Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

June 5, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 4:45 p.m.

Members Present:
Sue Birch
Carol Dotlich
Yvonne Tate
Harry Bossi
Tim Barclay

Members via Phone:
Tom MacRobert
Myra Johnson

Members Absent:
Greg Devereux

PEB Board Counsel:
Katy Hatfield, Assistant Attorney General

Call to Order

Sue Birch, Chair, called the meeting to order at 1:31 p.m. Sufficient members were present to allow a quorum. Audience and board self-introductions followed. TVW live streamed today's meeting.

Executive Session

The Board met in Executive Session, pursuant to RCW 42.30.110(1)(d), to review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs; and pursuant to RCW 42.30.110(1)(l), to consider propriety or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026.

Break

Meeting Overview

Dave Iseminger, Director, Employees and Retires Benefits Division, provided an overview of today's agenda.

Prior Meeting Follow Up

Dave Iseminger: Slide 2 – Prior Year Financial Insights. Last meeting Tanya Deuel presented financial information about the future funding rates and Tom asked what the funding rate was for last year, as well as the annual expenses from the various administrative accounts. The information on this slide is for fiscal year 2018, which is July 2017 through June 2018.

For fiscal year 2018, the funding rate was $913. The Uniform Medical Plan Administration Account is for administration aspects of the plan, not claims, was $57,612,000. The Uniform Dental Plan Administrative Account, again, not claims, was $6,165,000. The Flexible Spending Arrangement Administrative Account with Navia was $838,000.

Tom MacRobert: I just wanted to clarify the Uniform Medical Plan – Administration rate, the $57 million, was going to increase to $63 million in 2019. Is that correct?

Dave Iseminger: Every year that number goes up, in part because enrollment goes up. That is basically the total summation of the monthly per member per month (PMPM) we're paying. As enrollment goes up, that account needs additional expenditure authority and increases over time. Every January we see an increase of approximately 1,200 members in our PEBB Program portfolio. Outside January, on a month-by-month basis, it's approximately a 200 to 225 net increase in enrollment. We usually see the largest uptick in January because political subdivisions will contract with the Health Care Authority for benefits that begin at the start of the plan year. That positive trend has happened the last four or five years, with a need for a continual uptick in the expenditure authority of that account. Does that help, Tom?

Tom MacRobert: Yes.

Dave Iseminger: Slides 3 – 6 – Corrections to May 21, 2019 "Vision Benefit Strategy" Presentation. At the last Board Meeting, Lauren Johnson gave an update about the strategy related to the vision benefit and Harry had questions about if eye exams did or didn't have a copay in the Kaiser plans to UMP. Lauren has updated her slides. These slides are the corrected versions, with the revisions in red.

Slide 4 - PEBB Program Vision Benefits. There is no cost for a routine eye exam in UMP for vision. There is a copay that varies based on the plan in the Kaiser Northwest and Kaiser Washington plans.

Slide 5 – PEBB Program vs SEBB Program Frequency. The correction is on KPWA's eye exam frequency. It is every 12 months, not 24 months.

Slide 6 – Differences in Separate Benefit. The member cost for routine eye exams should be $0 for UMP, and varies by plan for KPNW and KPWA.

There are no slides for the following question. Tom asked about the legislative update related to Educational Service District employees. All Educational Service District employees were going to be moved into the SEBB Program. However, a last minute legislative change this session changed this and now non-represented Educational Service District (ESD) employees are not required to participate in the SEBB Program until plan year 2024. They can stay in the PEBB Program or access other commercial insurance options.

Tom asked for more information about these staff. The majority of ESD staff are program staff running programs like early learning, learning support, and professional development. The majority of represented staff are in those staffed positions. For non-represented staff, some support those program areas, but they also have other support services such as administrative and janitorial services.

Carol asked for more information about the Centers of Excellence (COE) Program and the utilization of those services. We will bring a presentation on the Centers of Excellence at a future Board Meeting.

Another question was what was the name of the Hepatitis C drug we're looking to procure. It is Maviret, spelled multiple ways. You could Google either M-A-V-I-R-E-T or M-A-V-Y-R-E-T.

