kim Wallace: One thing that I could offer is that the SoundChoice Plan has a small enrollment, so I don't know what kind of volatility that introduces for them, but we can address that with them as well.

Tim Barclay: Thank you.

Lou McDermott: Approximately how many people are in Sound Choice? My recollection is about 2,500.

Kim Wallace: I was going to say 1,800 to 2,200.

Lou McDermott: Something like that, as opposed to 16,000 in the ACP.

Tim Barclay: Okay.

Harry Bossi: Kim, could you tell me which of those plans has the 89% on the actuarial value?

Kim Wallace: Certainly. So the 89% is UMP Plus.

Dave Iseminger: Just for clarity you're talking about the actuarial value now right? Not dollars?

Kim Wallace: Yes, the actuarial value of the UMP Plus for 2018 is just over 89%. I can also add that the actuarial value of the Kaiser Washington Value Plan actually has the lowest AV at 83.4%. You may recall that last year we had a significant redesign of the Kaiser Washington Value Plan.

Back to Slide 5, if you look at the percent change in the subscriber rate, it's jumping all around; but essentially in aggregate, the employees' contribution is going up approximately 6.8% from 2017 to 2018.

Greg Devereux: That's the overall? All of them? I assume that the vast majority of people are still in UMP Classic?

Kim Wallace: Yes.

Dave Iseminger: Yes, Greg, that's definitely the highest number.

Greg Devereux: Can you ferret out why the 8.5% increase in that? Is that primarily driven by drugs or something else?

Kim Wallace: I can speak to the cost drivers. We have a medical trend, which is the increasing cost for medical services, not prescription drugs. It's about 6% to 7%. The trend we're seeing in UMP for prescription drug costs varies from UMP Classic, Plus, and CDHP; but the range is 13% to 19%. Rx continues to outpace medical trend. Does that answer part of your question?

Greg Devereux: No. It's more a comment than question. I mean 6% to 7%, I'm just amazed that it continues without end.

Harry Bossi: Would you clarify why, what Greg was talking about? Was that trend you were referring to primarily utilization as opposed to medical inflation?

Kim Wallace: When I say trend, I actually mean more than one factor. It is utilization, but it's combined with unit cost and general inflation.

Tim Barclay: Kim, can you answer a similar question to Greg's, specifically with respect to the Kaiser Washington plans? It's interesting that they are the three plans with double-digit increases. In particular maybe address the Classic plan which, on top of this, has a benefit reduction which we just talked about and which had a very substantial rate increase last year. In particular, does the transition to Kaiser Washington from Group Health have any impact on this, or different assumptions about administrative costs, or did the transition in some way impact experience underlying the program? Just your thoughts on what's happening here with Kaiser of Washington and their noticeably higher rate increases than everybody else.

Kim Wallace: I think your question is very much related to your question/comment from a few minutes ago. I can't speak to the impact of the acquisition per se; but we'd be happy to go back and ask them to confirm what really is driving their cost increases, and what components they are seeing that may have been analyzed or assessed differently under the new regime. I'm thinking we can have helpful information for you by the Board meeting next week.

Tim Barclay: Thank you.

Lou McDermott: Kim, the rate setting process for KP Northwest and KPWA was separate this year. Is that correct? So they still have their separate rate setting entities within the organization and they were using separate experience and separate assumptions? Things like that?

Kim Wallace: Yes.

Greg Devereux: To go back to Harry's point about utilization. What do we actually use? What does the Health Care Authority look at regarding utilization? Is it number of cases? I don't remember seeing how we measure utilization.

Kim Wallace: There are many different ways to measure it, but we definitely are reviewing, capturing data, various metrics; it is typically per thousand. We have admissions, we have office visits, lab/x-ray, etc. Sometimes it's per thousand and sometimes we look at our spend.

Greg Devereux: But is there a way to take over-arching metrics and look at the past five years, ten years, and say the utilization really is driving? I'd love to see that, if possible.

Kim Wallace: Yes, there is. We can commit to a deeper analysis and then report back on what is driving our costs and what the unit cost increases look like compared to utilization. We have a number of mechanisms in place that do attempt to control costs in contract; but we know that we are not seeing the trend that we wish we would.

Lou McDermott: Greg, I want to clarify. I think what you're asking is that you would like to know if that specified trend that's resulting in a rate increase, what portion of that trend is utilization and what portion of the trend is just costs.

Greg Devereux: Correct, over time. I want to ferret out Harry's point about how much is inflation, how much is utilization. I'd like to know that.

Lou McDermott: Understood.

Kim Wallace: I was going to the inpatient vs ER - that level, which is more granular, but we have that as well.

Dave Iseminger: I have a clarifying question for Greg. Is this information you want for this rate-setting season, or is this more like a Board retreat topic?

Greg Devereux: I don't think we need it in the next two weeks, but I'd like to see it during this season.

Kim Wallace: Thank you. Slide 6 is just a visual. There are no new numbers here but it's just a visual of the 2017 employee premium contributions compared by the 2018

proposed. The blue on the chart is the current year, 2017, and the green is the proposed for next year, 2018.

Slide 8 is the retiree non-Medicare subscribers. The same plans are listed down the left-hand side of the table and you see 2017 compared to 2018. These rates are increasing. If you look at the last column, you will see the percent change. These changes are lower than what you saw in the percent change column for the employee contributions. It's kind of apples and oranges. These numbers represent a more pure change in bid rate.

How much are the bid rates going up? The calculation of the share between the state and the employee payment, and then splitting that employee share down by plan, introduces different factors which causes the percentages to move around differently; but this is a depiction of essentially how much each plan rate is going up for next year.

Greg Devereux: Kim, how many total non-Medicare retirees are there? Just ball park. I can't imagine there are that many.

Kim Wallace: I'm thinking approximately 70,000 retirees.

Dave Iseminger: We'll definitely follow up.

Kim Wallace: We have staff in the audience that could look that up quickly and let us know.

Gwen Rench: I have a question about the UMP Plus. I noticed it's going up where in contrast for the active employees, it went down significantly. Can you explain why it goes up even though it's a small amount?

Kim Wallace: The overall rate is going up very slightly; but when we calculate the employee share, we go through that process of establishing the state index rate. We go through the process of saying 85% of the weighted average of all of the bid rates is going to be borne by the state. We then calculate that number, which is the \$551 that you saw on the first slide. There are different numbers of people in each plan, of course. We do a weighted average. So the UMP Classic rate weighs more in that calculation. For the UMP Plus and SoundChoice and some of the other small plans, their bid rate change weighs less in the calculation. We do that calculation and come up with what the state responsibility is - the 85%. The leftover, the difference between that \$551 and what the bid rate is, for any particular plan, is the employee share. That calculation ends up leaving a share to the employee that is affected by all of that calculation. It doesn't follow along purely with the percent rate change, which you're pointing out.

Gwen Rench: It's a 31.8% decrease for actives, where it's a .9% increase for retirees. I can see where maybe it's because there have been some studies that retirees cost more because they're older and more medical, but it's all due to this other formula?

Kim Wallace: Actually, I want to clarify that the non-Medicare retiree rates are not changed for retirees from what the state active rate is. I'll come up with a better way of describing it, but the dynamic that I was sharing a moment ago is what is creating that difference between the state actives and retirees; but there's no rate factor or rate change that we're applying that favors state employees over retirees or vice versa.

Gwen Rench: I just want to say I don't pretend to really follow, but I understand.

Kim Wallace: Well, let's try again.

Gwen Rench: No, that's okay.

Kim Wallace: Not right now, but I think it's important. We really do want to be able to explain and convey clearly and reasonably what is happening with the rates and how people are affected differently. We take that very seriously, so I'm taking that away as a to do.

Harry Bossi: I want to ask for clarification on whether or not the two dollar surcharge for the employer groups per member per month is based on utilization as opposed to just an administrative fee? Is that correct?

Kim Wallace: Right. The employer group surcharge that you're asking about that's mentioned in the footnote is the new employer group surcharge that is applied to the non-state active groups that are in our non-Medicare risk pool. Senate Bill 6475 (2016) required the HCA to calculate the costs associated with the political-sub, employer groups, that are in the non-Medicare risk pool and to apply a surcharge to cover the difference in the expected claims experience for those groups versus the rest of the pool.

Harry Bossi: Okay, so it's based on claims experience as opposed to just administrative?

Kim Wallace: Yes, it is.

Harry Bossi: So, I understand then that there's some kind of utilization studies done to determine that. Did I understand you earlier that there was a separate risk pool for the school employees as well? Is it separated from the active state?

Dave Iseminger: Currently, no. Currently Harry, there are two risk pools. There's the non-Medicare risk pool and the Medicare risk pool. A third risk pool would be brought in under House Bill 2242 just for active K-12 employees. So, right now, all the local

jurisdictions are within the non-Medicare risk pool, just like state agency and higher education employees are in the non-Medicare risk pool.

Harry Bossi: So, is it possible that K-12 cost more on average than state employees?

David Iseminger: I believe that part of monitoring in a third risk pool is to be able to make those comparators between the various risk pools.

Harry Bossi: I'm just trying to understand if what's applied to the employer groups is/should also be applied - or currently hasn't been applied to K-12.

Kim Wallace: Correct. They've been in a pool.

David Iseminger: Right. They've had the opportunity to join the non-Medicare risk pool on their own up to this point, and that will continue until January 1, 2020. Then, by moving into their own separate risk pool, they'll be community rated on their own. But this employer group surcharge that was authorized by Senate Bill 6475 (2016) did not apply to K-12 school districts. They have the remittance that's collected to help address the fact that the retirees are within our non-Medicare/Medicare risk pools; but that their actives aren't. I do want to clarify, Kim described this as a new surcharge.

Kim Wallace: New for last year.

Dave Iseminger: New for the current year. It's currently being paid by the political subdivisions in 2017; and then this describes what that offset would be for 2018, year two.

Lou McDermott: David, has it gone down for year two?

Dave Iseminger: The surcharge that is going to the political sub-divisions is going down slightly.

Kim Wallace: The analysis that we are just completing indicates that on a claims basis, the employer group surcharge for 2018 will go down from \$20 to \$18. Great questions.

Slides 10 through 13 review dental, life, and long-term disability rates for 2018. There is very little happening here. There is one change for dental. The vast majority of our employees are in the self-insured Uniform Dental Plan (UDP). We're experiencing a slight rate increase for UDP from \$45.07 per subscriber per month in 2017 to \$45.82 in 2018. On slide 10, you'll see that for DeltaCare and Willamette Dental Group, there is no change from 2017 to 2018 because we're in a period of rate guarantee. And the state active premiums are paid 100% by the employer.

Dave Iseminger: For dental.

Kim Wallace: For dental, for all tiers.

David Iseminger: I wanted the record clear on that one.

Lou McDermott: Kim, we're all dying to know what's on the note. Is it the non-Medicare retiree numbers?

Kim Wallace: Is it more interesting than basic life, AD&D, and LTD? Okay, there are 9,643 non-Medicare retirees split about half and half between K-12 and non-K-12.

Lou McDermott: Thanks Kim.

Kim Wallace: Thank you, team. Slide 11. For basic employer-funded life insurance, accidental death and dismemberment, and long-term disability, we have no rate change for 2018. It is staying at \$3.96 per employee per month and the basic LTD is the same story. There is no rate change for 2018.

Slide 13 is about optional benefits. Employees can choose to purchase optional life and/or optional long-term disability coverage. For optional life coverage, there is no change to age-banded rates. If someone changes age bands, then they will experience a rate change. Tobacco use also comes into play.

And then on long-term disability, there's no rate change for 2018. Those rates are somewhat complex. They are based on the subscriber's retirement plan and a waiting period that they select.

Lou McDermott: David, have we captured all the requests for additional information from our previous meeting?

David Iseminger: I believe we have. I do want to thank Kim for the heavy lifting on some of the questions.

Meeting Adjourned.

Public Employees Benefits Board
Meeting Minutes

DRAFT

July 19, 2017
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:

Harry Bossi
Gwen Rench
Mary Lindquist
Myra Johnson
Greg Devereux
Yvonne Tate
Tim Barclay

Members on the Phone:

Marilyn Guthrie

PEB Board Counsel:

Katy Hatfield

Call to Order

Lou McDermott, Chair, called the meeting to order at 1:33 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Agenda Overview

Dave Iseminger, Acting Director, Public Employees Benefits Division provided an overview of the agenda.

Approval of June 21, 2017 PEBB Meeting Minutes

It was moved and seconded to approve the June 21, 2017 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

July 12, 2017 Meeting Follow-up

Kim Wallace, HCA Financial Services Division Section Manager: I want to share information in follow-up to three questions or issues that were discussed at the July 12, 2017 Board meeting. Specifically, I will first reaffirm and provide additional information regarding PEBB plan actuarial values and the assignment of metal tiers; second, I will share information that we gathered from Kaiser Permanente of Washington regarding

their rate development assumptions; and third, attempt to provide a clearer response to Gwen's question regarding the UMP Plus employee contribution and the non-Medicare retiree premium.

First, the actuarial value and metal tiers. The actuarial value (AV) is an estimated percentage of a typical member's medical bills that a plan is expected to pay. The labels of platinum, gold, silver, and bronze are designations for plans offered on Affordable Care Act (ACA) exchanges across the country. The purpose of the ACA metal tier designations is to help people choose plans. In other words, they can choose to pay higher premiums for richer plans. Currently, the platinum label refers to plans with AVs that are, per the federal AV calculator, at 90%, plus or minus 2%.

Dave Iseminger: That's one of the things I learned in the last week. I thought it was just 60%, 70%, 80%, 90%, but there's actually de minimis variance that gives a plus or minus factor. That is something we wanted to make sure the Board was also aware of.

Kim Wallace: At the platinum level, the AV results from the calculator are 88% to 92%. For 2018, there's a change and the minus is going to 4% and the plus is remaining at 2%. So now platinum is down to 86% or up to 92%. Some of the PEBB plans have AVs in that range.

Currently, gold label plans, per the AV calculator, are 80% plus or minus 2%. For 2018, that's changing the same as the platinum. It's going from -4 to +2. You can see the pattern.

The silver and bronze tiers follow the same pattern around the 70% and the 60%.

You may be wondering about AVs that are in between 82% and 86%. The ACA metal tiers are deliberately separated by this gap so consumer A doesn't select a platinum plan with an AV of 86.1 and consumer B selects a gold plan with an AV that is lower by a minuscule amount such as 85.9%. One of the consumers is buying the platinum plan and paying more for that and one consumer is paying for a gold plan and paying less. It doesn't create sufficient separation for clear and reasonable purchasing on the exchanges.

The key point I want to make is that associating PEBB plans with metal tiers is done for general reference purposes as a way to comment on our plan richness. The metal tier labels were specifically created to be applied to plans offered on the exchanges. The better way to talk about PEBB plans is to use the actual AV percentages. The draft 2018 federal AV calculator results I referred to last week are in the process of being finalized. These numbers indicate that the 2018 AVs are going up slightly for Kaiser Washington's SoundChoice and the three PEBB CDHP plans, each of them going up approximately one percent in the AV calculation and down slightly for Kaiser Washington Classic and Kaiser Washington Value, each about one percent. The other

plans are essentially staying the same. With that additional information, do you have further questions about AVs and the calculator and metal tiers?

Greg Devereux: Kim, could you repeat the very first thing you said? It sounded like, “estimated cost the consumer is expected to pay.”

Kim Wallace: That the plan is expected to pay. Yes. The AVs in the 80%; 82%, 83%, 84%, 85% range mean that a typical member with that plan would experience the plan paying for that percentage of their bills.

Greg Devereux: Thanks.

Lou McDermott: Kim, does that include your initial deductible and premiums and things like that or is that excluding that?

Kim Wallace: Premium? I believe it is not the premium. It is the cost sharing, but it is all cost sharing associated with receiving services.

Dave Iseminger: And just to reiterate that those AVs are the typical member, not every member.

Kim Wallace: Thank you. There was an interesting and meaningful discussion about the metal tiers and AV percentages and we wanted to get a little bit technical and provide this clarification.

The second item that I have for follow-up is regarding Kaiser Permanente of Washington’s 2018 bid rates and premiums. In follow-up to the questions posed last week about the drivers of the Kaiser Permanente of Washington employee premiums, we discussed this with them and can share the following. The composite trend rates used in 2018 rate development were down about 0.1% from last year. The composite trend rates were generally just under 8%. The Kaiser acquisition of Group Health did not affect the development of the 2018 trend rates. Specifically, assumptions used were not more conservative for 2018 and they did not include additional administrative load.

Dave Iseminger: And that’s related to the acquisition, right?

Kim Wallace: Yes. The percentage increase for the 2018 bid rates is actually lower than their composite trend rates. Now that said, these bid rate increases are higher than the increase in the state index rate and higher than the increases in UMP bid rates because of these relative differences. Kaiser Washington’s employee contribution amounts are going up significantly and you saw the percentages. I believe one of them was 10.2%, which I think elicited the question.

The dynamic, between the bid rates and employee contributions takes us to the third follow-up item I have prepared. The third is in response to Gwen's question about how the UMP Plus employee contribution is going down by quite a bit, while the non-Medicare retiree premium for UMP Plus is going up slightly. This is the point in the meeting last week when I said we really want to figure out how to describe this in the most accessible, reasonable, and accurate way.

I am going to share from a different vantage point than I think we have in the past. I actually drew a picture, so you may want to draw a picture as I go along. If you imagine two vertical bars, side by side, that represent the UMP Plus total premiums for 2017 and for 2018, the 2017 bar is \$591 and the 2018 bar is slightly taller at \$596 dollars. You have the two bars side by side and 2018 is five dollars higher than 2017. This five dollar difference is the premium increase that the retirees will experience, just less than 1%, but you can see it is going up.

For active employees, the state paid \$525 of the \$591 in 2017, leaving \$66 to be paid by the employee at the single tier. All but \$66 of that bar of 2017 is state paid. You can shade in that portion of the bar. The state paid 88.8% or \$525 worth of the bar. Moving to the 2018 bar, the state will pay \$551, over 92% of the total bar, leaving only \$45 to be paid by the employee. If you shade in \$551 worth, or 92% of the 2018 bar, the state paid portion of the UMP Plus premium is going up more than the total premium is going up. The state paid portion of that premium is going up by \$26 while the total premium is only going up by five dollars. That creates the difference between what state employees are experiencing versus what the retirees are experiencing.

When we calculate the state paid portion, or the state index rate, the \$525 and the \$551, we do that using all the final bid rates for all the plans together, and we calculate a weighted average bid rate and multiply that by 85% to get what the state will pay. The state's responsibility went up by 26% from 2017 to 2018, but the total UMP Plus premium only went up by five dollars. For UMP Plus subscribers, the state will be paying a greater share of the premium in 2018 compared to 2017 and the employee will be paying a smaller share of the premium.

That is true, while at the same time, in aggregate, the state is meeting its 85% of total premium responsibilities and employees are not paying more than their 15% share in aggregate.