The last follow-up concerns information about the SEBB Program portfolio. We made you aware that the SEB Board created another version of the Uniform Medical Plan. They essentially copied, with minor variations, the Uniform Medical Plan Classic, the CDHP, and the UMP Plus plans. The SEBB Program also created a fourth Uniform Medical Plan similar to UMP classic, but with an 82% AV plan. That means there are some cost share differences and the member picks up more than the plan picks up – relative to UMP Classic. There was a question about the deductibles in that plan. If the Board is interested in including this plan in the portfolio, we will bring information to you in a future Board Meeting next year. It's a plan with a $750 single subscriber deductible and a $2,250 family deductible. It has a prescription deductible of $250 for the single subscriber and $750 for family. These are higher deductibles and higher cost shares, but the plan has a lower premium. Given the demographics of the school population, the SEB Board had interest in a wider range of AV plans within their portfolio.

Ryan Pistoresi, Assistant Chief Pharmacy Officer. Slides 7 – 10 – Uniform Medical Plan (UMP) Value Formulary Follow Up. Slide 8 – UMP Value Formulary Exception Process. Carol asked for a written version of the UMP Value Formulary exception process, which goes into effect January 1, 2020. Slide 8 is background information that shows what the structure of the UMP preferred drug list will be in 2020. The table shows four tiers and their associated cost shares for the member coinsurance or the member out-of-pocket maximum.

Slide 9 has a link to the UMP Preferred Drug List (PDL). Members can check to see if their medications are covered on PDL and when they qualify for an exception. If a member is prescribed a drug not on the formulary, the member will need to pay the full cost of the drug. Members should talk to their physician about prescribing an alternative drug that is on the formulary.

However, if a member has tried all the alternative drugs and none are found to be effective, or if the alternatives are found to be not medically appropriate, the member can request an exception. If approved, the requested non-formulary drug will be covered and the member will pay the appropriate Tier 2 cost share.

Slide 10 is the step-by-step process and the outcomes of such a process for requesting an exception. Carol, I believe this is what you were looking for, the steps the member and the provider would need to go through. The member or the member's physician can request a formulary exception by contacting Washington State Rx Services Customer Service at the phone number listed. Washington State Rx Services will contact the member's provider and the provider will submit the appropriate clinical information. They will let them know what information is needed for the specific drug being requested. The Washington State Rx Services clinical team will review the submitted information to determine if the formulary alternative(s) the member used were ineffective or were not clinically appropriate. If the member has used all the alternatives and none have been found to be medically appropriate, the member will be approved to use the non-formulary drug. If the exception is not approved, the member will be directed towards the appropriate alternatives on formulary, or the member may select to pay the full cost of the drug.

The Health Care Authority (HCA) is working closely with MODA on developing a comprehensive communication plan to get this information out and available to members prior to open enrollment so they can make the best decisions in selecting their health plans. HCA has met with MODA since the passing of the Value Formulary to develop this communication. We are working on documents for members to help them understand the process and select the right health plans for them.

Carol Dotlich: Under your plan, the members will have the formulary list in time so they're not without their medication? I don't want them to go to the pharmacy and discover they're not covered and then start this process. I want them to know ahead so they're prepared for this.

Ryan Pistoresi: HCA is working on several different aspects of providing this information to members. One is to update the UMP PDL lookup tool referenced on Slide 9. This is the online tool showing what drugs are covered and how they're covered. We're also working on a transition plan to identify members currently using these drugs to send them mailings to let them know they can start this exception process early, or how they may be able to transition to a drug that is on the UMP PDL starting in 2020. We are looking at all the different ways to get in front of this and let members know how they can receive their prescription medications starting January 1, 2020. Whether it's an alternative medication or how to start the exception process and then be approved to use their current medication going forward.

Carol Dotlich: I appreciate the proactive stance very much.

Dave Iseminger: Ryan, to be clear, the PDL lookup tool you're describing will be completed before the November open enrollment so people will have that information in addition to this targeted customized letter campaign for individuals who could be impacted?

Ryan Pistoresi: That is correct. We are working with MODA to get the tool updated prior to open enrollment to let members know there are changes occurring in 2020. It will assist the member in asking MODA questions on the process or their prescription drugs.

Carol Dotlich: I wanted to say I like the idea of the letter going to the people using non-formulary drugs because a lot of the elderly folks don't use a computer and would not look them up online. So thank you for that.

Long-Term Disability (LTD) Insurance Benefit Strategy

Kimberly Gazard, Contract Manager, Employees and Retirees Benefits Division. Side 2 – Timeline for Decision Making. At the April Board Meeting, we looked at timelines for decision making around changes to the LTD basic benefit. After July 1, budget language permits the Board to reallocate funding within the portfolio. HCA could also submit a decision package to the Governor's Office for the 2021 plan year budget.

Slide 3 – Employer-Paid Basic LTD Plan Design. This chart shows small changes to the basic benefit that might be available through horse trading benefits. The maximum monthly benefit ranges are $240 to $1,408. The Board will have the authority July 1 to reallocate funding within the portfolio to change the LTD basic benefit for the 2020 plan year.

Slides 4 and 5 – 2020 LTD Basic Benefit Design Options. At the April 24 Board Meeting, we introduced ideas for budget neutral horse trading options but the Board did not seem interested in those options. HCA needs a clear indication at this meeting from the Board about any changes to evaluate for the 2020 plan year because changes for the 2020 benefit will impact the rate setting currently underway.

Dave Iseminger: To add context, at the April 24 Board Meeting, we described benefit options we pursued at the direction of the SEB Board. We looked at reducing the life insurance basic benefit from $35,000 to $25,000, and use that offset to increase the LTD benefit. That could generate a $1 per subscriber per month (PSPM) and make the basic LTD benefit in the PEBB Program $400 a month.

We evaluated changes in the dental portfolio to cap the orthodontia benefit within the fully insured plans. That was something the SEB Board was interested in seeing. But because the predominant enrollment, roughly 75% to 80% of enrollment is in the Uniform Dental Plan, which already has a cap benefit, there wasn't any savings that could be generated to make any sort of LTD benefit change.

We evaluated eliminating the orthodontia benefit in the dental plans. That would have allowed moving the basic LTD benefit up two or three notches on the sliding scale on Slide 3. But people have become accustomed to and desire an orthodontia benefit. The SEB Board wasn't interested in that idea either.

HCA presented a couple of different ideas we looked at but didn't find anything that felt particularly palatable. We're also working on, from a PEBB Program perspective, an expedited timeline with regards to the authority you're going to have in about 30 days. We're in the middle of rate development now, and it's almost too late to make changes for plan year 2020. If you do a benefit swap on the medical plan, that will be taken into

consideration because we are negotiating with carriers now. We can look at ideas for plan year 2021 later.

Our recommendation at this point is there is not adequate time to take advantage of your benefit swap authority for plan year 2020 unless you have a very clear idea today. We've been struggling with this concept with the SEB Board for a while and we evlauted options for both program portfolios at the same time. We've struggled to find something a majority of Board Members on either Board would feel is a tolerable swap within the portfolio. HCA will continue to look at different pieces, but if you can identify something specific, we will look at that.

We know that legislative staff, OFM, and the Governor's Office are aware the benefit design on basic LTD has not changed in 40 years. Our recommendation is that HCA put forward a decision package for evaluation. Later in Kimberly's presentation, she will ask you what you think the range of incremental steps should be as we prepare our decision package. We will also talk with you about other benefit swaps you can make after the next legislative session when we know whether they added more to the funding rate for LTD.

HCA is in a tough spot with timing and have been looking at this as an agency for both programs for well over a year. We started working on the LTD benefit and the SEBB Program about this time last year after we completed the procurement. None of us like the basic benefit. We're committed to working on it and, at the least, make a run for additional funding. We will also keep the discussion going about benefit swaps that could happen during the next Board season.

Sue Birch: I would ask the Board to give me a signal. Are we all in agreement that we would like to see the benefit moved significantly? I personally think we need to be in the $700 to $800 range as the minimum. When you look at the income distribution of our employees, that's still pretty minimal for an LTD benefit.

Dave Iseminger: Chair Birch, we can have Kimberly go through the income pieces to tee that up, and then maybe revisit that question.

Sue Birch: That would be great.

Kimberly Gazard: Slide 6 – 2021 LTD Basic Benefit Design. Dave touched on this slide. Today we're seeking insight from the Board about recommended changes for incremental improvements to the basic LTD benefit.

Slide 7 – PEBB Program Member Income. The last time we showed you the salary ranges of PEBB Program members, 81% earn $80,000 or less. Only 18% earn $81,000 or more. We assume the Board would want to shoot for a benefit plan that replaces a higher percentage of that $80,000 annual salary.