Greg Devereux: But doesn't that drive the cost up in UMP Classic?

Kim Wallace: We do have a dynamic where people with higher or lower risk are choosing different plans. If a plan like UMP Plus, with a relatively high actuarial value, is perceived that it costs less for members to join, then they will have a type of incentive to switch into UMP Plus. I think that's what you're asking about, the degree to which members are leaving. The risk score could actually get higher in the UMP Classic as people who are able to leave to UMP Plus, or feel that it's a good deal for them do.

That is something that we watch on a regular basis by measuring and watching which enrollees are in which plans.

Greg Devereux: Maybe I missed it in the presentation, but why are folks moving to Plus versus Classic in UMP? What are the drivers?

Dave Iseminger: I think there are actually a couple different incentives within the plan design structure to keep in mind. One of those would be that there is no cost share for members for primary care visits. There's also a lower deductible. It's \$125, and then if you tack on the wellness incentive, it becomes a zero deductible plan. Those are a couple of other features beyond just the premium differential that also may incentivize individuals to go to UMP Plus.

Greg Devereux: What has been the migration from the first year to this year into UMP Plus? How much has it grown?

Dave Iseminger: At the end of 2016, we were at approximately 10,000 covered lives. We're now between 16,000 to 17,000 covered lives.

Greg Devereux: Thank you.

Lou McDermott: Dave, it seems like we have a younger, healthier population going into the Accountable Care Program (ACP); but it also seems like the benefit design for the ACP lends itself well to people who are sick and have chronic conditions and need to see their doctor often. Is there any plans on trying to encourage folks that have more chronic conditions to take another look at ACP in our marketing and the other things that we do to try and let people know? I think at the end of the day, they're trying to keep their flexibility because they do have medical issues and they want to make sure they can go anywhere they need to go, but I think the benefit design lends itself to folks who have more medical needs.

Dave Iseminger: I think we're fortunate in the PEBB Program that we have a variety of products that can meet a variety of different people's needs. One of the things that is in the works is a more targeted communication campaign so that people are looking and actively reviewing the plan designs and evaluating their circumstances with those plan designs. For some people that will be UMP Plus, for some that will be UMP Classic, and for some it will be Kaiser Permanente SoundChoice. We really are working on a communication campaign to get people actively thinking about the different parts of their circumstances so they make sure they're picking the right plan design for themselves.

Harry Bossi: I think your presentation was really good. I understood all of it, but you can only get a certain saturation point in the Plus plan that revolves around the Puget Sound area without expanding the network. Anybody who lives east of the mountains or outside the metro-plex area doesn't have that opportunity or choice. I think it's obviously something to keep in mind moving forward with the Classic plan and the

others, if they are viewed as attractive as possible, and not that they're less of a plan than the ACP.

Dave Iseminger: I would just remind you, Harry, that this year the UMP Plus did expand into Spokane County, Yakima County, Grays Harbor County, and Skagit County. There is a little bit of expansion east of the mountains that we have. There isn't any particular planned expansion for calendar year 2018, but we're hoping to continue working with our partners in the networks to see what other expansion opportunities there are.

There is actually one more follow-up piece. There was a question about the Kaiser Washington network change for their consumer directed health plan and whether there would be a continuity of care consideration for those individuals who have providers who would now be out of network. The answer is yes, there will be continuity of care factored into those situations where an individual has a provider that would now be out of network as of January 1.

Lou McDermott: Dave, is that going to be communicated with members?

Dave Iseminger: Yes, it will be.

2018 Non-Medicare Premium Resolutions

Lou McDermott: Kim will review the 2018 Non-Medicare Premium Resolutions that were introduced last week and are up for vote today. Kim's materials are behind Tab 4. As a reference, behind the goldenrod papers in Tab 4 is a one-page list of the resolutions, selected pages from Kim's presentation from last week, and a copy of the 2018 medical plan benefits summary that Beth Heston said she would provide.

Kim Wallace: I want to make sure that you're also able to reference the one-page table of rates titled, "Revised Non-Medicare Retiree Rates by Tier."

Lou McDermott: Kim, can I just check to see if Marilyn has joined us yet via phone?

Marilyn Guthrie: Yes, I have.

Lou McDermott: Thank you, Marilyn.

Dave Iseminger: Kim's referring to a tab that is embedded within the second goldenrod sheet. There are a couple slides that were presented last time about the non-Medicare rates and premium increases. As you flip through those, you'll see that Slide 8 is in there twice because one is labeled "Revised Non-Medicare Retiree Rates," and the other one is the original. Kim will provide a brief update on this chart.

Kim Wallace: We prepared this replacement slide because when we were finalizing the Medicare rates and working in the model that we use to establish rates, we identified a

column of hard coded numbers where there should have been a formula. When we re-implemented the formula, the non-Medicare retiree rates changed slightly to what you now have in front of you marked "Revised." This affected only the non-Medicare retiree rates. Six of the rates have changed slightly. The range of the change is a decrease of \$6 in SoundChoice up to an increase of \$3 on Kaiser Washington Value plan.

Dave Iseminger: Kim, are you describing the range at the single subscriber level? And those ranges would also be multiplied out by the multiplier across the tiers?

Kim Wallace: Yes.

Lou McDermott: Can I ask one question, Kim? When the error was discovered and the change was made, was the information shared with our partners to make sure they understood the change?

Kim Wallace: It went out to our authorizing environment partners and shared with Kaiser Washington.

Dave Iseminger: Kaiser Northwest was not impacted. We did not share with them.

Lou McDermott: Okay, I just wanted to make sure.

Kim Wallace: Yes. We have many different partners, and yes, we shared. As I mentioned, six of the rates have changed slightly. I do want to apologize for presenting this change as you are getting ready to vote. The rates are not changing significantly, but please do feel free to express any concerns you have about proceeding to the vote or to ask any questions you have about the rates.

Lou McDermott: Are there any issues from the Board on voting on these rates with the changes that have been presented today? I think we can proceed.

Kim Wallace: 2018 Non-Medicare Premium Resolution 1: **Resolved**, that the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Non-Medicare employee and retiree premiums.

Dave Iseminger: Kim, if the Board members are looking for a reference, that would be the top two rows of the chart on Slide 8, Tab 4?

Kim Wallace: Kaiser Northwest. Are there questions or comments?

2018 Non-Medicare Premium Resolution 2: **Resolved**, that the PEB Board endorses the Kaiser Permanente of Washington Non-Medicare employee and retiree premiums.

2018 Non-Medicare Premium Resolution 3: **Resolved**, that the PEB Board endorses the Uniform Medical Plan Non-Medicare employee and retiree premiums.

Lou McDermott: Thanks Kim. We will now vote.

2018 Non-Medicare Premium Resolution Number 1: Resolved, that the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Non-Medicare employee and retiree premiums.

Moved. Seconded.

Greg Devereux: My concern, I understand a number of the plans don't have changes, especially the CDHPs, but I do have concerns about the inflation within a number of the classic and that will be reflected in my vote.

Lou McDermott: Understood, thank you, Greg.

Moved. Seconded. Approved.

Voting to Approve: 6

Voting No: 1

No Vote: Greg Devereux

Lou McDermott:

2018 Non-Medicare Premium Resolution Number 2: Resolved, that the PEB Board endorses the Kaiser Permanente of Washington Non-Medicare employee and retiree premiums.

Moved. Seconded.

Tim Barclay: Lou. I share Greg's concern, particularly the rate increases on the Kaiser Washington plans. For me it's disappointing that our managed care organization (MCO) is trending higher than our broad UMP PPO plan that's statewide. I also think it's inconsistent with the objective. I think that the SoundChoice plan is going up by 10% for our members. I think the whole goal of that was an ACP look-alike whose specified objective is to manage trends. I think at this hour, I'm still going to vote yes to pass these this year; but I think I would like to put on our Board agenda next year, maybe in our April meeting a conversation about how the MCO plans fit into the portfolio and what our objectives are. Whether that needs to be an executive session or not, I don't know, but I think we need to have a conversation about what our expectations are for the MCO plans as part of the portfolio.

Lou McDermott: All right, thank you, Tim.

Moved. Seconded. Approved.

Voting to Approve: 6

Voting No: 1

No Vote: Greg Devereux

Lou McDermott:

2018 Non-Medicare Premium Resolution Number 3: Resolved, that the PEB Board endorses the Uniform Medical Plan Non-Medicare employee and retiree premiums.

Moved. Seconded. Approved.

Voting to Approve: 6

Voting No: 1

No Vote: Greg Devereux

2018 Medicare Plan Design Changes

Beth Heston, PEB Division Procurement Manager: Our plan design changes are on the Kaiser Permanente of Washington, formerly Group Health, Medicare Advantage Plan and the changes are to align with Kaiser National coverages and new federal regulations. The additions to the plan will be at no cost share or co-pay. They are: Diabetes Prevention Program; an annual physical exam; telehealth; and a sixth pharmacy prescription drug tier, which is a zero dollar vaccine tier. Those changes were simply put in because of the acquisition of Group Health and the change to Kaiser.

Mary Lindquist: What is telehealth?

Beth Heston: Telehealth is a program that both Kaisers have. Kaiser Washington and Kaiser Northwest have that to enable visits with your doctor via telephone video sharing, for chronic disease management, and sometimes urgent care. They've been available and were introduced for Kaiser Washington in 2016. They added it to the 2017 benefit while they were still Group Health. Kaiser Northwest and Kaiser National have had them for some time.

2018 Medicare Premiums Overview

Kim Wallace: I will share the proposed 2018 Medicare Retiree Premiums. Slide 2 shows the single subscriber premiums by plan. The middle column shows the value of the Medicare explicit subsidy. When you add those together, then you get the composite premium on the far right. You'll notice that the explicit subsidy is \$150 for all of the plans except for Medicare Supplement Plan F Retired, and that is because the explicit subsidy is equal to \$150 per month or 50% of the total premium, whichever is less. There was a proposal earlier in the budget cycle to increase that but that did not follow through to the final budget. So for 2018 it's remaining at \$150 or 50% of the total premium, whichever is less.

Slide 3 shows 2018 compared to 2017 so that you can see the percentage change. Plan-by-plan you'll see that there is a relatively modest increase or, in one case, a very modest decrease in the premium. On the far right, it's the absolute dollar change on a monthly basis for single subscriber. The UMP Classic Medicare premium, in the middle, does stand out with a 20% increase, or a \$55.51 increase per month.

I'd like to share some information about what's driving this increase and then respond to questions that you may have. On the UMP Classic Medicare plan, the medical trend over the past couple of years has actually been quite reasonable. 2.7% from 2016 to 2017, and 3.2% projected in these rates from 2017 to 2018.

Lou McDermott: And this is UMP Classic Medicare?

Kim Wallace: Yes. It's very important to recall that UMP Classic Medicare pays secondary for medical care and it pays primary for pharmacy. That's a very powerful factor in what is happening to the premiums. So specifically with regard to pharmacy trends in UMP Classic Medicare, the trend is 13.7% for 2016 to 2017 and projected at 16.2% from 2017 to 2018. Pharmacy claims' costs make up approximately 61% of our total projected claims for this plan. The high pharmacy trend is really the driver of the expected cost increases for 2018. If you think about the pharmacy spend, a lot of people think about specialty drugs. I have a couple of numbers regarding specialty drugs without Hepatitis C. The trend model from our Pharmacy Benefits Manager projects specialty drugs to be 50% of the total pharmacy spend and the specialty trend from 2016 to 2017 at 21.9% and 23.8% for 2017 to 2018. Obviously those trend rates are much higher than what we expect on medical. With regard to specific drug classes and specific drugs that sometimes can be, in and of themselves the primary driver of the high rates that you see, we are doing more analysis and working with Milliman to ferret out some additional helpful data, hopefully by our meeting next week.

Lou McDermott: Kim, I think it's fair to say that a 20% increase is unsustainable. What are some plans for the near future to try and alleviate some of that pressure.

Kim Wallace: Absolutely. I was going to comment that we do want to express that we are extremely concerned about this rate of increase and we have been looking for ways to mitigate this as early as 2018. We were not able to identify actions that could be taken for plan year 2018. We are, however, committed to identifying and reviewing changes that could be made for 2019 and beyond. I think Dave is going to speak to some of those.

Dave Iseminger: There are a variety of ideas that I we'll be bringing back to the Board to talk about. I think we need to look at the entire retiree medical portfolio and present to the Board some options and implications for closing the formulary. That has a lot of different iterations of what that phrase means, closed formulary. If you asked all eight of you on the Board, all of you would give different answers as to exactly what that means, but in some way controlling some of the drugs that are the higher-spend drugs and pushing towards more value-based drugs.

There's another piece that can be looked at by the Board which is driving off of some of Harry's questions from recent Board meetings, which is, "What's the relationship for the drug coverage and the value that's given in UMP Classic versus Medicare Part D plans." We're also at this precipice where under federal law Plan F retires at the end of

2019. There needs to be an evaluation for replacements of supplemental plans. This creates the perfect crucible to bring the Board a systemic approach for looking at the entire portfolio of medical retiree plans. My intent is to have this be one of the major Board topics as we enter the next Board season so that we can get your insight about directions that you would like the product portfolio to go for the 2019 year. Fortunately, under the SEBB consolidation bill, we have to be working on a retiree analysis anyway. This is all dove-tailing well.

Lou McDermott: That was my next question. With SEBB coming in, that's going to be a resource draw. How do we ensure that this work gets done without missing another cycle, so to speak?

Dave Iseminger: As I said, fortunately, there is some pressure within the SEBB consolidation effort to do a review of the retiree portfolio for K-12 retirees and so we can dove-tail that work at the same time. It really is being able to leverage the work that already has to be done as part of evaluating K-12 retiree options and using that to do the same kind of analysis on the PEBB side of the world.

Gwen Rench: I do want to say thank you for having the composite rates without the subsidy. That does help a lot; but of course, I'm very concerned about the vast increase. I think Harry's idea might be a good way to explore because I tried to do some analysis of what we're paying because Medicare retirees are also paying \$105 out of their social security, and some people even higher than that. So it comes out that we're paying almost as much as the non-Medicare retirees. It gets real close even with the subsidy. It's only approximately \$70 difference for our total medical expenses.

Kim Wallace: Yes, and I just wanted to share one other bit of information. We do have 100,000 retirees in the PEBB Program. We want to acknowledge this is not a small number of folks that we are concerning ourselves with.

Dave Iseminger: Kim, is that covered lives or subscribers?

Kim Wallace: Total members.

Greg Devereux: Is that non-Medicare retirees?

Kim Wallace: No, Medicare and non-Medicare total.

Dave Iseminger: I believe at last month's meeting we had just under 10,000 that were identified as non-Medicare retirees.

Kim Wallace: Yes, 9,643.

Yvonne Tate: So those are all the younger people, right?

Dave Iseminger: They're the non-Medicare eligible folks, yes.

Lou McDermott: Kim, how many people are in UMP Classic Medicare?

Dave Iseminger: The enrollment numbers for UMP Classic are between 55 and 60 percent of the covered lives are within UMP Classic Medicare and then another 25% is approximately in the Kaiser Washington Medicare Advantage Plan.

Kim Wallace: I have an exact number. In UMP Classic there are 52,969 Medicare retirees. In UMP Classic Medicare, essentially 53,000 people and 6,700 people non-Medicare UMP Classic, for a total of almost 60,000 people.

Lou McDermott: Sounds like 60,000 good reasons to get this done.

Dave Iseminger: And 60,000 opportunities to improve this experience.

Proposed 2018 PEB Board Meeting Schedule

Dave Iseminger: The tentative dates for the 2018 PEB Board meetings are behind Tab 7. There are plenty of additional topics for consideration by the Board in the next year. Although you may have become reliant on one or two of those meetings being cancelled in the spring months, I wouldn't be so sure that any of those would be cancelled considering the work that's before us for 2019. Please mark these dates on your calendar.

Harry Bossi: I'd like to second the comment that Tim made earlier relative to more specific discussion concerning MCO and propose that be a good component to include in the January Board Retreat. It does allow a few more months for consideration if there is a direction that the Board would like to pursue in terms of rate development or proposals.

Dave Iseminger: Duly noted.

Gwen Rench: I'd like to put in a pitch again for enhanced fitness to be covered by the UMP. Kaiser covers this and we're increasing the premium so much it would be one way of giving some little reward and it contributes for good health.

Lou McDermott: Our next meeting is scheduled for July 27, 1:30 to 3:30, same location.

Meeting adjourned at 2:25 p.m.

Public Employees Benefits Board
Meeting Minutes

DRAFT

July 27, 2017
Health Care Authority, Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:

Louis McDermott
Yvonne Tate
Greg Devereux
Gwen Rench
Myra Johnson

Members on the Phone:

Tim Barclay
Harry Bossi
Marilyn Guthrie
Mary Lindquist (joined late)

PEB Board Counsel:

Katy Hatfield

Call to Order

Lou McDermott, Chair, called the meeting to order at 1:39 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Agenda Overview

Dave Iseminger, PEB Division Acting Director, provided an overview of the agenda.

2018 Medicare Premium Resolutions

Greg Devereux: Is there the opportunity for testimony during the resolution process?

Lou McDermott: Yes, there is.

Greg Devereux: There are quite a few folks here today and I want to make sure there is the opportunity before we vote on anything that they have that.

Lou McDermott: Correct. We read the resolution, we do the motion to adopt, the second, public comment, and discussion from the Board. Each resolution has that opportunity.

Greg Devereux: Great, thank you Lou.

Kim Wallace, HCA and PEB Finance Section Manager, presented the 2018 Medicare Retiree Premium resolutions. The purpose of this segment is to have a vote on the resolutions for Medicare premiums that were presented on July 19, 2017.

Medicare Premium Resolution 1: Resolved, that the PEB Board endorses the monthly Medicare Explicit Subsidy of \$150 or 50% of premium, whichever is less.

Dave Iseminger: For this resolution, I want to remind the Board that the statutory authority to set the explicit subsidy is with the Board within the parameters the Legislature gives the Board. This resolution represents the maximum authority within the legislative parameters that are given to the Board. If the Board were to set a different subsidy that is less than \$150 or less than 50%, then that would result in larger member premium increases in the premium rates. The rates that were presented at the last meeting assumed that the maximum subsidy would be authorized by the Board as represented in this resolution.

Lou McDermott:

2018 Medicare Premium Resolution 1: Resolved, that the PEB Board endorses the monthly Medicare Explicit Subsidy of \$150 or 50% of premium, whichever is less.

Moved. Seconded. Approved.

Voting to Approve: 6

Voting No: 0

Mary Lindquist not available via phone for this vote.

Gwen Rench: I would like to take this opportunity to say thank you for having this resolution separate from the premium. It is an advancement over the recent years.

Kim Wallace: Medicare Premium Resolution 2: Resolved, that the PEB Board endorses the Kaiser Permanente of Washington Medicare Premiums.