Slide 8 – Employer-Paid Basic LTD Plan Design details the cost of significant changes to the basic LTD benefit that might be proposed in the decision packages. It shows a range of the maximum monthly benefit from $240, what it is currently, up to $10,000 for a maximum monthly benefit.

Dave Iseminger: I want to be clear. When we put together a decision package, we usually put forward a specific targeted request. For this decision package, we are envisioning a range of options. We want some progress made, so we want to give what we believe is the appropriate range and the cost for each of those increments and let the Governor's Office and Legislature decide if and what increment to approve.

As we're working on this decision package, what do you think the range should be? The chart on Slide 8 has more dramatic jumps in the benefit than you saw on Slide 3. We have an outdated benefit of $240. It takes a substantial amount of money to make significant progress to the larger amounts. We knew that as we were evaluating benefit swaps that you were never going to find $24 PSPM anywhere else to get you to a $4,000 benefit. We created the chart on Slide 3 to show possible improvements with smaller tweaks. To get a major jump in the benefit, additional funding is required.

As Kimberly said, we focused on the upper range of that incremental target for the decision package on Slide 8, with an annual salary of $80,000 and a $4,000 monthly benefit. Slide 7 shows that range of income. We believe the upper end would be an ideal target. Do you agree with that assessment? What do you think the lower end of the range should be?

Sue Birch: My thought is somewhere between $500 and $1,000 should be the minimum monthly benefit.

Tim Barclay: I would say the $1,500 to $2,000 range.

Harry Bossi: I agree with Sue. It's a good recommendation but also more likely to be achieved. The number might be more palatable for the budget decision makers. I don't know enough about the process that if you went in at $50,000 and it's not approved, you get nothing. Or will they identify a certain amount. If there is a better chance of getting $500 to $1,000, that might be the right place.

Carol Dotlich: I agree with Tim. I think it needs to be more.

Sue Birch: $1,500 to $2,500?

Carol Dotlich: I do. I don't know how a family survives a terrible disability.

Tom MacRobert: I would agree with that also.

Myra Johnson: I'm looking at the $1,500 to $2,500, as well.

Yvonne Tate: That's about a $25 million increase in cost. The question is whether or not our decision makers will put that much money into the fund.

Tim Barclay: Dave, can you tell us what our total spend is for PEBB in a year? All benefits, all expenses.

Tanya Deuel: It's about $2.5 billion.

Tim Barclay: $25 million is about .1%. I just want to keep that in perspective. What we're asking for is something within the variance of trend assumptions on our medical benefit. I understand to everyone sitting at this table $25 million is a big number. But in the context of what we're working with, it's not an unreasonable ask.

Dave Iseminger: There is a lot of interest in the LTD benefit from many stakeholders. Both Boards have expressed concern about the existing benefit. I personally have been concerned about the benefit. I knew when I stepped into the director role it was an area I wanted to focus on. I made sure legislative staff and OFM are aware of the benefit. Both Coalitions that bargain for benefits for employees currently have an interest in the employer-paid LTD benefit that's fully paid by the state. I believe many of those stakeholders are interested in pursuing and supporting such a funding request in the next legislative session. Now seems like the time to strike.

We're asking what you think is the tolerable minimum/maximum range, hearing something in the $1,500 to $4,000 range. We will provide a range of options and preferred targets to hit. We will describe how this makes the benefit competitive or not competitive with the rest of the market. We know many employers pay 60% of salary replacement as a fully employer-paid benefit. Our $240 is nowhere near that. As we build the decision package, we will indicate if this incremental change is made, it will cost this much and you still won't be competitive with the entire market.

I appreciate your guidance about the range you think is tolerable and we will incorporate that in the decision package. The decision package will include both programs. The occupational differences of school employees versus PEBB Program employees makes it cheaper for school employees to get a higher increment, but I'm sure the Legislature and OFM will look at the total spend between both programs. The combined annual spend for the two programs is closer to $5 billion.

Yvonne Tate: All the more reason to have just one program.

Dave Iseminger: As Yvonne said, all the more reason to have one program! We'll be doing that report, too.

Tim Barclay: Dave, a while back, I think I asked you for information and I want to remind you of that request. I was hoping to get the distribution of long-term disability supplemental take-up rates by income level.

Kimberly Gazard: We weren't able to provide the breakdown of member enrollment in supplemental LTD by salary as The Standard does not collect that information. We have system limitations within Pay1 to be able to obtain that information.

Dave Iseminger: Not the answer you were looking for, Tim.

Tim Barclay: I'm not surprised, but yet I'm a little surprised there wasn't a workaround. Somebody's collecting premium, right? Somebody should be recording that, right?

Dave Iseminger: Tim, in reality, the premium is collected on a list bill basis. When somebody makes the claim, there is a reconciliation backwards. Why don't we do a little bit of a follow-up for you of exactly how the money flows between an employer and

The Standard. We will set up a separate call to go through exactly how the money flows through the system.

Tim Barclay: I appreciate that. Thank you.

Emerging Medications

Ryan Pistoresi, HCA Assistant Chief Pharmacy Officer. Today I will review six novel pharmaceuticals approved by the FDA since the last emerging medications update. I will provide a quick review of the six drug profiles and present a summary budget impact analysis.

Slide 3 – Spravato (esketamine nasal spray). Spravato was the first medication approved by the FDA for treatment-resistant depression in adults who have not responded to at least two previous antidepressant therapies. This medication is used in conjunction with an oral antidepressant. This is augmentation therapy, meant to help the other oral antidepressant have a better effect. If the name sounds familiar, esketamine is the same chemical but with a slightly different arrangement to Ketamine, which is an anesthetic and an analgesic that has a well-known abuse potential. Because of this, esketamine is a schedule three medication only administered by health care professionals in approved settings. Approved pharmacies ship the drug to approved centers and approved providers administer to approved patients. There is a very strong, robust safety program to make sure everyone knows how this about this medication and how to use it. After administration of this medication, it requires monitoring the patient for at least two hours in case they have sedating or dissociation from the medication.

Treatment-resistant depression is uncommon in the UMP population. Some patients with depression do not respond to traditional oral antidepressant therapies even for different drug classes of antidepressants. However, there are other treatment options available for these patients, which include other monotherapy, other augmentation therapy, and cognitive behavioral therapy.

Slide 4 – Zulresso (brexanolone) is the first medication approved for postpartum depression, which can occur up to 12 months after childbirth. This medication requires a 60-hour continuous infusion. It requires a health care provider to be present throughout monitoring because the medication can cause excessive sedation and loss of consciousness. There is a robust safety program to ensure a health care provider is always present and there are steps to take in case the patient loses consciousness while on this medication.

Fortunately, there are other treatment options available for postpartum depression, which includes traditional antidepressants and psychotherapy. We anticipate severe postpartum depression will be rare in the UMP population because most patients with postpartum depression are treated first with oral antidepressants, which they usually respond to. This is only for very, very severe cases of depression that doesn't respond to treatment.

Slide 5 – Egaten (triclabendazole), the first medication approved for Fascioliasis, which is a parasitic infection of liver flukes. This is a liver infection caused by the parasite Fasciola Hepatica, which is endemic to Central and South America, Asia, Africa, and

the Middle East. It is anticipated that 2.4 to 17 million patients are infected with this parasite in 51 countries across the world. We're bringing this to you today to remind you we have UMP members who live internationally. Many UMP members travel internationally throughout the year. There may be some risk of this infection that warrants the UMP member to use this medication.

Dave Iseminger: We have about 100 UMP members that live internationally in about 15 to 20 countries. They are in the areas where this is endemic. It's often individuals who work in higher education whose work is international.

Ryan Pistoresi: This is an older medication approved in other countries around the world. If people were traveling overseas, they could get it in other countries. It just wasn't approved in the US. If Americans did contract this infection, they could get this medication through a special program at the Center for Disease Control. The FDA approved it for general use in February 2019. We expect this disease will be ultra-rare for UMP because it's only contracted by members who live or travel internationally.

Slide 6 – Evenity (romosozumab) is approved for the treatment of Osteoporosis and postmenopausal women at high risk for fracture where patients have failed or are intolerant to other therapies. It's the first medication that is a sclerostin inhibitor. Sclerostin is a molecule naturally in the body that inhibits bone formation. This drug was discovered when they noticed people with a mutation in sclerostin, or that had developed antibodies that fought against sclerostin, had very strong bones. They used this target to develop this medication. Unfortunately, there is a higher risk of heart attack, stroke, and cardiovascular death with this medication. It received a black box warning from the FDA. It should not be used by patients who had cardiovascular disease in the past, or who are at risk of cardiovascular disease. For patients without those conditions, this may be an option.