Dave Iseminger: I'll just remind the Board that behind Tab 3 in your Briefing Book, behind the goldenrod sheet are the same slides from last week which show the premiums. This is the premium from the first row that has a 77 cents decrease per member per month.

Connie Bergener: Board Member Mary Lindquist is trying to call in and needs assistance.

Lou McDermott: Okay. We'll hold off on the Resolution 2 vote. Let's take a recess and wait for Mary to call in. Mary, is that you?

Mary Lindquist: Yes, it's me. I'm on the line.

Lou McDermott: We're going to go through Resolution Number 2.

Mary Lindquist: Thank you.

Lou McDermott:

2018 Medicare Premium Resolution 2: Resolved, that the PEB Board endorses the Kaiser Permanente of Washington Medicare Premiums.

Moved. Seconded.

Lou McDermott: Is there any comment from the audience? Any discussion from the Board?

Betty Anderson-Till: My name is Betty Anderson-Till. I didn't have a chance to look through all of this material. How did you arrive at the 20% change in subscriber rate for the UMP Classic Medicare?

Lou McDermott: Katy, I'm assuming it's okay to go a little bit out of order?

Katy Hatfield: Yes.

Kim Wallace: Thank you for your question. Regarding how the UMP Classic Medicare Premium rate is set, the HCA consults with an actuarial firm, and we review the claims' costs, all the medical costs, that include pharmacy and prescription drugs that the plan has experienced over the past year or two. We then project what we estimate the total costs are going to be in the upcoming year. There are many, many factors that are taken into account in making those projections or those estimates. While we do not ever purport to know exactly what will happen, we do monitor our estimates carefully and watch from month to month, quarter to quarter.

Our estimates for this upcoming year are based on expected cost increases that the members in the UMP Classic Medicare Plan will have. That's based on costs for a variety of medical services and prescription drugs. Specifically, for the UMP Classic Medicare Plan, over half of the expenses that are covered by that plan, and paid by that plan every year, are actually related to pharmacy, to prescription drugs. We are seeing double digit increases in the costs associated with prescription drugs from year to year. The prescription drugs that are being covered and paid for under the Classic Plan are the most powerful driver of the cost increase. Because the UMP Classic Plan is a coordination of benefits (COB) plan, that means, with Medicare, UMP Classic pays first, we're primary for prescription drugs. With medical, Medicare pays first and then UMP Classic covers largely what is left remaining to the member. That's one of the other factors that contributes to the importance, and in this case, the negative effect of the strong increases in prescription drugs costs.

Betty Anderson-Till: May I ask another question? Does the UMP Classic Plan negotiate with the drug companies over the prices or do they just accept what they are charged from the drug companies?

Kim Wallace: We have a rebate program in place through our pharmacy benefits manager. That is a separate company that specializes in acquiring and administering pharmacy benefits. We do have a very strong rebate program that we participate in that helps us off-set some of the costs. There are a number of other cost management mechanisms that we conduct, that we administer in partnership with them as well. We're constantly looking for ways to moderate the cost increases as best we can. But, clearly, we in Washington and many other states and employers across the country are experiencing this extreme pressure with cost increases. We are looking for even more and better ways to do this in the future. But, despite the myriad of efforts, initiatives, and special programs that we have in place to help with the cost containment, we are still seeing the 10, 11, 12, 13, even 16% to 19% cost increases in prescription drugs each year.

Betty Anderson-Till: More than that in some cases. And there's nothing that can be done about that? There's nothing that we can do to help?

Kim Wallace: Well there certainly are. Dave could probably weigh in about this. There are efforts that we are all aware of that are spreading across the country. Many people are being affected by this and we do what we can as a major purchaser of these services and benefits in Washington. But we do feel that we're caught up in what is essentially a national phenomenon and it's very concerning.

Betty Anderson-Till: Thank you for your answer. I appreciate it.

Kim Wallace: You're welcome.

Dave Iseminger: You know, I did want to give a couple more pieces of context for you and everyone. One of them being that we do leverage our purchasing power with a consortium of drug purchasers. We do purchasing in a consortium with the state of Oregon and we're working on bulk purchasing and leveraging even a larger population to get the best rates that we can on drugs. Another piece is it's the specialty drugs that are part of the phenomenon with drug trends right now. We hear in the news quite a bit about new drugs that are coming out that are very targeted to specific diseases, are very effective, but impact smaller populations. They tend to have a higher cost associated with them. So, that specialty drug trend, even though it is a small proportion of members who are accessing them, it's a larger driver of part of the increase.

The third thing I would add is related to Premium Resolution Number 1 that the Board just voted on. There is a state subsidy that comes to retirees and the Legislature sets parameters for that state subsidy. That state subsidy is something set within the state budget and the Legislature is constantly reviewing that framework. The Legislature sets a scaffold by which this Board then passes a resolution for setting a subsidy for the retiree premiums. That \$150 retiree subsidy has been the same level for the last four or five years. That subsidy has remained at that level, but that is another piece when you ask, "What's something that we can do?" The framework for the explicit subsidy is established in the state budget and so that is a piece of this puzzle as well.

Betty Anderson-Till: I know people have problems paying their co-pays and I see these little cards that come in the mail where you can go and get a discount on your prescriptions. But if you have insurance, even if you can't afford the co-pay, you can't use those cards. It's a Catch-22 situation for many people who are retired that they can't make their co-pays and so it makes it difficult for them to get their prescriptions and they can't make their co-pays to go see the doctor either. It's a sad situation and I just wondered how they came to that. That's the largest increase I've had with this particular plan since I entered state service in 1963; and it's the highest increase I've ever seen, especially with all the other taxes that are coming up and salaries are not raised similarly. But thank you. I appreciate your explanation.

Lou McDermott: I'd also like to note that we have many folks who indicated they want to testify and we do have an opportunity at the end to testify. We also have an opportunity during each of the resolutions to testify. So, if you wrote your name down and you would like to testify after the resolution is read, that's fine. You don't have to come up at the end. Or if you want to save it until the end, we can do that as well. I'm assuming you folks know who you are and who said, "Yes, I want to testify." Just know you can do it at different parts of the meeting.

Dave Iseminger: I'm assuming most people probably want to testify with regards to resolution number three. If you're trying to track which resolution relates to which premiums, resolution three is likely the reason that you are here to testify.

Connie Bergener: Actually, it's four.

Lou McDermott: Any other comment from the audience? Any discussion from the Board?

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

Kim Wallace: Medicare Premium Resolution 3: Resolved, that the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare premiums.

Lou McDermott:

2018 Medicare Premium Resolution 3: Resolved, that the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare premiums.

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

Kim Wallace: Medicare Premium Resolution 4: Resolved, that the PEB Board endorses the Uniform Medical Plan Medicare premiums.

Lou McDermott:

2018 Medicare Premium Resolution 4: Resolved, that the PEB Board endorses the Uniform Medical Plan Medicare premiums.

Moved. Seconded.

Lou McDermott: Is there any comment from the audience?

Carol Dotlich: Hi, my name is Carol Dotlich and I'm a retiree and a representative of Chapter 12 which is Pierce County Retired Public Employees Group and I have about 456 members. A lot of them can't come to these meetings because they have mobility issues and serious health concerns. They can't come to meetings and speak out about how this premium increase will affect them. But I want you to know that I have members, I called some of them on the phone and said, "What's the impact on you?" I have members who have PERS1. One gentleman retired in 1992 and has been with this UMP plan all this time and it's now 2017 and he tells me he now earns less money per month than he did in 1992, and it's 2017. They haven't gotten adequate increases in cost of living adjustments.

We lobbied very hard and you brought up the subsidy that the Legislature has some control over. We worked very hard, members came to Olympia, lobbied legislators, asked them to please restore the money that they took away in 2011. They took almost \$40 away from us in 2011 when the budget was a mess. They were furloughing active people and they cut the subsidy for the retirees. Everyone else got restored; seniors never did. They took the money, they never gave it back. And this session they didn't give it back either and it was only \$30. I mean that doesn't sound like much, but it's huge when you're living on a fixed income and you have serious drug costs, and we do. The formularies change so some of the drugs that we had prescriptions for are no longer covered. They're telling people to go get it over the counter. The over the counter drugs are not the same as the drugs that they were using.

I just need you to know that this impact is very serious and very real. In my case, my husband and I will pay \$110 more a month, every month for a year. I don't have that money. I don't know where I'm going to get it from and I'm probably better off than a lot of my members, and that's frightening. When I think about the service that state employees gave through all those years, I mean we never were paid a good salary, an adequate salary for the work that we did. We were always 25% or more below the private sector market for the same jobs. We accepted that because we had good health care, and we knew one day we'd have a pension, and we thought we could retire in dignity. We're finding that's not the case. The costs have gone up for everything from hamburgers to gasoline. A lot of us still have mortgage payments. Our homes are not paid off. We can't afford \$55 extra dollars per month per person. It's not reachable for a lot of the members here. As you can see there are about fifteen people that came to say to you we don't have that money. We don't, and there must be some other way. There are a lot of people.

I got a lot of questions from the members I represent, and they wanted to know is there a disparity between the younger people's premiums and the older people's premiums? Is there an "age tax" at play in this premium increase? That's one question.

Another question is, there's been an effort to force people into Medicare Advantage Plans. There's been huge ads and there's been a big push to do that. Are you trying to get people out of the PEBB, out of Uniform? Is that sort of a goal that people have in mind to force people out of the PEBB system and into Medicare Advantage Plans where the Insurance Commissioner has no input or say about what happens with those plans? And so those are two questions I have.

I heard Betty talk about what can we do to reduce the cost? We're doing everything we can. We're trying to be as healthy as we can. We're trying to take the meds that the doctor's tell us to take, in the amounts we're supposed to, when we're supposed to; but I myself, a year ago, I was taking a med every other day that I was supposed to take every day because I didn't have \$200 extra dollars a month to pay for that and it wasn't on the formulary so I had to pay out of pocket. Then they gave me another drug that was \$300 a month and I just told my doctor that I'm not doing it. I can't do it. So, as you consider this resolution, I want you to know that it has a really severe impact on a lot of people. Thank you for giving me the opportunity to speak and if you could answer those questions about the disparity and about whether or not you are trying to force people into Medicare Advantage, I would appreciate it. Thank you.

Lou McDermott: Thank you for your testimony.

Kim Wallace: With respect to the question about a potential, possible age tax or differentiation in the way that the premiums are set and what goes into them for older members versus younger members in PEBB, there is no specific factor, or adjustment, or special extra amount of money that's added based on age. We do have, as Dave mentioned, a part of our financing approach is that we have what we call risk pools. There are two major groupings or risks, or pools of folks that we use when we look at setting our premiums and rates. There is separation for our Medicare, what we call the Medicare risk pool for those retirees who're eligible for Medicare versus the non-Medicare risk pool, which of course, is those who are not Medicare eligible. What we are doing by creating that separation is that we are measuring and tracking the costs that I mentioned earlier, the costs of all of the services, supplies, prescription drugs, etc. that these two groups of members are utilizing from year to year. We track the costs separately. As you can imagine, in the non-Medicare risk pool, the average age and the age range of the members is lower. They're a younger group.

Dave Iseminger: Kim, who is in the non-Medicare risk pool? That's state agency employees, higher education employees, and those retirees who are not yet eligible for Medicare?

Kim Wallace: Correct. Those folks under 65, who've retired but are not yet eligible for Medicare. If anyone in the room is in that group then you are included, from our financing standpoint, in the non-Medicare risk pool. There is an age differentiation, but we're very careful to assess and evaluate the costs of the care, the services, by pool; and then to do the projections and estimates that I mentioned earlier based on what we see historically happening, and also based on a number of actuarial factors; what we believe will happen for the next year, what those total costs will be over the next year. The premiums that you're seeing here for UMP Classic are the result of that calculation. It is an actuarial, mathematical - as I'm saying that, it feels like cold language and that's unfortunate. But, the calculations are very straight forward. They're complex, but it is an actuarially sound calculation of what we estimate the costs truly to be. There is no additional factor or surcharge that is added to the retiree premium.

Dave Iseminger: We manage those separate risk pools as that's the authority and framework that is set up within statute for this agency. That's why we manage those risk pools; that wasn't a discretionary decision.

Audience: Are dependents included in the non-Medicare pool? Like the youngsters and what not?

Dave Iseminger: And so the question, just so that it's officially on the record is, "How are dependents factored into the risk pools?"

Kim Wallace: The subscriber is the person who defines which pool the person is in. You may have family members on your account, but that account is in the risk pool based on your assignment.

Dave Iseminger: I think the question, Kim, is the claims and risks costs of dependents in the calculation for setting the rates in both the non-Medicare and Medicare risk pools. So yes, the claims analysis in each risk pool takes into account all the experience for all subscribers and their enrolled dependents; separately in the non-Medicare pool and separately in the Medicare pool.

And then the second question from the prior testimony was about the relationship to Medicare Advantage. I think it's important to realize that in these premiums for Medicare there is no subsidization across the plans. Each plan's premium is set based on its own claims experience and so there is not a deliberate choice one way or the other to increase the premium. I think the suggestion was that perhaps there would be a raising of the premium to push people to select other plans. The premium is set based on the claims experience for that plan independent of the others and there's no deliberate mechanism to encourage, in the Medicare plans, enrollment for one or the other. There's no such lever in the Medicare rates setting process.

Kim Wallace: Correct. I agree.

Lou McDermott: Thank you Kim and David. Carol, do you feel like that gave you the answer?

Carol Dotlich: Yes, thank you.

Rudolpho Franko: Yeah, my name is Rudolph Franko, I was a state employee for 33½ years. I retired last August and I probably won't be as eloquent as Carol was, but I do want to tell you that this affects not only me, but a lot of other retirees. We have been giving and giving, in terms of takeaways from this and that and education and we gave \$40 away a while back. We were supposed to get it back; we never did and now here we have you asking us to subsidize again the plan by paying another \$40. I really resent the fact that you are being asked to fulfil the obligation of the legislators that can't come together and fund these things in a manner that doesn't affect the people at the bottom of the scale. This happens, not just here.

It's happening in city councils in Seattle. It's happening through taxes, whatever. I'm being driven out of my house in Seattle. When I first lived there I was paying around \$1,300 in taxes; I'm paying over \$5,700 and some cents a year. It's hard to remain calm and not angry and speak eloquently when you're feeling squeezed. But, in saying that, I know that I'm speaking for a lot of people; and for you people here, I don't know how it affects you. I don't know how it affects you at all and I hope it doesn't. But, I would expect that you, as a Board, would hear that this is unjust to ask us to pay for something that clearly the Legislature ... you know, we need to prioritize where our money is going. I believe that the legislators need to do a better job of prioritizing where our money is going.

I'm not here to talk about Socialism, but I wish we'd stop that for corporate America and certainly for the state. You give them the money and they take it off to some other place. I didn't come here to say this to you. I didn't come here to berate you or anything like that. But I want you to understand where I'm coming from and I want you to understand that I'm paying \$551 right now to keep my state insurance because I got beat up pretty bad at work. I've had a couple of accidents that required that I have neck surgery. I got caught between some trees and a backhoe. The operator wasn't very good and he caught me in there, tore my sternum and all that stuff. I was in the hospital. So, I'm still suffering from that. I've had 1, 2, 3, 4, 5 surgeries; and everytime I have one of those, because I can't prove that they were at work, and every time I try to do that I have to get an attorney and I just gave up on that. So, I have to pay for that, too. It doesn't only come out in terms of premiums, it comes out in terms of my pocket.

I'd like to believe that when I was working I was doing the best job I could and I'm not here to cry foul or anything like that. I'm just telling you that it affects us. It affects us financially. It affects us financially when you have a soda pop. I don't drink soda, but you know some people at the bottom of the scale, it's the people that...I'll leave it at that. But I would hope that you turn this one down.

T Hall: Hi, my name is T Hall. I am a retiree; I am not yet 65. I retired because I got injured off the job doing union business. The 20% increase is ridiculous. Last year when I did my taxes, I had paid out-of-pocket \$7,000+ dollars. That's out-of-pocket. That didn't include my medication because, well it just didn't. I didn't have the stats there. That was just my costs for doctor visits. I opted out of the PEBB plans and went to a Medicare Advantage Plan. I saved just premium costs of over \$200 a month. The benefits are about the same. They're paying about the same. We'll pay 80%, you pay 20%; we'll pay-you pay 12%, we'll pay the rest. I mean it kind of goes back and forth. There's just not enough money in retirement to pay these dramatic increases in bills from the health care providers. The plans, I mean I understand they're not non-profit, I understand that. But just how big of a profit do they need to make? I mean really? I worked 35 years for the state and when I can get my health care subsidy cheaper somewhere else there's a big problem. There's a very big problem. Thank you.

Lisa Randlette: Hello, my name is Lisa Randlette. I am not Medicare eligible. I do have a procedural question for you in your deliberations today. Seeing that this is a resolution before you, I would appreciate a little more information about what your timeline is for the types of decisions you're making today; and also I'm wondering, in your deliberations, if you choose to not pass this resolution today, what are the options for you and how can we support you in further considering whether or not this is an appropriate increase? Thank you.

Dave Iseminger: I suspected that question might come up today. So thank you for asking it because I did think it was an important one to get on the record. I do say this with the heaviest of hearts as to where we are in our development process for benefits for 2018, the reality is the runway for 2018 benefits is at its end. In order to operationalize any other types of possible changes, none of that would be available for 2018. The reality is if the UMP Medicare Premium is not passed by the Board for the 2018 plan year, there would not be a Uniform Medical Plan Classic offering to the retiree pool. These plans are independent of each other. Those plans that are approved with the premiums by the Board will be plans that are offered for 2018. So the roughly 60,000 members that are in UMP Classic Medicare right now would either have to select another plan offered by the PEB Board, which would be one of the other plans in the premium chart, or they would be able to select a non-PEBB plan. But, importantly, if they were to elect a non-PEBB coverage, they would have to seek deferral of their eligibility for PEBB benefits which would require submitting a form indicating they're going out into the outside PEBB market to be able to maintain their eligibility; and then if they wanted to come back into the risk pool, they would have to show that they met those eligibility requirements during deferral. One of those requirements is continuous coverage. There are certain types of coverage that have been authorized to be in the outside non-PEBB world and that's the unfortunate practicalities of where we are today. If the resolution for UMP Classic Medicare was not approved, that would effectively mean there is no UMP Classic for Medicare for 2018.

Lisa Randlette: Does that mean it has to be decided today?

Dave Iseminger: The question was, “Does this decision have to be made today?” There really aren’t other levers that can be pulled to change the information in order to be operationalized for 2018. For example, some of the things that need to be evaluated by the Board for 2019 benefits I’ve foreshadowed at prior Board meetings, things like:

- Should the non-Medicare covered services that are covered by UMP Classic right now be reduced or eliminated?
- Should there be different requirements on the drug coverage within UMP Classic?
- Should there be elimination of the pharmacy benefit from UMP Classic or a reduction in some of the coverages and creation of a Part D Supplemental plan?