Osteoporosis is a common condition for UMP but this is a medication that will be competing with a pretty crowded market of second line therapies for osteoporosis. Other alternatives include Forteo, Tymlos, Prolia, or raloxifene. This medication is limited to 12 months of use per lifetime. At that point, the patient may be able to step into another treatment, or if they're using another treatment, they may step into this.

Slide 7 – Vyndaqel and Vyndamax (tafamidis) are medications approved for the treatment of cardiomyopathy in patients with transthyretin-mediated amyloidosis. This medication stabilizes the protein transthyretin, which prevents the protein from falling apart in the bloodstream, attaching to different tissue, and accumulating amyloid plaque. This medication helps the heart function normally.

This medication was approved in Europe and Japan in 2011. The FDA rejected it and required additional studies. The manufacturer completed the additional studies, submitted it for re-review, and got it approved earlier this year. This medication is considered ultra-rare for UMP.

Slide 8 – Balversa (erdafitinib) is approved for adult patients with locally advanced or metastatic urothelial carcinoma with FGFR3 or FGFR2 genetic mutations. Those are specific gene mutations associated with cancer. I wouldn't say necessarily what are causing the cancer, but are what are associated to the growth and proliferation of that

cancer. The most common type of bladder cancer is the urothelial carcinoma. These specific mutations are found in about 20% of the relapsed or refractory cancers. This is a somewhat sizeable cancer population relative to some of the other cancer drugs we've talked about at previous meetings.

However, this medication will compete with many other treatment options for patients with locally advanced or metastatic urothelial carcinoma. Since there are many treatment options available for these patients, it's difficult to anticipate how this drug may be used by this population. It will be a new treatment option available if they have the specific mutations and are refractory to other treatment options.

Slide 9 – UMP Budget Impact. For the six drugs reviewed today, we anticipate these drugs may total an increase of $2.19 million per year. Medications like Vyndaqel or Vyndamax cost upwards of $225,000 per patient per year. Remember we consider drug usage for those as ultra-rare. Spravato, which addresses treatment-resistant depression, is likely to have a higher patient population use and a higher budget impact overall. This budget impact is estimated based on plan size and the per member per month estimates from third party analyses.

We've reviewed a total of 19 drugs in Board meetings since the beginning of the year. Combining these six with those 19, the 25 drugs reviewed we anticipate to be $3.87 million annual impact.

Dave Iseminger: I want to thank Ryan for continuing to do the education of 25 drugs. He'll be at our next meeting to talk about Zolgensma.

Ryan Pistoresi: Zolgensma is the new gene therapy for spinal muscular atrophy.

Dave Iseminger: That is the drug you've seen in the headlines that costs millions of dollars. It is $2.5 million for a treatment.

<u>Policy Resolutions</u>

Rob Parkman, Rules and Policy Coordinator, ERB Division. Slide 2 – PEB Board Policy Resolutions. There are three policy resolutions to take action on today. Slide 3 – RCW 41.05.080(1) is included to show the Board their authority when making decisions on these resolutions.

Dave Iseminger: In particular, the blue highlighted verbiage on Slide 3 is to help you understand where your authority stems from in order to take action on these resolutions. We found this to be a particularly useful context in SEBB Board Meetings adding what your statutory authority is to be very clear where the authorities stem from for the rules that eventually follow.

Slide 4 – Policy Resolution PEBB 2019-03 – Retiree Insurance Coverage Deferral – CHAMPVA Survivors. This is to amend to policy resolution passed last summer for CHAMPVA. Changes since the last Board Meeting: this is a global change for all three policies. We are changing this policy number from PEBB 2019-01 to PEBB 2019-03. We need unique numbers for each resolution so we can track them over history. Earlier this year, the Board already passed two resolutions. We do not want to reuse those numbers so today, this resolution will change from PEBB 2019-01 to PEBB 2019-03,

but the resolution from the May Meeting is located in the Appendix. There are no changes to this resolution except the numbering.