Those are all questions that are in the works for 2019 in response to this. But, the reality is those pieces can’t be operationalized to change the world for 2018. There’s no other information or circumstances that can be brought back to the Board with a different question. We do have to begin preparing for open enrollment and the materials to push out for retirees for open enrollment. We are at the end of that timeline.

Lou McDermott: Dave, can you talk a little bit about the RDS subsidy as it relates to the explicit subsidy and what we’ll be going for next year?

Dave Iseminger: One of the other factors that’s happening right now is that we do qualify, as the State, for an RDS refund (Retiree Drug Subsidy). Basically we get a refund because we have qualifying coverage in UMP Classic that is at least as good as, or better than, a Supplemental D plan at the federal level. Because we have that qualifying plan, we receive a refund that goes into the General Fund State account. With the explicit subsidy, we are reaching the pressure point where the state would be at risk for qualifying for that refund. There will be a broader discussion with the Legislature from the Health Care Authority about the implications of maintaining a \$150 explicit subsidy going forward and the risk of not receiving that RDS refund in the future. There is that piece that’s also in play. But, again, that is not for the 2018 plan year. That would be for 2019 plan year changes.

Gwen Rench: Can I have some clarifications regarding the deferral process? What would be the impact if a lot of people did choose to defer? Are there any grounds for denying a request for deferral?

Dave Iseminger: With the deferral option, the front end is the easier part. Gwen, somebody would fill out the appropriate form that we have on our website. We would be able to convey to our members as to what the proper form is to fill out. They indicate their intent to go out and get non-PEBB coverage and it outlines some of the criteria that they have to meet. Unfortunately, we won’t know if they meet those criteria until they ask to come back into the PEBB pool. It’s a notification as to what those requirements are to make sure the individual knows what criteria they have to meet and prove whenever they come back in. The denial isn’t on the front end for going out for deferral,

it's on the back end coming back into the pool. Someone could be denied if they have a one month break in coverage, a multi-month break in coverage, or they enrolled in a Medicaid Plan; there's very limited options for enrolling in a Medicaid Plan that counts under the continuous coverage rule in the deferral setting. They might not have the right type of coverage; and if they didn't have that coverage, then they wouldn't be eligible to come back in. The whole deferral process fundamentally was set up to be able to anticipate and manage risk on the state's behalf because some people would opt to not be in that risk pool. It's a way for the state and the agency to be able to manage and have more predictive modelling around the risks that exists in that pool.

Gwen Rench: But if 20% of the current UMP Medicare enrollees deferred, would that have an impact on the rates for those continuing?

Lou McDermott: Basically it would not because the premiums are set using the risk pool and using the claims experience that we already have. If 20% would have deferred in the fall, there's no way to go in and adjust the rates to understand that these certain people left and they have a risk profile that looks like this. As a matter of fact, if some of the healthier people were to leave, it would have upward pressure on the rates. If the average person left, it would stay the same. If the sicker population left, then the rates, theoretically, could go down. But, there's no way to make that adjustment on the fly. It would be felt in the next rate setting.

Gwen Rench: Thank you.

Greg Devereux: So, I appreciate Carol and Rudolpho, T Hall, and Lisa's comments. I find it hard to believe that there isn't any leeway in the process. We're three months away from open enrollment and it just seems to me, and I'm not shooting the messenger, Dave, but almost everything you mentioned that we're looking at for next year are things that are taken away from employees. Maybe we, in a very expedited manner, look to see if there is a way to do additional consortium purchasing right now. You know, include more entities in the state, or include folks outside of the state; do something very quickly that could have an impact this year. I can't believe there isn't any time to step back and say, "Is there something that we can do that would alleviate this kind of increase?"

Dave Iseminger: We can go into a couple of different examples. I'll choose one of them. For example, one of the ideas that could be up for discussion with the Board for 2019 is, and I know that this is a takeaway example but it's just an illustrative one from an operational standpoint, if we were to look at changing cost shares of something or eliminating some of the non-Medicare services that are supplementary to Medicare, that would fundamentally be changing the UMP Classic product. We would have to launch a new plan. The question then would be before the Board as to whether that should be for all of UMP Classic or just on the retiree side? You would have to talk about bifurcating the plans between the two risk pools and either creating a new plan or reopening the rates for non-Medicare and establishing what would be the implications on those non-Medicare rates. That's with the underlying assumption that our vendors

are able to implement and bifurcate data streams in those pieces. It starts to get complicated quickly.

Greg Devereux: I understand that this is inconvenient and it would not be easy for the Health Care Authority staff. But as you've heard from the folks, this is a critical piece in peoples' lives; and at the bottom of this is just outright greed by the pharmaceutical companies. At some point, we collectively, and we're not going to get it from D.C., have to take it in the streets everywhere, city by city, and do something to stand up to them. I don't think we're going to get it somewhere else. We have to make a statement to them to say we're not, this is ridiculous; 19 - 16% increases...it's outrageous and surely there's something we can do here in a short period of time.

Lou McDermott: Greg, one of the problems we have is that anytime we want to reduce the premiums, it's going to have an impact in other ways. Either you're going to tell people they can't have this medication but they can have this other medication because it's more cost effective and equally effective, or you're telling people they have higher cost share. That's the only way to make the premium go down. We are leveraging the largest amount of purchasing we can. We've purchased for 360,000 people on the PEBB side; and we're going to be bringing in SEBB, which is approximately another 250,000 people. That might give us some additional leverage in the market. The real lever is that \$150 subsidy from the Legislature. We have expressed to the Legislature the impact of not raising the \$150. I believe an increase was slated in the House budget, but it did not make it through to the Conference budget.

Greg Devereux: So the bulk purchasing with Oregon is not a result of decreasing folks' premiums? I mean, it's not takeaways? That is, as far as I'm concerned.

Lou McDermott: Oregon bulk purchasing is already baked in.

Greg Devereux: What I'm saying is let's take the pie out of the oven and bake, put something else in quickly and see if there's something we can do. Maybe there's not, but for 24 years I've been on this Board and this is a continuing problem. At some point we have to do something extraordinary to deal with this problem.

Lou McDermott: One of our other constraints is that the manufacturers make the medications, the FDA approves the medications, and we cover the medications, and they get to set the price. That's all there is to it. We don't get to say we're not going to pay for that. As a matter of fact, if we were just to tell drug companies that we're going to pay them 50 cents on the dollar, they would refuse to sell them to us. We would have litigation, litigation would say you must cover that, and you must pay the appropriate price for it. We've already been forced in various litigation efforts to cover medications regardless of cost.

Greg Devereux: I just heard earlier that bulk purchasing has an impact on the cost.

Lou McDermott: We are purchasing in bulk and we're getting the benefit of it. I mean to say that it could be worse is kind of ridiculous. If we were trying to do our purchasing with just our pool it would be worse.

Greg Devereux: Right. That's my point. My point is could we quickly talk to Boeing, talk to the machinists, talk to others, Microsoft, talk to other folks in the state and say is there a way to do bulk purchasing together in this state? Is there a way to talk to other states quickly and say we want to, in addition to Oregon, do bulk purchasing with you? That doesn't take anything away from folks here and then Milliman can bake that into the formula for next year.

Lou McDermott: We do purchase with Oregon now. We are in the Consortium. I don't know what those opportunities would be in order to expand the Consortium's footprint. I would imagine it's a fairly lengthy process, it's complex. People are having to give up their Consortiums that they're in. Many people are in group purchasing already, and to be honest with you, I think the drug manufacturers move that money around the country and they leverage different discounts in different areas. I don't think it matters if you're with a group that purchases for 20 million people, or 25 million people, or 16 million people. At the end of the day, I think you wind up paying approximately the same. You may have a different mix and a ratio of rebates, you may get more of a rebate on drug X and less on drug Y, but when it comes out in the end, I honestly don't think it makes much difference. I hear your concern and I hear that we want to do something. Unfortunately, the one lever that isn't a takeaway lever is the subsidy. We pressed on the subsidy and indicated what would happen if the subsidy didn't increase; and it did not increase.

Yvonne Tate: You know, Greg, I've been complaining about pharmacy costs ever since I've been on this Board, probably 20 years. It bothers me so much that the people we've elected to represent us in Washington, D.C. aren't focused on the real issues when it comes to health care. Pharmacy has been the real issue for a long time. Now I know why they're not focused on that issue; it's because our system is structured in a way that our representatives have to raise so much money to stay in office and where do they get that money from? They get a lot of it from the drug companies. We have got to find a way to change our system. What troubles me the most about all of this is you could go to Mexico or Canada and get the same drugs for little or nothing. There is absolutely something wrong with this system and it's bigger than what this Board can fix, unfortunately. But, none of that really deals with the issue that we have retirees that cannot afford these increased costs. I, myself, am retired. I'm not a part of the PEBB medical system, but I pay more for health care now that I've retired than I ever did when I was working. It just doesn't make sense. I could go on and on, but none of that is going to resolve the issue we have before us today. But, we're seeing how this bigger problem, this national issue, affects all of us on a personal level.

Greg Devereux: Yvonne, you've probably been on longer than I. So I defer to your seniority. And I do appreciate your comments very much. I don't think either that this Board can solve this problem. I do not think that. But I think creative minds, really

sitting in a room, thinking “What can we do? What alternative might there be?” That kind of percolation of brain power, that’s what will come up with something. This Board, over the Governor’s opinion, voted for domestic partners. This Board pushed transgender coverage. Neither one were easy issues; and I for one am tired of each year saying it’s a bigger problem, its big pharma, you know, we can’t really deal with it. That’s never going to end until some Boards and some people around the country take a stand and say, “Enough is enough.” We have to do something else and I don’t disagree with you. We should push hard on our elected officials in D.C. We should push on the Legislature here. But the explicit subsidy isn’t an answer either. We can keep raising the subsidy forever and big pharma is still going to get their money. We, somehow, we have to deal with that bigger issue ... it starts somewhere.

Tim Barclay: Lou, this is Tim, if I may jump in? I agree with Greg. I think as a Board we need to do something. I think it’s unfortunate that we sit here today, so late in the process, looking at a 20% increase. I feel like our hands are tied at this point given Dave’s comments and I appreciate Greg’s desire to find solutions. It has been my experience with this market, those things don’t happen quickly. What I would like to see us do as a Board is not just pass this, shrug our shoulders, and then wait until next year. I’d like to see us actively pursuing this, see the Health Care Authority actively pursuing this. And at a minimum, put this on our January agenda, as well as the topic we talked about at the last meeting, and really sit and ask the question as a Board, “What can we do to press this issue going forward,” because I agree, increasing the subsidy is a good idea and it will be a helpful thing, but it’s not the long-term solution either. So, I would just like to echo my support of Greg’s comments. I think we need to, as a Board, find a way to take a stand and make some noise. Let’s make sure we put that on our agenda and we do that.

Karen Mork: Hi, I’m Karen Mork, recent retiree and also not under this, however, it’s going to be my future. In listening to your conversations I did hear you saying, “Well, oh, we’ll have to say we can’t cover that,” and that you said that pharma is what’s really driving this. The Epipen is a perfect example of how that cost has horrendously increased. When there is another one called the Adrenaclick, which you cannot get unless the pharmacist, your doctor prescribes it because it’s a two click dispenser. The Epipen is a one click and it’s significantly lower. Has the PEBB considered fighting back these pharms and saying, “No we’re not going to even allow that?” Who picks the formulary? Can we say, no, we’re not going to pay for an Epipen, but we will pay for the Adrenaclick, which is just as good, like you were saying, just as effective? It’s just not that name. It would be significantly lower in cost. So, there’s that question.

The other question I have is, having worked in the Community Services Office (CSO) with DSHS clients for 36 years, what we see is clients who will use the ER instead. With my seniors we have the spend-down program where you have to meet a specific... I don’t know if you are familiar with spend-down? It’s basically a deductible program. Some of these people its \$5,000-\$6,000 because it’s a stupid program. No offense, I want to get rid of it. Let’s just do like HWD where you pay a premium and what they’re doing is going without their meds, going without that stuff until it becomes a catastrophic

event. Now, our medical is having to pay for a catastrophic event instead of paying \$50 a month for some meds that would have kept them away from this catastrophic event. Has the PEBB considered that making a change like this is going to stop people from going until they have a catastrophic event and then it's going to be higher costs for PEBB? So, those are my two questions.

Dave Iseminger: One is formulary; the formulary creator. Where to start on the formulary creation? There's a couple different parts of this. The way that the UMP Classic is structured at this point is all drugs that are...it's an open formulary concept and so there are a couple of different players that set up the formulary. First, Board has some jurisdiction over setting up different parameters of the formulary. Earlier this session Donna Sullivan presented about the history of the formulary within the Uniform Medical Plan; and so there are some contours within which the Board can set different parameters around the formulary; and that's one of the things that was discussed a couple Board meetings ago. Several Board members asked some questions and indicated is there a way to pilot that for 2018? As we went through those pieces, that just isn't in the cards for 2018. That is, again, part of the 2019 discussion that we'll be bringing back to the Board. Yes, Tim, it's already on the agenda with regards to retiree plan options. The other parts of the formulary are with the state Pharmacy and Therapeutics (PNT) Committee. There are various committees that review the evidence-based basis and effectiveness of various drugs, and those decisions are recommendations for how drugs are paid for once they are approved in a plan. There's a couple of different pieces that come together for creating the formulary. Is there anything, Kim, that you think can be added to that?

Kim Wallace: No, but I do want to confirm and recognize that the Board did receive information, I believe it was in April; and so there is a commitment that the Board made and the HCA staff are well aware of and have started to put into motion to evaluate appropriate and helpful changes potentially to the formulary for 2019. Again, the spot we got stuck on was in whether any of those changes could be made for 2018. We learned by consulting with a number of different people and partners that would be required to cooperate and to be able to move quickly with us in order to enact changes to the formulary for 2018, that it was not possible. That's why it was immediately put on the priority list for 2019.

Lou McDermott: Karen's second question was related to extraordinary medical expenses incurred because pharmaceuticals weren't being utilized appropriately because of cost.

Karen Mork: That's something I see where \$50 a month turns into a \$300,000 hospital bill.

Lou McDermott: The thing with this plan in particular is that it's weighted so heavily towards pharmacy and pharmacy changes have an impact. In some strange world, if everybody stopped taking their drugs and all of the costs were born on the medical side, these premiums would go way down because they are disconnected; because Medicare

is primary and they're taking care of hospital and the medical stuff. What you are talking about is a capitated world where you're saying we give the delivery system x-number of dollars and we say do good things, take care of these patients, take care of our members; and therefore, it's in their best interest to make sure they're maximizing their efficiency so that they're using pharmaceuticals appropriately, they're using the medical stuff appropriately, they're using hospital care appropriately, and they're trying to stay below a bottom line. We are trying to implement that through our accountable care product for active state employees. We went live January 1, 2016 and we're monitoring that program. We're trying to determine:

- How well is it working?
- What are the outcomes?
- Are people getting better care?
- And, if that's the case, how do we spread that through other products?

We have fully insured products and we have our self-insured product. Unfortunately, our self-insured product is a wide-open Preferred Provider Organization ((PPO) which allows people to do what they want to do; go to the ER when they want, whatever they want to do. We are going in that direction, but it takes time to evaluate these programs and to spread them to other products.

Greg Devereux: There have been a number of references to the earlier discussion with the Board regarding the formulary. As I remember it, that discussion started with talking about a closed formulary and that makes the hair on the back of my neck go up, to start with a closed formulary. I see takeaway right away. I don't have any problem talking about formulary, and I think I told you that at the time, Lou, and I will be very active in that process. I think we should look at these drugs and see if there are alternatives and other ways to do things; but I just want to note that I remember it as a discussion about a closed formulary and I think that's not the best way to start that discussion.

Lou McDermott: I think that closed formulary is a typical description that's used to say you're not going to cover certain things, but you're going to cover other things. I think at the end of the day we don't want to go to a system where we're just saying, "For these conditions it's one medication, and for another condition it's one medication." We have members on anti-seizure medication, we have cancer medications; we have a lot of different medications and therapeutic classes. What we do what to do is address the Epipen-type issues within. Now, are there enough of the Epipen issues within the total dollars to have a substantive impact on the rates? That analysis is complex, a heavy lift, and being undertaken by our pharmacists and our Pharmacy Benefits Manager (PBM). There are over 20,000 members who are taking medications.

When you have a certain condition, there are multiple medications. We have a lot of members who are taking the higher cost medications, so back to Greg's point, we don't want to just slam the door and say tomorrow you get a letter in the mail that says you're no longer allowed to take this. The trick is how do we implement something like that where it makes sense; where we say to the Epipen, we're not going to do that anymore

because that's crazy; paying \$600 for an Epipen, we're going to do the alternative. If there's a medical reason why that alternative doesn't work, then you can use the primary medication. There's a lot of complexity there. I think closed formulary is not an accurate description of what we want to do. I think it's something for people to recognize that it's just not a wide open formulary anymore.

Kim Wallace: I want to confirm that when I mentioned the earlier presentation by Donna Sullivan, it absolutely included alternatives or different scenarios that are not a completely closed formulary. When I referenced the thinking, the work and the analysis that HCA staff are teeing up with respect to changes in the formulary, it is absolutely not limited to a closed formulary solution.

Greg Devereux: I understand that, but as I remember it, the words "closed formulary" were on the page.

Kim Wallace: Yes, it was, and hybrid formulas as well.

Greg Devereux: Yes, but words matter.

Kim Wallace: Yes, I acknowledge that.

Denny Johnston: My name is Denny Johnston. I'm a retired public employee living here in Olympia. I just wanted to say that the people's comments so far have been excellent. I think by now you are fully aware, if you weren't already, of the pain this is going to cause people. I particularly enjoyed Mr. Devereux's comments. I appreciate your distaste for the use of the word "can't" because I think we can always do things. I think we need to do more though. When we ask people for a rate increase such as this I believe we have a moral obligation to do everything possible to mitigate that increase; and to go a little bit further down the road than Greg went, I think we need to look long range at this. Years ago we declared war on the illegal drug trade and I think it is time that we declare war on the legal drug trade. Pablo Escobar, in his wildest dreams, could not imagine what the pharmaceutical industry has been able to do. If he were still with us he would look upon it with envy and say, "Why didn't I think of that?"

Other states are much more active, perhaps, than we are. California had an initiative last year that failed at the ballot, but it would rein in the pharmaceutical industry. The pharmacy industry had to spend \$102,000,000 to defeat it compared to \$19,000,000 for the proponents of that initiative. Ohio is considering something along the same lines. California is pending a Senate Bill 482 which would establish a state monitoring system for prescription drugs, take away the heavy-duty opiate drugs, prevent doctor shopping, and other things like that. Other states are involved here, including here in Washington, Everett and/or Snohomish County has filed suit against Purdue Pharmaceuticals for basically pushing hard-core pain drugs on its population. We can go anti-trust suits, legal pressure, bulk purchasing, and negotiating. I appreciate what we do in that regard already. There are four states that have caps on drug co-pays for those people who haven't exhausted what they are obligated to do for out-of-pocket expenses. I think

when I say we have a moral obligation, I think I do, I think the Health Care Authority, the PEBB, the Governor, the Legislature, the Attorney General's office, and many others need to work in this effort of perhaps not on this particular increase here, but on increases that we're going to experience down the road if we allow things to continue as they have gone. I could go on. Thank you.

Lou McDermott: I think we need to get you down to the Legislature to testify. I think that was excellent.

Tom Ripley: Hi, I am Tom Ripley, a retired public employee. Both my wife and I went into service of the state to, as with our own, because of social commitment. We've worked hard and she a retired teacher. I've retired from DSHS Children's Services and what I find at this point is that we're really heavily burdened with our own medical expenses for drugs and for other things, and this is another add on that makes it more difficult for us. When I retired from DSHS, at that point we had not had a raise for the better part of a decade and that affected my retirement amount, of course, and my wife had also not seen much in the way of increases. That also reduces our financial abilities to pay things. It's just a hard thing to swallow to see a 20% increase at this point. I don't know where the money will come from quite honestly. I appreciate what you do to work on that. I think that we, you know, as we've been committed to social justice, I know that you folks are too, and I hope that you will work your best to figure out a solution to this so that we're not faced with the same situation year after year, decade after decade. The one question I did have, is obviously the large increase here is with Uniform as opposed to Kaiser. I would like an explanation why we have such a large increase in Uniform and why is that much more than Kaiser? Thank you.

Kim Wallace: Thank you for your question. I can share that while we don't have all of the details on the rate development assumptions that go into the final proposed rates and negotiated resulting rates with Kaiser Permanente of Washington and Kaiser Foundation Health Plan of the Northwest, what we do know is that we negotiate hard to do everything we possibly can to maintain flat premiums every year. One factor that plays into their rates and premiums that is very different than with UMP Classic is that they receive, because of the type of Medicare plan that they are offering, Medicare Advantage Plans, they do receive a set amount of money directly from CMS, a subsidy from CMS that goes into their consideration and it's a sizable amount of money, several hundred dollars per month; and so that CMS subsidy and all the rules in the setting of that amount, together with \$150 Medicare explicit subsidy, together with the amount that's paid by the retiree directly, is the amount of money that they are actually receiving to offer to run their plan and to offer their plan. It's a fundamentally different financial scenario than the Uniform Medical Plan Classic COB plan that's self-insured by the state.

Katy Hatfield: I heard someone asking quietly in the audience, "What is CMS?"

Kim Wallace: The Centers for Medicare and Medicaid in the Department of Health and Human Services in the federal government. Basically, the headquarters, the

administration, administrative body that runs Medicare and Medicaid and it's shortened to CMS rather than CMMS.

T Hall: I just have one question. What happens if you don't endorse? You're basically hearing from us we don't want you to endorse it. So what happens if you don't endorse it?

Lou McDermott: Basically, the product would not available for 2018.

T Hall: The whole Uniform Medical Plan would go away?

Lou McDermott: That particular product goes away. Not the the Uniform Medical Plan as it relates to active employees, but this particular product for retirees would not be available for 2018.

Dave Iseminger: And for the record, the question was, "What would happen if this resolution were not passed by the Board?"

Lou McDermott: Other questions or comments from the public? From the Board?

Greg Devereux: I guess sometimes it seems to me that when there is a crisis answers are born from that crisis. I understand what it would mean to vote it down, but I wouldn't mind the opportunity to go to Governor Inslee and say let's really think about is there anything we can do quickly that would change this outcome and make it a real focus of the administration?

Lou McDermott: I guess my thought is it's not one or the other. It can be both. We can carry the resolution and we can still approach the Governor. All of the testimony that's been given today has been recorded and will be transcribed into a document which the Board will approve as minutes and we can bring that forward to the Governor and key legislators for review.

Yvonne Tate: I just wanted to say, speaking for the Board, I'm sure we really appreciate having you all here. Your public comment to us helps enrich our decision making. Our meetings are always open to the public and I would invite you to come any time you choose because we are deciding on your behalf. It is very, very helpful to hear from you. Thank you.

Gwen Rench: I will be voting no as this increase harms retirees with limited income and I feel like it enables the excessive profits of the pharmaceutical industry; and because of those two reasons, and the fact, of course, no cost of living increase for people of limited income for many years, I feel obligated to vote no.
(Applause)

Myra Johnson: As a non-voting member on this Board, I would like to piggy-back what Yvonne said and I thank all of you who've come in and testified today. I will be retired

one day soon, probably, and so I do appreciate where you're at because I will be there. I also know that as a member of this Board, while I may not vote, your words are definitely heard and I truly believe that everything will be done to make sure that hits like this aren't taken lightly. I think times are hard. I work in the school district, and so I understand not having a cost of living. I too bring home less than I used to. So, it's real and we do hear you. I'm not sure how this vote will come out, but please be assured that your words are not taken lightly and it will be negotiated and talked about with this Board and the work that the HCA does. So, thank you for your comments.

Dave Iseminger: Lou, I did just want to add for the record that it's not typical that we get a lot of correspondence to the Board that is directly lobbying the Board for one action or another. Usually it's questions that the staff can answer and then give a copy to the Board as to how the staff responded. I did want to note for the record that in the last 48 hours, there were four different emails sent to the Board Correspondence Mailbox that were more directive, please vote no. I wanted that to be noted for the record that there were a few that came in over the past couple of days in addition to the people that have come today.

Gail McGaffick: Thank you, Mr. Chair. Gail McGaffick. I'm a PEBB subscriber through my husband who is retired. Thankfully, I'm not retired because of these sorts of increases, but I want to say this. I think you're in a really tough place and I would not like to see the UMP Classic Medicare go away. I do not want to be a part of Kaiser. I do not want to be a part of a Medicare Advantage Plan. Having said that, I know you're in a tough place. What I would like from the group because you landed in this place because you started talking about it in April. I'm kind of curious about how your meetings go. Having said that, I'm super impressed with all of you; how well you listen, how you conduct your meetings. As a lobbyist myself, I sit in a lot of meetings and I'm just so impressed with how you do business.

I would like to suggest that this issue is so big and so important that you not put off until January talking about this. That you revisit how you schedule your meetings and perhaps look at what kinds of things you can tee up now to be sure you are well prepared to do the type of work that Greg, Yvonne, and Gwen, I mean all of you have, pardon me if I say your first names, that all of you have talked about. I mean it really is time, I think, to look at different solutions here. I mean this is not tenable; but having said that, at the end of the day, I still, I guess I'm speaking as someone who would still like this plan over the others as bad a choice as it is, and I mean for the large increase in premiums. So, that's what I wanted to say and I thank you very much for listening.

Greg Devereux: I agree with Gail. I would not want to see the Uniform Plan not available this year. I think voting it down today doesn't necessarily mean that it has to go away this year. I can't believe there isn't some leeway in the process that would give us some time to look at alternatives.

Carol Dotlich: I'm Carol Dotlich. I have a question. I don't know how the vote will end up among the Board members, and I don't know how far the testimony given today will

travel. So my question to you is, you've had quite a turnout to this meeting. Obviously people are very, very concerned about what is going on. Will somebody be relaying the objections to the insurance company? And let them know how very unhappy we are about a 20% increase? Will there be some message to UMP to let them know that this is damaging to us?

Lou McDermott: The strange thing in this case is that we are UMP. It's a self-insured plan.

Carol Dotlich: Oh. (laughing)

Lou McDermott: So we have told ourselves about this. (Laughter) We are not happy, and I think this gets back to the Board's schedule and the rates; and without going into excruciating complexity, some of the issues we have is that it takes a long time to implement a change. A change in our plan normally takes about 18 months. There's also rate setting activities which are done on an annual basis. There's a legislative process which occurs every January. It's all a delicate balance between the Governor's office, the Legislature, the claims experience, the rates setting, and the timing that those things happen in. Part of the problem is that we don't know there's a problem until we start getting into rate season, until the numbers start coming in and we start looking at that experience. You can't look at January 1 and say how did last year go? You have to wait until March, April, and May to wonder how last year went.

Carol Dotlich: If you called, my house, I'm happy to tell you how last year went.

Lou McDermott: I understand. On an aggregate basis with the population, a little more difficult, and so part of our issue has been that there is a delay in action occurring because of these cycles and when people do their thing. When the Legislature comes to town, when they produce the budget, when we begin to evaluate the rates, when we begin to evaluate new ideas for plan design changes; and so unfortunately, there is a lag in that whole process. This year when that experience came in and we discovered there was going to be a large increase, I can let folks know we didn't just say okay, well, I guess that's how it is. We worked all of the avenues we felt were available to us. We communicated clearly with the Legislature to indicate the impact of the change. We did a lot of activities to try and offset the increase and we were unsuccessful. It was a brutal legislative season and they almost didn't get out of town with a budget. They had the McCleary Decision over them. They had a lot a financial issues they were dealing with; and so unfortunately, they did not resolve this issue with one of the levers that is available.

Carol Dotlich: I would like to leave you with one word. I watched the news more than I used to since it's available to me and there's a program, I think it's "The Last Word of the Day," and I think the word you used is perfect for us to share with you and that word is "excruciating" because this is financially excruciating.

Lou McDermott: I understand.

Carol Dotlich: Thank you.

Lou McDermott: Thank you. Would anyone else like to say anything? We will do a roll-call vote on this resolution.

2018 Medicare Premium Resolution 4: Resolved, that the PEB Board endorses the Uniform Medical Plan Medicare premiums.

Moved. Seconded. Approved.

Voting to Approve: 5

Voting No: 2

Yes: Tim Barclay, Mary Lindquist, Yvonne Tate, Marilyn Guthrie, Lou McDermott

No: Gwen Rench, Greg Devereux

Lou McDermott: 2018 Medicare Premium Resolution 4 passes.

I voted yes, but I will commit to working with the Governor's office and our Legislature so that they fully understand the impact of their decision, the impact of the pharmaceutical increase, and the impact to our members. I will provide them with the testimony that was given today.

Kim Wallace: 2018 Medicare Premium Resolution 5: Resolved, that the PEB Board endorses the Premera Medicare premiums.

Lou McDermott:

2018 Medicare Premium Resolution 5: Resolved, that the PEB Board endorses the Premera Medicare premiums.

Moved. Seconded. Approved.

Voting to Approve: 7

Voting No: 0

Lou McDermott: 2018 Medicare Premium Resolution 5 passes.

2018 PEB Board Meeting Schedule

Dave Iseminger: There is one slight change on this schedule from what I presented a week ago. A June 7, 2018 meeting was added to the list. As we've been talking about all the work before the Board and the delicate conversations that we need to have, we wanted to build in some extra flexibility, pre-planned, for having more discussions during the procurement season. So we added that date to the agenda. I will highlight because this question and the topic was breached during the testimony a little while ago. These are just the pre-planned regularly scheduled meetings. This does not mean that, if necessary, the Board can't be called for a special meeting. The Open Public Meeting Act does have a mechanism to have special meetings. It just requires additional

notifications and pieces to have additional meetings of the Board. These are just the pre-planned meetings of the Board that make us all aware of the dedicated times that we're already thinking we need to meet. But if there is the need, the desire, and issues pop up, we can have the Board meet additionally. I just wanted to highlight that in addition to these regularly scheduled meetings.

Lou McDermott: It's the time for public comment if. Is there anyone that feels like they would like to testify and didn't get an opportunity?

Gail McGaffick: Mr. Chair, I would like to testify.

Lou McDermott: Absolutely, come on up.

Gail McGaffick: Thanks again, Mr. Chair, committee members. Gail McGaffick. You may recall a year ago I called you up and wondered about the increase in this same plan and my question was around the fact that I didn't think there was very much information in the explanation that went out to members as to why there was an increase. I guess what I would like to suggest is two things: one is to increase the amount of information that goes out so that people understand exactly what's going on, what's driving the increase; and then the other piece is I'm really a big believer in maximum information out to people and education about what they can do. I think the Epipen example was a really good one. One that I didn't know about because thankfully, knock on wood, I don't need to buy one. But I wonder if there could be some sort of outreach by PEBB to people really educating them and informing them about medications, about different choices, maybe even about here are the questions you should ask your prescriber because I think we all need to be more empowered in this. I think you all play such a special role because of the HCA and all the staff you have and your pharmacy benefit manager, all your specialized expertise, so I would just like to encourage more information and more outreach to help teach all of us how we can be as responsible as possible, and to not take anything from all of the other suggestions about dealing with pharmacy costs but...

Lou McDermott: One of the initiatives that we're embarking on is the health literacy initiative.

Gail McGaffick: Wow, I love that.

Lou McDermott: We are trying to communicate with members. We're in a little bit of a predicament sometimes because we are the employer as well.

Gail McGaffick: Sure.

Lou McDermott: And we don't want members feeling like we're looking over their shoulder knowing what medication they're on, making suggestions to them; but we do want members to understand that there are other therapeutic options that could be far less financially burdensome. It's walking that fine line. For every call we get for

someone being thankful that an alternative was suggested, we get a similar call asking, "Why are you looking at what medications I'm taking and why are you contacting me?" So it is a fine line. I do think it's something that we may just have to take more of a risk and on the side of getting people upset. Informing people of these things, Epipen is a great example of that.

Gail McGaffick: Well, I hadn't even really thought about it from that kind of drill down level into one individual. I can certainly see the push-pull of that. I was thinking of it actually a little more globally because I was taken with the comment that one individual made on one type of pill. \$200 a month and her physician wants to give her one at \$300 per month. Well, what are the kinds of questions we could all be teed up to ask in those types of situations and how might we be able to do research or get more information. Just kind of more in that generic sense of places to go, maybe a web page, assuming there's so much online now. I appreciate you listening; and again, I had the privilege of sitting in about four of your meetings and have just very much enjoyed it and I'm so impressed with how you conduct your business. Again, I'm so grateful that my husband went to work for a community college and I got to be covered under this plan. Thank you so much.

Lou McDermott: Thank you for your comment.

Betty Anderson-Till: I would like to ask one more question. The Insurance Commissioner's Office has a program where the people come out and speak about the benefits, explain everything. Do you work in connection with those people so that you get stories along the way so that you can let the Governor's Office know about what's going on as far as health care and all the problems that they see every year? Because we certainly see a lot of them and decisions that are made that make absolutely no sense.

Lou McDermott: We do have numerous Benefit Fairs we run every year around open enrollment.

Dave Iseminger: We do between 20-25 Benefit Fairs throughout the state.

Lou McDermott: At Benefit Fairs we get an opportunity to interact with our members. We also, because we're all state employees, get the stories from our friends, family, and each other. We all talk to each other. We all work in the same building with folks who administer the Medicaid program so we hear from them. We get complaints that come in, the retirees who call in those complaints are logged and so we keep track of them and try to prioritize those issues. We know how many complaints we get and on what topics. Maybe our website isn't clear; maybe this information hasn't gone out? We do try and collect that information and do something productive with it.

Betty Anderson-Till: Do you collect it from the Insurance Commissioner's Office? I heard a presentation they gave and they have a rather unique approach to things.

Some of the problems they've run into and the things that they've dealt with is very impressive and I think they're a good group to work with.

Lou McDermott: We do have meetings occasionally with the OIC. Maybe we can bring that up with them and ask them to have some of those folks talk to us.

Betty Anderson Till: Thank you.

Greg Devereux: I just want to follow up to Gail McGaffick's earlier comment about how this is so important we shouldn't wait until January. I'm not a proponent of more meetings, but I really do think pharmacy is at a critical stage and we can't keep saying we can't do it by ourselves; we can't do anything. I think we really need to dig in and think about what we can do with other folks to make a difference and waiting until January might not be a good idea.

Dave Iseminger: I think it's fair to say as we're diving into different pieces and to be able to present to the Board, it's not, with all diligence, and if there's the ability to call a special meeting and we feel we have enough information to be able to begin that next stage, then we'll certainly consult the Board to convene a special meeting.

Lou McDermott: I think it's fair to say that we have already started work on 2019. As we finish up the vote for 2018, the work already begins on 2019. The work groups are formed, the analyses are being done, the legal impacts are being identified. So all that work is being done. It's sort of pre-packaged and ready to go for the January Board meeting. But, if we want to have an earlier Board meeting sort of mid-flight and talk about where we are on those things, we can definitely share that with the Board. I think we can make something happen in that arena.

Other comments from the Board? Last chance audience? This is our final Board meeting for this season and next year's schedule is in the notebooks. Our next planned meeting is at the retreat on January 31, 2018. The caveat is we may have some fall meetings prior to the Governor's budget going in that's where we put a lot of the cost implications for changes that we're going to make going to the Governor's budget and we'll see if we can have a meeting prior to that.

Meeting adjourned at 3:20 p.m.