Dave Iseminger: Last year we had a robust conversation about retroactive versus prospective effective dates and we felt it was best knowing there hadn't been a particular instance. If it did come up in an appeal later, it would be clear this was the intent all along. We believe this is what the Board intended last year and it's a cleanup piece to include survivors in addition to the others described last year. Instead of dependents, the survivors.

Sue Birch: **Policy Resolution PEBB 2019-03 - Retiree Insurance Coverage Deferral - CHAMPVA Survivors.**

Resolved that, beginning July 17, 2018 enrollment in a PEBB program health plan may be deferred when the subscriber is enrolled as a retiree or a survivor of a retiree who was enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

Tim Barclay moved and Harry Bossi seconded a motion to adopt.

Voting to Approve: 6
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-03 passes.

Rob Parkman: Policy Resolution PEBB 2019-04 - SEBB Program Employees and PEBB Program Retiree Term Life Insurance Eligibility. Changes since the last meeting: This was PEBB 2019-02 and has been changed to PEBB 2019-04. The Policy Resolution from the May Meeting is located in the Appendix. There are no other changes to the resolution.

Dave Iseminger: In order to access the PEBB Program retiree life insurance, the current rules require you have to have participated in PEBB Program life insurance. With the addition of the SEBB Program, the same contractor is offering the exact benefit to active K-12 employees. Those K-12 employees, when they become retirees, have access to PEBB Program benefits, if you pass this resolution you are saying the benefit is identical coverage and serves as a qualifier for accessing PEBB Program retiree coverage. It's optional coverage for the PEBB Program retiree.

Sue Birch: Policy Resolution PEBB 2019-04 - SEBB Program Employees and PEBB Program Retiree Term Life Insurance Eligibility.

Resolved that, beginning January 1, 2020, an eligible school employee who participates in the SEBB Program life insurance and meets the eligibility requirements for PEBB Program retiree insurance coverage, is eligible for PEBB Program retiree term life insurance.

Yvonne Tate moved and Carol Dotlich seconded motion to adopt.

Voting to Approve: 6
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-04 passes.

Myra Johnson: I know I'm not a voting member, but I'm in favor of this resolution.

Rob Parkman: Policy Resolution PEBB 2019-05 – Error Correction Incorrect Information. Changes since the last Board Meeting: the resolution changed from PEBB Resolution 2019-03 to PEBB Resolution 2019-05. We also made a number of changes within the resolution. We added "then" in the third row before the word "relied upon." We added "at a minimum" in the fourth row before the wording "the error" and added "which may include retroactive enrollment" in the last two rows before the wording "is warranted." The Policy Resolution slide from the May Meeting is located in the Appendix.

The Board also asked for additional information on retroactive enrollment, the error correction timeline, and the process flow. Slide 7 lists the prior Error Correction Resolutions passed by the Board. The first error correction was in 2013 establishing the error correction process within PEBB Program rules. It provided instructions to employers on how to correct errors. It also established the HCA authority to provide recourse based on each situation.

In 2014, the Board passed another error correction resolution that established once an error is identified, enrollment would be perspective to the start of the next month unless it is identified on the first day of the month, then it would start on that day. This policy also retained HCA's authority to address the effect of the error through recourse.

In 2018, a policy resolution passed addressing employing agency who enrolled ineligible dependents in coverage. The current resolution adds another subject area where incorrect information was provided to the employee and the employee acted upon that information.

Dave Iseminger: At the last meeting there were questions from the Board wondering if what we were proposing in Policy Resolution PEBB 2019-05 was a departure from past practices. We wanted to show the order of the resolutions that set up the answer to a very specific question giving the agency authority to say on a case-by-case basis, work with the employer to decide if additional recourse is warranted. There was concern that might be a departure from the past. It's actually perfectly in line with the prior resolutions that were passed. That's one of the reasons the lines are highlighted in blue on Slide 7. Some Board Members had particular concerns about what that language looked like in the new resolution that's before you.

Rob Parkman: Slide 8 – Error Correction Data. These data are from a couple of different sources. The first source is from our current error correction process. This data is the last quarter of 2018, from September through December 2018. There are four different categories. There's a total of 131 events. The takeaway is that approximately 20% of these actually included retroactive enrollment.