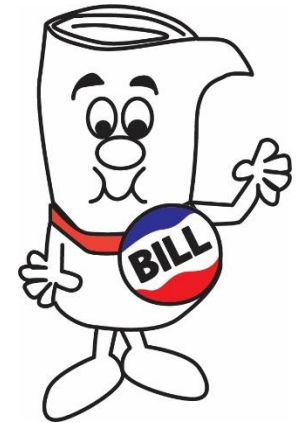
TAB 4



Legislative Update

David Iseminger, Director
Employees and Retirees Benefits Division
March 21, 2018

Number of Bill Analyses by ERB Division in 2018

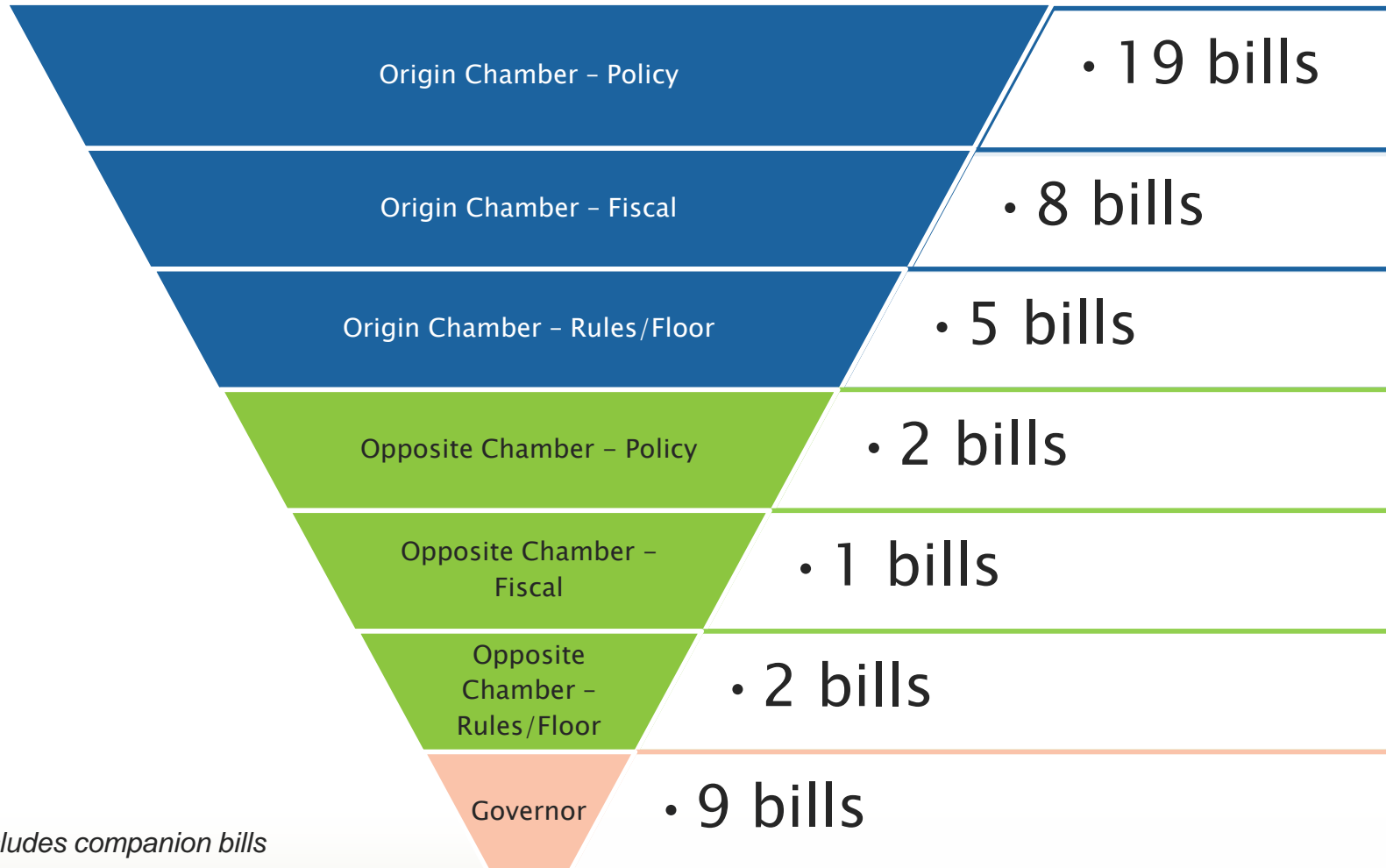


	ERB Lead	ERB Support	
High Impact	52	84	136
Low Impact	44	26	70
	96	110	206

There are also several bills originally introduced in the 2017 session that have significant 2018 session activity

Final Analysis Information for the 2018 Session

Legislative Update – ERB high lead bills



Excludes companion bills

PEBB Program Impact Bills

- ESHB 2408 - Preserving access to individual market health care coverage throughout Washington State
- ESSB 6214 - Allowing industrial insurance coverage for posttraumatic stress disorders of law enforcement and firefighters
- ESSB 6241 - Concerning the January 1, 2020 implementation of the school employees' benefits board program

Benefits Bills

- 2SSB 5179 – An act relating to requiring coverage for hearing instruments under public employees and medicaid programs
- ESSB 5518 – Requiring fair reimbursement for chiropractic services
- SB 5912 – Concerning insurance coverage of tomosynthesis or three-dimensional mammography
- SSB 6219 – Concerning health plan coverage of reproductive health care

2018 Supplemental Budget Update

- \$916 State Funding Rate (per employee per month)
 - Adequate to maintain current level of benefits
- \$168 Medicare Explicit Subsidy (per Medicare retiree per month) for calendar year 2019
 - Increase from current level of \$150 per month
- SEBB Program admin funds are now a GF-state loan
- The Board may adopt a virtual diabetes prevention program and adjust the UDP dental crown replacement waiting period

Full Funding for All Decision Packages

- Enrollment Growth in UMP – Administrative Increase (\$8.7M)
- PEBB Program Customer Support (\$274K and 2.0 FTE)
- PEBB Program Medicare Portfolio Evaluation (\$169K)

Questions?

David Iseminger, Director
Employees and Retirees Benefits Division
David.iseminger@hca.wa.gov

TAB 5



2018 Open Enrollment Summary

Renee Bourbeau, Manager
Benefits Accounts Section
Employees and Retirees Benefits Division
March 21, 2018

Open Enrollment Engagement

Benefits Fairs and Messaging

- 22 benefits fairs conducted across the state
 - 8 benefits fairs in eastern Washington
 - 14 benefits fairs in western Washington
- Approximately 2,100 attendees at these fairs
- Health plans and vendors participated at the benefits fairs
- Six GovDelivery email messages distributed to employees' personnel, payroll, and benefits offices at Open Enrollment

MyAccount

- Access from **www.hca.wa.gov/pebb**
- Redesigned for mobile in November 2017
- Increased use of *MyAccount* for open enrollment change rather than paper form
 - In 2017: 79.4% open enrollment changes made online out of 8,700 plan changes
 - In 2018: 86.4% open enrollment changes made online out of 10,811 plan changes

Public employee benefits

Information for... 

Forms & publications

News

Wellness

PEB Board

SEB Board

Rules & policies

Contact

My Account 

 [Preparing for retirement](#)


 [School employee? Find out about SEBB.](#)

 [For Your Benefit newsletter](#)

Open Enrollment Engagement

E-Subscription

- Increased E-subscription:
 - 2015: 22% subscribers signed up (42,781 subscribers/out of 193,188)
 - 2016: 28% subscribers signed up (55,785 subscribers/out of 199,068)
 - 2017: 29% subscribers signed up (58,862 subscribers/out of 203,851)



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

PEBB/My Account login

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

Returning member login

Email Address

Password

[Log into My Account](#)

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

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

Actions you can take using My Account year-round

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

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

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

Open Enrollment Engagement

- My medical/dental coverage
- My life/LTD coverage
- My attestations
- My login information

2018 medical and dental coverage information

 Statement of Insurance

Use this page to perform the following actions:

- Review your current account information and coverage selections
- View your Statement of Insurance
- Subscribe or unsubscribe from email notifications
- **During open enrollment:** Review/change your enrollment

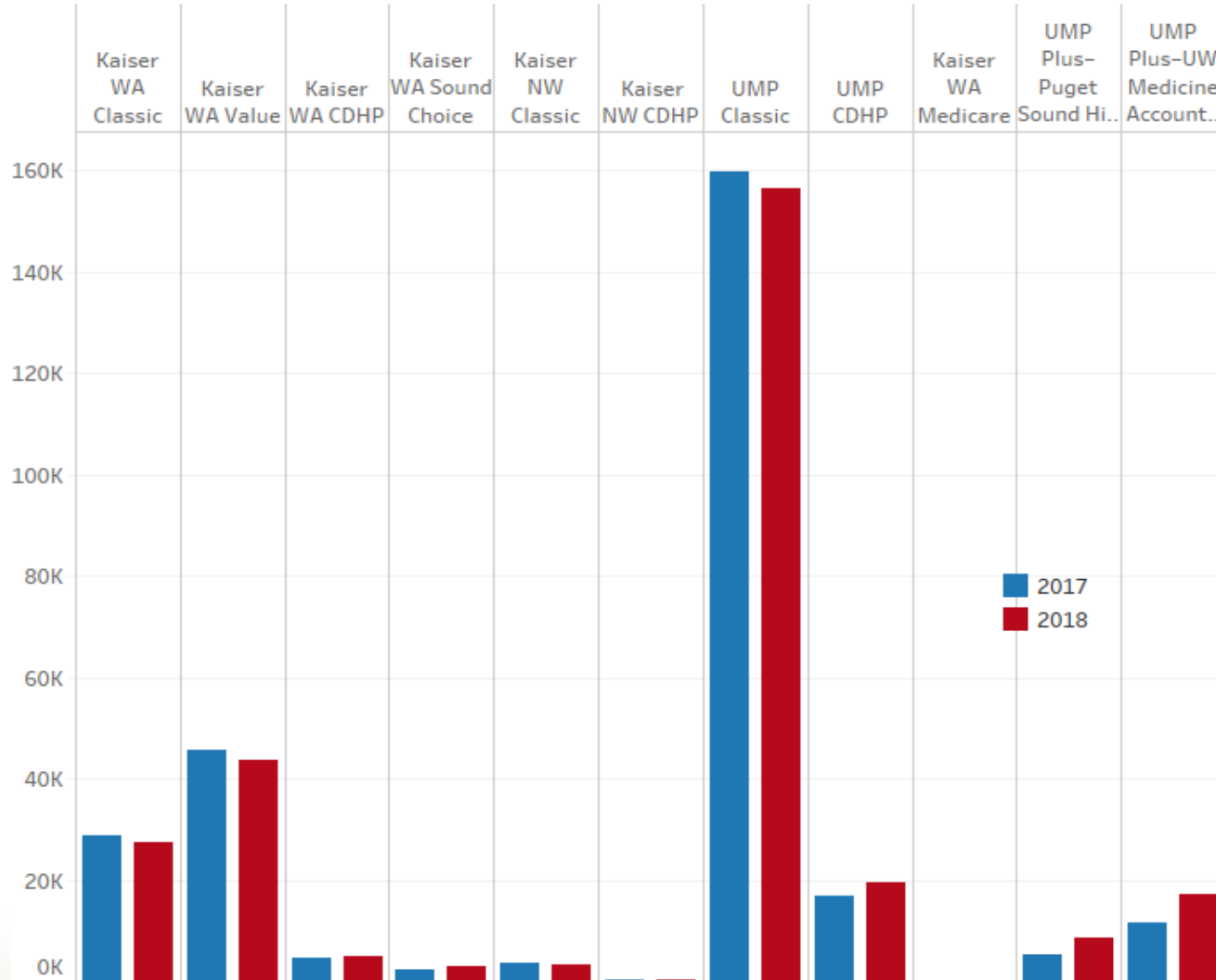
Section A - Subscriber account information

Subscriber name: PEBB Subscriber
County of residence: Pierce
Email address: Not on file [Subscribe \(or unsubscribe\) to email notifications](#)
Change of address? Notify your personnel, payroll, or benefits office.

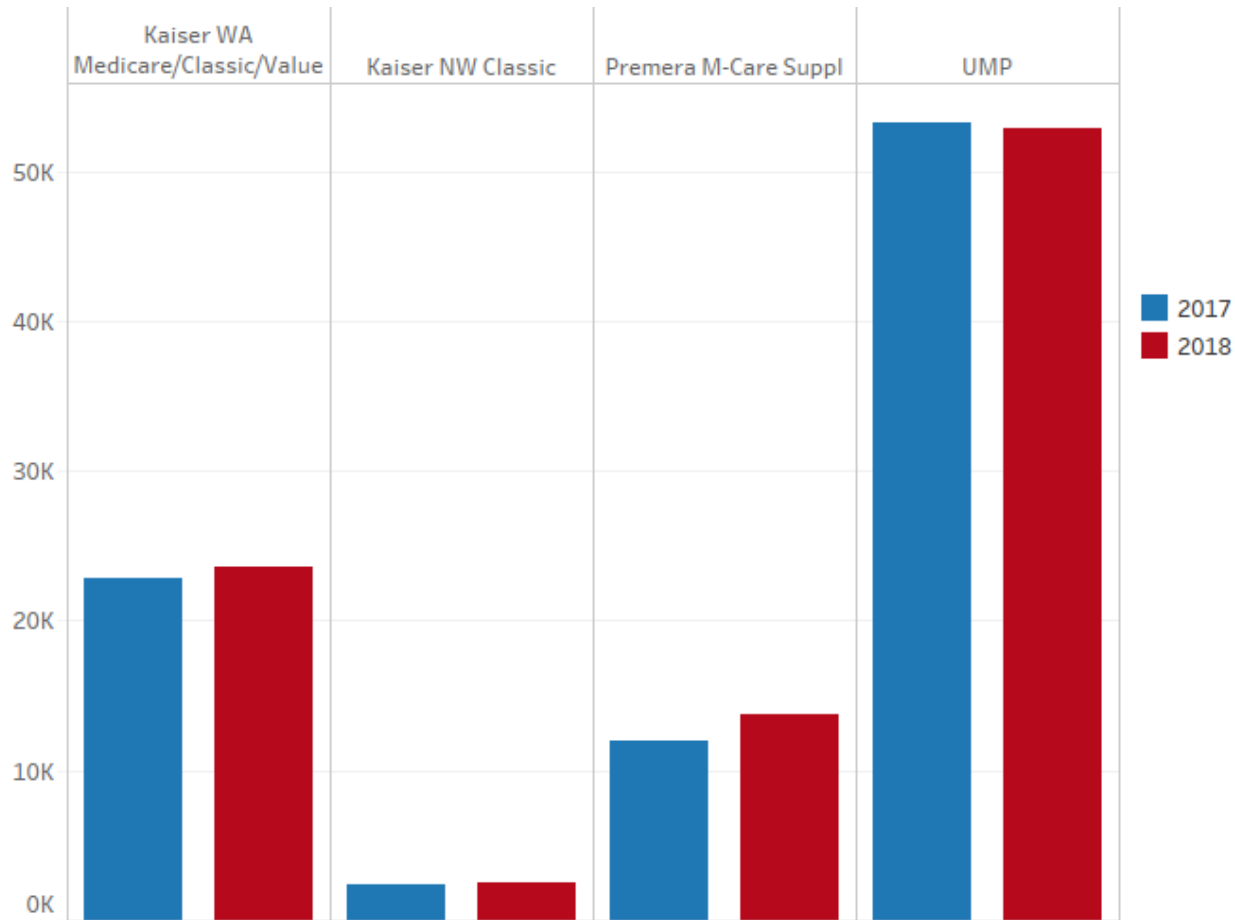
Current medical plan: UMP Plus-UW Medicine ACN
Medical premium: \$45.00
Tobacco use surcharge*: \$0.00
Total: \$45.00
**Surcharges are in addition to the medical premium.*

Current dental plan: Uniform Dental Plan
Dental premium: \$0.00

Employees and Non-Medicare Retirees (Member Count)



Medicare-Enrolled Retirees (Member Count)



PEBB Enrollment Changes 2017-2018

Members/Non-Medicare Retirees

	Jan. 2017	Jan. 2018	Change	% Changed	% Total Members
Kaiser WA Classic	28,824	27,390	-1,434	-5%	10%
Kaiser WA Value	45,847	43,609	-2,238	-5%	15%
Kaiser WA CDHP	4,419	4,973	554	13%	2%
Kaiser WA Sound Choice	2,275	2,924	649	29%	1%
Kaiser NW Classic	3,560	3,408	-152	-4%	1%
Kaiser NW CDHP	407	462	55	14%	0%
Uniform Medical Plan Classic	161,641	157,746	-3,895	-2%	55%
Uniform Medical Plan CDHP	16,601	19,536	2,935	18%	7%
UMP Plus–Puget Sound High Value Network	4,935	8,545	3,610	73%	3%
UMP Plus–UW Medicine Accountable Care Network	11,190	17,172	5,982	53%	6%
Kaiser WA Medicare	9	7	-2	-22%	0%
Total Members	279,708	285,772	6,064	2%	100%

Medicare Retirees

	Jan. 2017	Jan. 2018	Change	% Changed	% Total Retiree Members
Kaiser WA Medicare/Classic/Value	22,608	23,590	982	4%	25%
Kaiser NW Classic	2,397	2,472	75	3%	3%
UMP	52,446	52,844	398	1%	57%
Premera Blue Cross Medicare Supplement Plan F	11,595	13,697	2,102	18%	15%
Total Members	89,046	92,603	3,557	4%	100%

Customer Service Relations

1-800-200-1004 Retiree Line:

- August-October 2017: 25,455 calls received
- November-January 2018: 45,967 calls received

Strategies implemented:

- Use a workforce management tool
- Offer other ways for customers to contact us with questions (secure email)
- Update members' accounts while on the phone when possible
- Offer overtime
- Use rolling messages and FAQs menu on the phone system as self-service options
- Implemented a call-back feature and redesigned phone menu in May 2017
- Researched what other vendors are doing after open enrollment

New strategies the agency is considering:

- Hiring additional staffing
- Offering extended hours for phone coverage
- Using retirees or additional agency staff to help at peak times
- Offering in-house workshops, online tutorial, and video on "How to fill out the Retiree Form"

Questions?

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

Renee.bourbeau@hca.wa.gov


Tel: 360-725-0823

TAB 6



NW Prescription Drug Consortium

Ray Hanley, Director
Prescription Drug Program
March 21, 2018



Purpose

State-backed innovative pharmacy program designed to meet the broad and unique pharmacy benefit needs of both public and private Washington entities

- Established by the Legislature in 2005
- Participation is mandatory for state agencies that purchase prescription drugs directly unless they demonstrate they can achieve greater discounts by using another purchasing mechanism
- Open to local government, private sector businesses, labor organizations, and individuals, total current participants ~1 million across two states
- Services administered by Moda Health, a health insurer based in Portland, Oregon

Outline

- I. Background on NW Drug Consortium
- II. NW Consortium service offerings:
 - Group Pharmacy Benefits Management
 - NW Consortium Group “Value Proposition”
- III. Pharmacy Discount Card
- IV. Market expansion and growth

History

2005

WPDP was established by the Washington State legislature.

2006

WPDP joined with the Oregon Prescription Drug Program (OPDP) to form the Northwest Prescription Drug Consortium to pool drug purchasing and bring the best price to participants.

2007-08

Moda Health selected to administer the Consortium program and expand participation. Consortium wins UMP business with better prices than incumbent Pharmacy Benefit Management (PBM) vendor.

2010

Consortium expands scope of services with new RFP to include Medicaid, Medicare, Group Purchasing Organization (GPO), and 340B programs. Moda Health selected to administer program.

2016

Specialized and customized service offerings to Consortium allows WPDP and OPDP to extend current agreement with Moda Health through 2021.

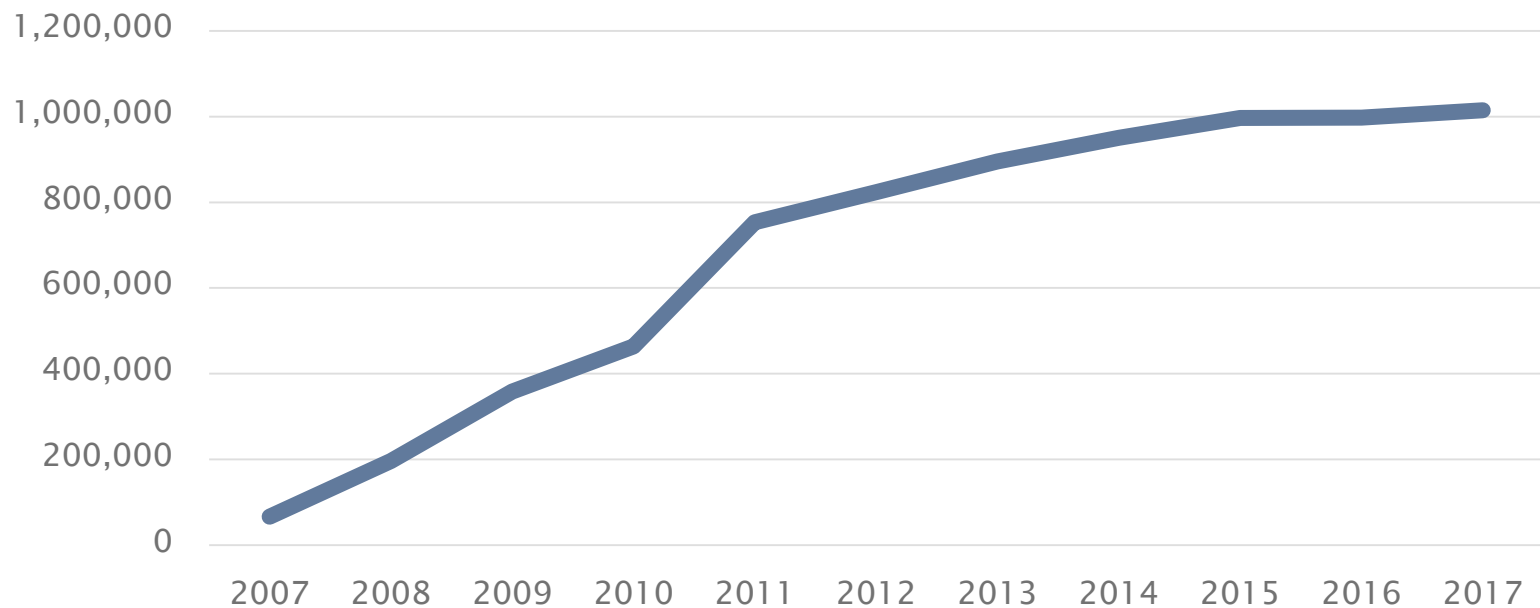
2018

WPDP facilitates more than \$800 million in annual drug purchases for over 1,000,000 people in participating groups and facilities.

Success

More than a decade of continued and sustainable growth

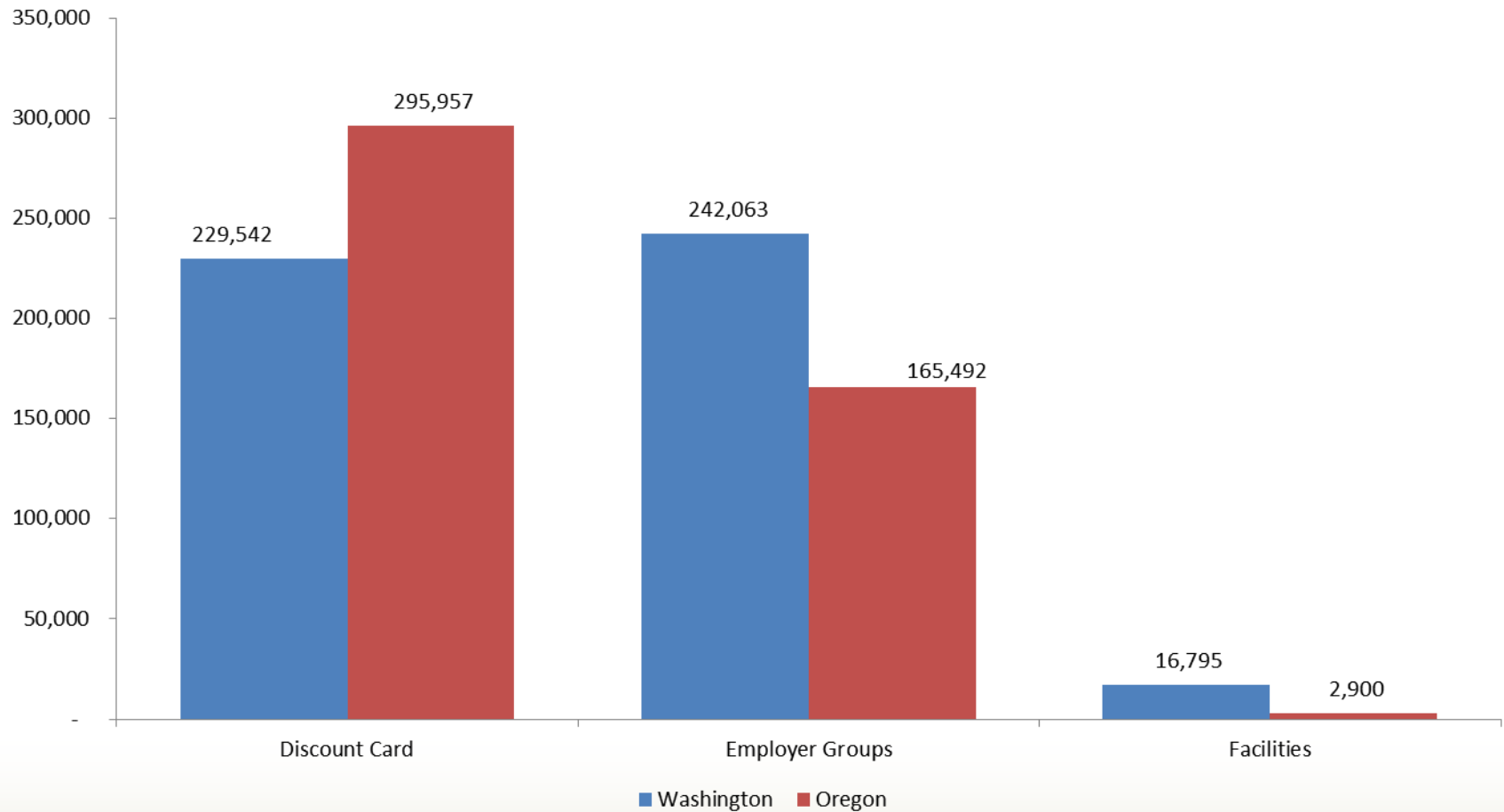
Northwest Drug Purchasing Consortium Enrollment



Total enrolled lives

Success

Program enrollment by State (2016)



Major clients

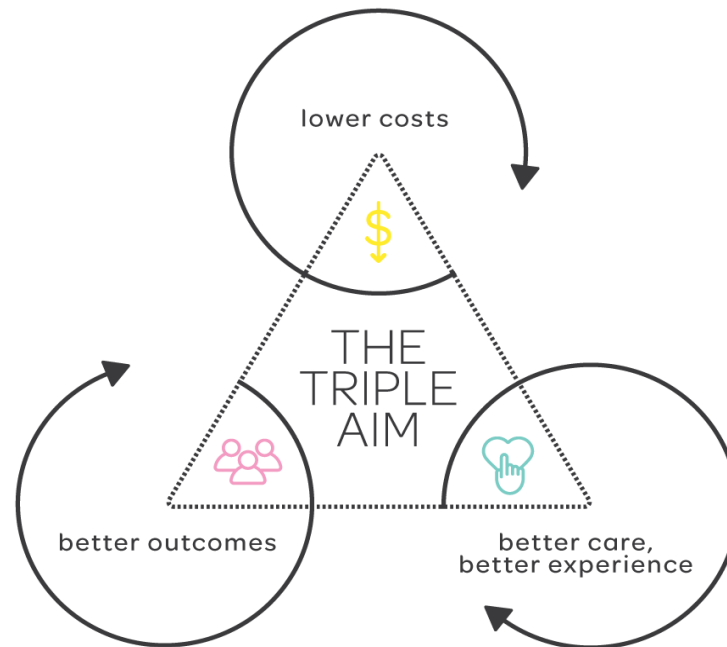


NW Consortium Services

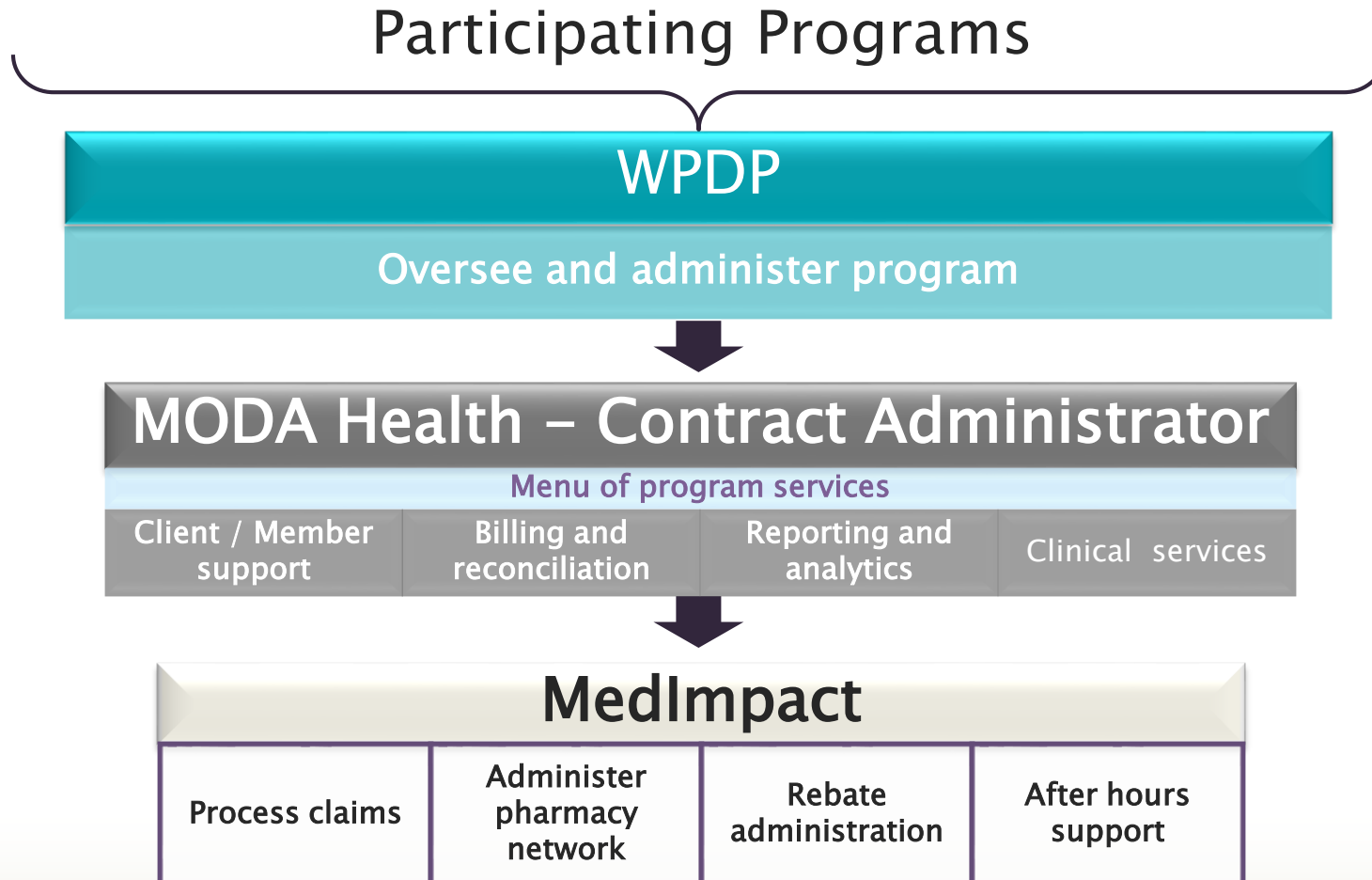
II. Group Pharmacy Benefits Management

Group Pharmacy Benefits Management

The pharmacy benefits management program designed to meet the specific needs of clients (e.g., employer groups and government entities) and achieve the Triple Aim



How it works



The Consortium is pulling together best-in-class group pharmacy management expertise and experience with state purchasing power



Program Management

- Purchasing power
- Consortium; pooled purchasing
- Contract administration and oversight
- Aggressive guarantees

Contract Administrator

- Data analytics and insights reporting
- High touch client/member support services
- Billing and reconciliation
- Broad range of innovative clinical programs

Network & Claims Management

- Prescription claim processing
- Pharmacy network administration
- Eligibility verification
- Rebate administration
- After hour member support

Autonomy

Flexibility

- Ability to design and manage own pharmacy program
- Option to use the pharmacy management resources available through WPDP

Choice

- Select between broad and value pharmacy networks
- Broad range of evidence-based clinical services
- Innovative pharmacy programs (e.g., 340B, Discount Card, GPO)

Customization

- Ability to customize program to meet employer group needs and goals
- Ability to provide customized pharmacy analytics to support quality initiatives

Collaboration

- Clinician consulting services on programs and initiatives
- Coordination with HCA to improve pharmacy best practices with all offerings

Reporting

- Quality metrics reporting
- Cost and utilization reporting
- Ad hoc and customized reporting options

Savings

Pricing

- Aggressive discount guarantees
- Fixed administration fees
- Many fee items included free of charge
- Alternative competitive contracting programs

Transparency

- 100% pass-through agreement (including pharmacy costs and rebates)
- 100% transparency on pharmacy discounts, rebates and administration fees

Predictability

- Flat administration fee per paid transaction
- Discount guarantees that improve over time
- Detailed data analytics to track costs and savings

Accuracy

- Stringent performance guarantees that are measured and audited yearly
- Quarterly monitoring of Most Favored Nation status
- Third-party payment annual audits and optional annual benefit audits

Assurance

- More than 22 performance guarantee measures
- Quarterly reimbursement performance reports
- Price competitiveness annual market checks
- WPDP oversight to ensure contract amendments in rapidly changing market

Experience

Access

- Robust "value-based" pharmacy network with over 56,000 pharmacies nationwide
- All major pharmacies included, with one exception (Walgreens)
- Critical Access Pharmacies

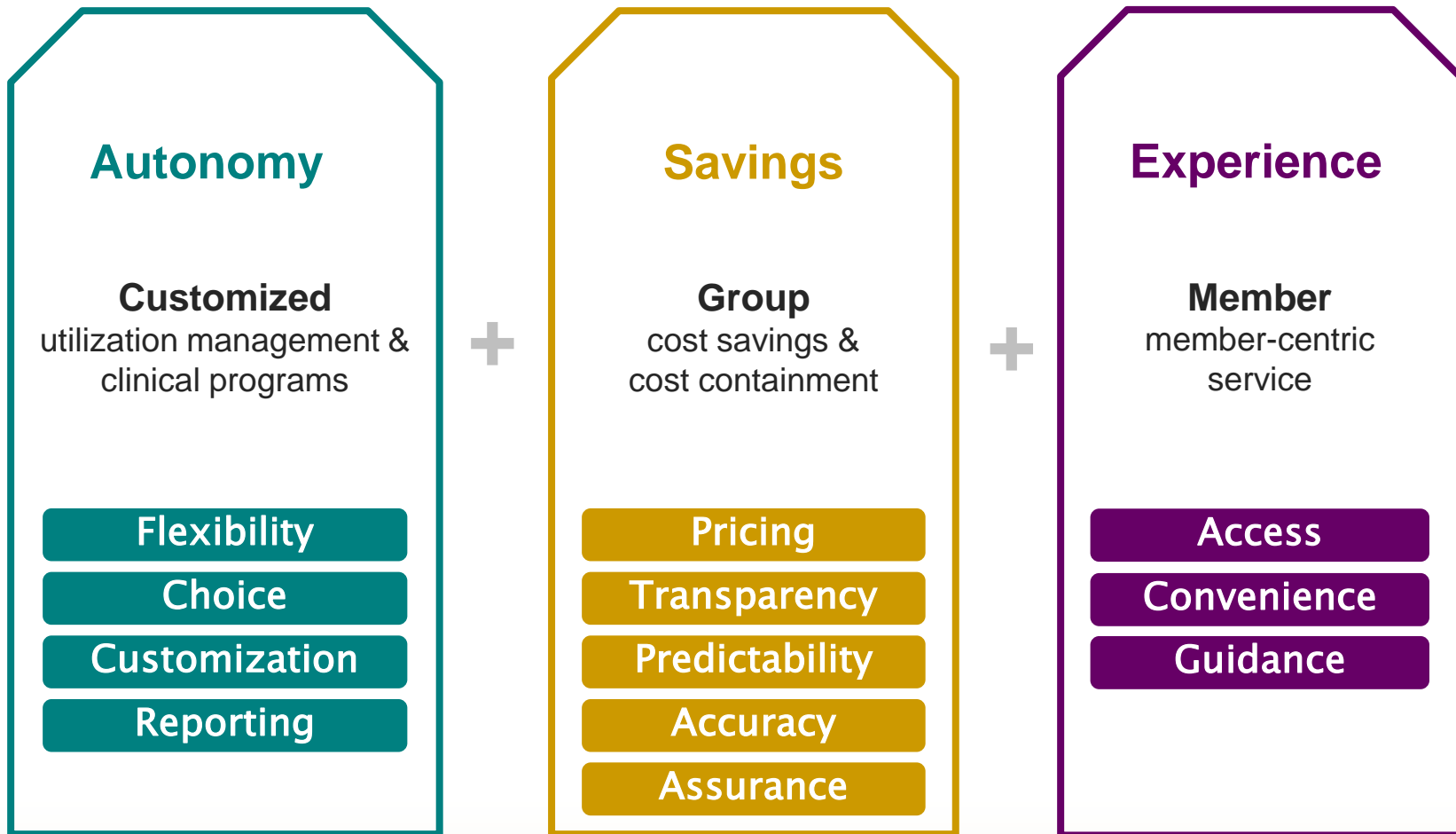
Convenience

- Oregon-based mail order enabling faster delivery and guaranteed packaging integrity
- Local specialty pharmacy with strong ties to prescriber community
- Member access to specialty clinical pharmacist available 24/7

Guidance

- Access to clinical pharmacists
- Treatment and medication support
- Access to patient care programs

Value Proposition



✓ **Excerpt from 2017 NW Drug Consortium Annual Market Report:**

1. “Overall Consortium pricing was competitive;
2. Market conditions could yield 0.5% or more savings if exclusive specialty pharmacy guarantees are improved;
3. Consider eliminating the effective rate guarantee over all specialty drugs and obtaining drug-by-drug pricing;
4. Generic specialty drugs can be used to improve the overall effective discount, allowing for a reduction of the discount on the specialty brand drugs, the largest area of drug cost growth; and consider acquisition cost plus fee pricing for specialty drugs.”

✓ **Excerpt from 2017 UMP Benefit Audit Report:**

“...Burchfield’s report noted findings on 73 claims out of 1.4 million (a 0.0052% observed error rate). Typical error rates, in Burchfield’s experience, are in the range of 1 – 5% of overall claims population. Thus, the overall claim adjudication accuracy observed in this audit is much higher than the average rate observed in Burchfield audits...”

Other Services


III. Pharmacy Discount Card

Pharmacy Discount Card: www.hca.wa.gov/pdp

Programs & initiatives

- Apple Health (Medicaid) >
- Clinical collaboration and initiatives >
- Health Information Technology >
- Health Technology Assessment >
- Healthier Washington >
- Making informed health care decisions
- Program Integrity >
- Public Employees Benefits Board (PEBB) Program >
- School Employees Benefits Board (SEBB) Program >
- Tribal Affairs >
- Uniform Medical Plan (UMP) >

Washington Prescription Drug Program (WPDP)




Washington Prescription Drug Program (WPDP)

We ensure the value of prescription drug purchasing by the state.

The Washington Prescription Drug Program provides prescription information and assistance for the residents of Washington.

How do I...



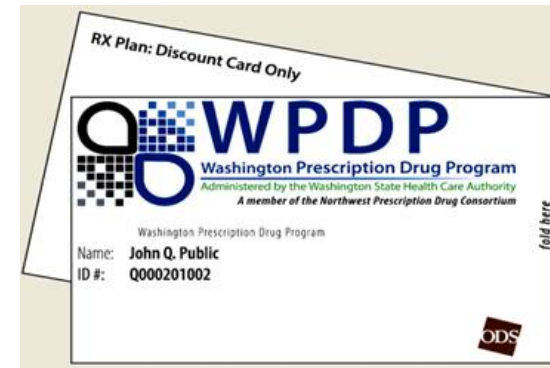
<ul style="list-style-type: none"> Contact the program Get the prescription drug Discount Card Find drug prices Find the Washington PDL and drug class updates Find the P&T Committee meetings and materials 	<ul style="list-style-type: none"> Become an Endorsing Practitioner for the Washington PDL Find prescription assistance programs Learn more about the NW Prescription Drug Consortium Join the employer group prescription drug plans
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How does the Discount Card Program work?

- 100% cash payment by member; purchases are not subsidized by state funds
- More than 1,150 Washington pharmacies have chosen to contract with the NW Consortium statewide
- Pharmacies that choose to contract with us agree to accept the discounted rates
- To get the discount, the card must be used at one of our participating pharmacies

Pharmacy Discount Card Eligibility and Benefits

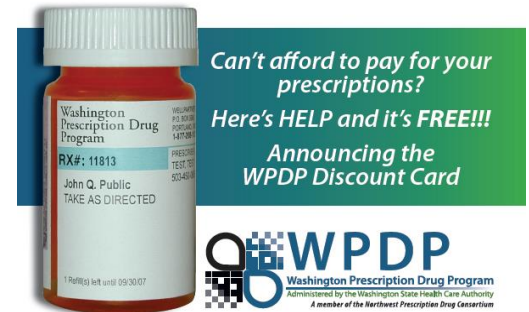
- No annual fee ... It's FREE!
- Everyone in Washington is eligible to join
 - No income restriction
 - No age restriction
- Excellent discounts:
 - Average 80% on generic drugs
 - Up to 20% on brand name drugs
- No formulary restrictions:
 - All drugs are eligible for a discount
 - Some vaccinations and immunizations also covered
- Over 1,150 network pharmacies in Washington and 56,000 Nationwide
- Mail order service available through Postal Prescription Services
- “Specialty” drugs available through Ardon Health Pharmacy



Four Ways to get a Pharmacy Discount Card

Only need to enroll once:

1. Enroll online at www.hca.wa.gov/pdp
 - English or Spanish
2. Complete one of the postage-paid enrollment forms
3. Download an enrollment form
 - English or Spanish
 - Complete a separate enrollment form for each person applying and send it to the address shown on the form
4. Call toll-free 1-800-913-4146



Benefits of website www.hca.wa.gov/pdp



Enroll Online

- Enroll in English or Spanish in less than one minute
- Downloadable application also available in English and Spanish

Pharmacy Locator

- Search for network pharmacies using address, city, state, zip code, or pharmacy name
- Printable maps also available via MapQuest



Drug Price Look Up

- Look up the current discount price of medications
- Prices can change daily based on Average Wholesale Price
- Can be used for mail order service
- Provides comparative information: Generics vs. Brand



Order Enrollment Materials

- Postage-paid, self-addressed enrollment mailers available in 8 languages
- Tri-fold informational brochures in English and Spanish
- Promotional flyers in English only
- PDF version of flyers in Spanish and Russian available on request



WPDP Rx Discount Card Program

Total members enrolled through January 31, 2018:

235,864

- ✓ TOTAL PRESCRIPTION DRUG CHARGES: **\$162 MILLION ***
- ✓ TOTAL SPENT BY CARD MEMBERS: **\$68.9 MILLION ***
- ✓ TOTAL SAVINGS BY CARD MEMBERS: **\$93 MILLION ***
- ✓ MEMBER SAVINGS OVER LAST 12-MONTHS: **\$10.3 MILLION**
 - TOTAL MEMBER SAVINGS LAST MONTH: **\$.9 MILLION**
 - SAVINGS PER UTILIZING MEMBER LAST MONTH: **\$170**
 - SAVINGS PER PRESCRIPTION LAST MONTH: **\$84 OR 78%**
 - PERCENTAGE OF PRESCRIPTIONS FILLED GENERIC LAST MONTH: **96%**



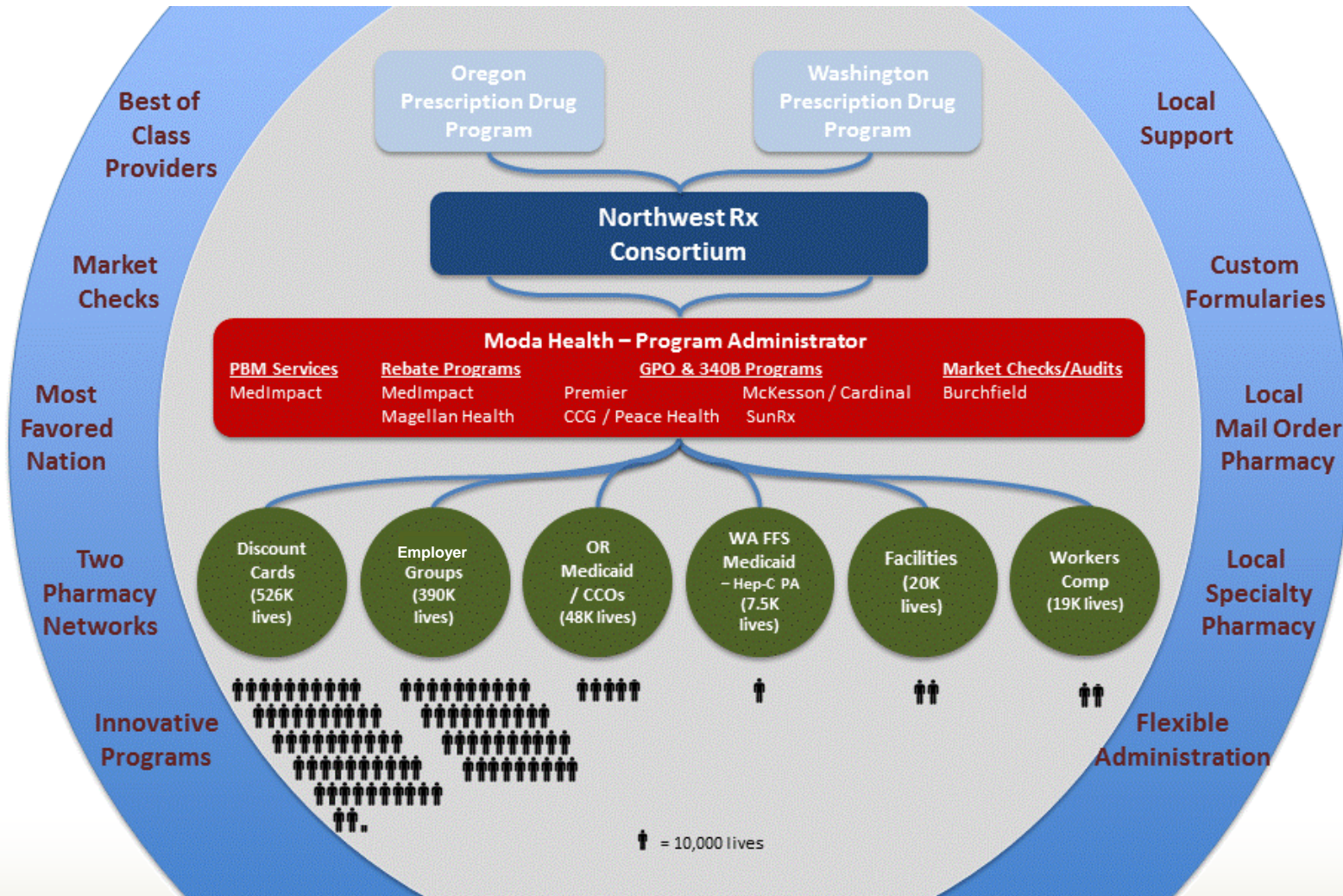
* "Total" reflects all WPDP discount card member utilization from February 2007 implementation through January 2018; "monthly" amounts average only January 2018

IV. Marketing and Expansion

Market Expansion and Growth

1. In WA and OR, the NW Drug Consortium responds to both public and private RFPs for pharmacy benefit services. Over just the last year, consortium-based contracted rates and services proposals have been submitted to:
 - Multnomah County, OR and Snohomish County, WA
 - Oregon Health Sciences University (OHSU), Nike and OEBC
 - WA Department of Health Aids Drug Assistance Program (ADAP)
2. The NW Drug Consortium has also attracted the interest of other states, most recently from Alaska, Delaware, and Louisiana. We're currently working with OR and Moda Health to develop a "Value Proposition" of joining presentation for other states. Planning to approach NASHP and NGA on sponsoring presentations at upcoming state meetings.
3. Two groups of foundation-funded academic researchers, one from the Arnold Foundation, the other from Lown Foundation, are currently studying the NW Drug Consortium operations for upcoming monographs on statewide drug purchasing strategies.

Northwest Prescription Drug Consortium



Questions?

More Information:

<http://www.hca.wa.gov/pdp>

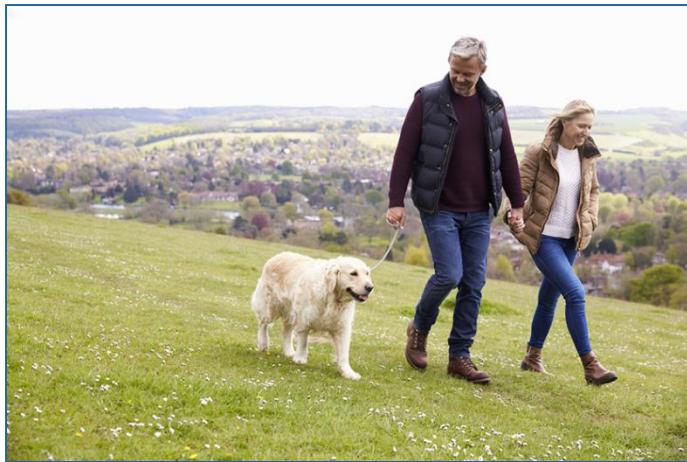
Ray Hanley, Director
Prescription Drug Program

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TAB 7

Washington State Health Care Authority



- Silver Sneakers
- Other Programs & Discounts

Martin Thies
PEBB Account Manager
Employees and Retirees Benefits Division
March 21, 2018

What is Silver Sneakers?

- For those age 65 and over
- Discounted or Free Gym Memberships
- An array of exercise options and programs for seniors
 - Cardio, yoga, flexibility and stretching, circuit training
 - Saunas, pools—thousands of facilities across the country
- To provide incentives and opportunities to keep fit
 - Exercise, Stability, and Fitness
 - Longevity, Support, and Community
- <https://www.silversneakers.com/>

Locally

- Currently offered to 65+ population through:
 - Aetna
 - Amerigroup
 - Humana
 - Kaiser Permanente of Washington
- Thurston County Facilities
 - Downtown YMCA
 - Anytime, Planet, Whetstone, and 24-hour Fitness
 - Curves and The Strong Center

Example: Kaiser Permanente of WA

- Offered under their Medicare Advantage Program
- Covers 93,700 retirees (not all PEBB Program)
- Average monthly participation: about 9,800
 - 6.9 average monthly visits per participating member
 - Can use any Silver Sneakers location
- Program Cost to a Plan:
 - (Proprietary)
 - A per member per class fee, plus an administration fee



Silver Sneakers & UMP Classic Medicare

- As Medicare Advantage (MA) plans, Aetna, Humana, Amerigroup, and Kaiser receive federal funds to defray costs
- UMP Classic Medicare is a self-insured Preferred Provider Organization (PPO)
 - Does not receive federal funding
 - Offering Silver Sneakers would therefore result in a per member cost across the UMP Classic retiree population, not just those utilizing the benefit.
- Each month 90% at Kaiser don't participate
- Not all members can access participating facilities



PEBB Plan Discounts

- PEBB Program members are entitled to discounts
- UMP (and Kaiser) offer additional benefits to subscribers and their dependents
- Online Access to Information:
 - <https://wa.kaiserpermanente.org/html/public/member-guide/perks>
 - <https://www.hca.wa.gov/public-employee-benefits/employees/plan-discounts>

Gyms and Fitness: UMP & Premera Plan F

UMP

Active&Fit Direct™ Program: Access to 9,000 fitness centers for \$25/month

The Active and Healthy Program

- *LA Fitness*: \$74 savings on enrollment fee, \$3 off monthly dues
- *Anytime Fitness*: 50% savings on enrollment, 10% off monthly dues
- *Curves International*: Free week trial, \$80 savings on initiation fee

Premera Plan F

- *Active&Fit Direct™* Program (as described above)
- *LA Fitness*: No joining fee and discounted monthly fee
- *Curves International*: \$19 enrollment fee plus one week free

Health Discounts

- Vision products and services
 - Price matching and free home delivery
 - LASIK
 - Percentage discounts on frames and contacts
- Alternative medicine (for access after UMP Limits)
 - Chiropractic, Acupuncture, and Massage Services
 - Naturopathic Health
- Hearing products and services



Healthy Lifestyle Discounts

- Health care library and tools to create “health profile”
- Healthy meals and weight loss services
- Non-drug allergy relief supplies
- Tobacco cessation programs
- Apps for online health information
- Access to classes:
 - Childbirth, Breastfeeding, and Parenting
 - Healthy Aging, etc.



Age Specific Health Care Discounts

- Fertility services
- Umbilical cord blood collection
- Child Health products: safety gates, outlet covers, etc.

Senior Services:

- In-home care, consulting nurses
- Smart cell phones and urgent response/alert devices
- Funeral Services



Other Discounts

- Savings on theatre, movies, symphony tickets, and sporting activities
- Ski lift tickets
- Hotels, zoos, aquariums
- Car rentals
- Wellness plans for pets
- Health club memberships



Questions?

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PEBB Dental Plan Comparison

Betsy Cottle, Contract Manager
Employees and Retirees Benefits Division
March 21, 2018

Dental Plan Comparison

	HEALTH CARE AUTHORITY (PEBB Benefits)		BOEING (REPRESENTATIVE SAMPLE)		FRED HUTCHINSON CANCER RESEARCH CENTER		WEA SELECT PLANS (REPRESENTATIVE SAMPLE)	
	PPO (3 tiers of Providers*)	Managed Care	PPO	Managed Care	Plan A PPO (3 tiers of Providers*)	Plan B PPO (3 tiers of Providers*)	PPO (3 tiers of Providers*)	Managed Care
Annual Plan Maximum	\$1,750	None	\$2,000	None	\$2,000	\$1,000	*Tier 1: \$2,000, Tier 2: \$1,750 Tier 3: \$1,750	None
Annual Deductible	\$50 per person, \$150 maximum	None	In network: \$0 Out of network: \$50	None	In network: \$0 Out of network: \$50	In network: \$0 Out of network: \$50	\$0 or \$50 per person, \$150 maximum	\$0 or \$50 per person, \$150 maximum
Orthodontia (cosmetic)	50% of costs until the plan has paid \$1,750 for PPO, out of state, or non-PPO	Up to \$1,500 copay per case	50% covered. \$1,500 lifetime maximum	50% covered. \$2,000 lifetime maximum	50% covered. \$1,500 lifetime maximum	Excluded	Excluded	50% covered

*For dental plans with tiers, the plan contracts with providers resulting in three different reimbursement rates (for the dentist) that results in different cost shares for members.

Dental Plan Comparison

	HEALTH CARE AUTHORITY (PEBB Benefits)		BOEING (REPRESENTATIVE SAMPLE)		FRED HUTCHINSON CANCER RESEARCH CENTER		WEA SELECT (REPRESENTATIVE SAMPLE)	
	PPO (3 tiers of Providers*)	Managed Care	PPO	Managed Care	Plan A PPO (3-tiers of Providers*)	Plan B PPO (3-tiers of Providers*)	PPO	Managed Care
Class I – Diagnostic & Preventive	Tier 1: \$0 member coinsurance Tier 2: 10% member coinsurance, Tier 3: 20% member coinsurance	\$0 - \$30 member copay, depending on procedure	0 – 30% member coinsurance	\$0 member copay	Tiers 1-3: \$0 member coinsurance	Tiers 1-3: \$0 member coinsurance	In and out of network: 0 - 30% member coinsurance	100% covered
Class II – Restorative	Tier 1: 20% member coinsurance. Tier 2: 20% member coinsurance, Tier 3: 70% member coinsurance	\$10 - \$50 member copay, depending on procedure	0 – 30% member coinsurance	\$47 - \$250 member copay, depending on procedure	Tiers 1-3: 20% member coinsurance	Tiers 1-3: 50% member coinsurance	In and out of network: 0 - 30% member coinsurance	\$10 member copay
Class III – Major	Tier 1: 50% member coinsurance Tier 2: 50% member coinsurance, Tier 3: 60% member coinsurance	\$15 - \$175 member copay, depending on procedure	50% member coinsurance	\$0 - \$530 member copay depending on procedure	Tiers 1-3: 50% member coinsurance	Tiers 1-3: 50% member coinsurance	In and out of network: 20 – 50% member coinsurance	\$10 member copay

Class I: exams, cleaning, fluoride, x-rays

Class II: fillings, root canals, oral surgery

Class III: dentures, crowns, implants, general anesthesia

*For dental plans with tiers, the plan contracts with providers resulting in three different reimbursement rates (for the dentist) that results in different cost shares for members.

Dental Plan Comparison Summary

- In comparison to the other large group plans illustrated in this presentation, the Dental plans offered by the PEBB Program are very comparable and may even provide a richer benefit.
 - Deductibles are within range.
 - Orthodontia coverage is similar or richer than other large group plans, as this benefit is excluded in some plans.
 - Member costs for Class I – III procedures are very comparable.

Questions?

Betsy Cottle, Contract Manager
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