The next bullet deals with appeals data. If we had this issue, it would actually go the appeals route. There is a very small data set on the 2019 data. Of nine appeals, all nine received retroactive enrollment. I hope this data answers your questions.

Slide 9 – Error Correction Incorrect Information Process Flow. This slide is basically a swim lane slide. The top is the employee, the middle is the employer, and at the bottom is HCA. In Step 1, the employer provided incorrect information to the employee. Sometime after that happens, Step 3 is the intersection where a lot of back and forth between the employer and HCA happens. The employer will send a Fuze email to HCA. Fuze email is a secure email system used by HCA. They would describe the issue. Step 4, HCA and the employer and employee gather the necessary information to determine the options available and the best recourse given. Many of these are unique situations. In Step 5, HCA would approve the error correction recourse. Step 6, the employer sends the error correction letter to the employee. Step 7, the employee acknowledges the letter by signing it and acknowledging the error correction recourse. Step 8 is when the employer implements the HCA approved recourse.

Steps 1 and 2 are indeterminate timing on those, but Steps 3 through 8, the average is about 40 days in our current system to execute error correction recourse.

Dave Iseminger: We can't underscore enough how these are all very unique situations. The stake in the ground is what does the employee believe is appropriate recourse? Sometimes they're not interested in retroactive enrollment. By going through the error correction process and putting them on benefits prospectively, or giving them that option, and them acknowledging that option, it's an important piece of reducing liability for the entire program because they acknowledge they don't want a retroactive enrollment.

We have had questions asking why we wouldn't always retroactively enroll. It might not be a recourse an individual wants, or for whatever circumstance, isn't appropriate. This process allows us to document those conversations have occurred; and then if there was any future concern about how something was done, we would be able to show the employee, the employer, and HCA engaged in a process to provide recourse that was tailored in the particular instance.

Sue Birch: **Policy Resolution PEB B 2019-05 – Error Correction Incorrect Information.**

Resolved that, if an employing agency provides incorrect information regarding PEBB Program benefits to the employee that they then relied upon, at a minimum the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified. The Health Care Authority approves all error correction actions and determines if additional recourse, which may include retroactive enrollment, is warranted. Is there a motion to adopt?

Tom MacRobert moved and Tim Barclay seconded a motion to adopt.,

Voting to Approve: 6
Voting No: 0

Sue Birch: Policy Resolution PEBB 2019-05 passes.

2019 Annual Rule Making

Stella Ng, Senior Policy Analyst, Policy, Rules and Compliance Section, ERB Division. I will highlight significant changes and rule making actions HCA is considering. No action is needed from the Board.

Slide 2 – Rule Making Timeline. July 2019 we will file the CR102, the proposed rule making on our proposed amendments and new rules with the Code Reviser's Office. In August, we will conduct a public hearing on proposed amendments and new rules. After the public hearing, we will file a CR103, the rule making order. The adopted rules will be effective January 1, 2020.

Slide 3 – Focus of Rule Making. The focus of this year's rule making is: administration and benefits management, regulatory alignment, amendments within HCA authority, and to implement PEB Board policy resolutions. HCA is adding clarity to rules to better administer and manage PEBB Program benefits as identified by staff and stakeholders and making changes to implement state legislation and to comply with federal requirements. The amendments are within HCA's authority. We will implement PEB Board policy resolutions the Board passed this year.

Slides 4 – Administration and Benefits Management. HCA will amend PEBB Program rules to have consistent use of language, to avoid confusion for staff, and to help our communications team as they produce materials. We will provide clarity on HCA's brief adjudicated proceedings and formal administrative hearing processes. Last year, we amended and updated PEBB Program appeals rules to streamline the appeals process and improve appeal resolution timelines. We continue to work on refining the appeals rules language for clarity.

Slide 5. Under our premium payment rule, we clarify HCA may develop a reasonable payment plan of up to 12 months in duration upon subscriber or subscriber's legal representative's request based on hardship. We also have a new rule regarding subscriber address requirements. It clarifies all employees must provide their employing agency with their correct address and update address if it changes. This also applies to retirees. They must update their addresses with the PEBB Program.

Slide 6 – Regulatory Alignment. HCA will make some changes to align with changes in regulations, implement legislation, and align with state statutes. This includes amending rules to align with Engrossed Substitute Senate Bill 6241 from the 2018 legislative session, which includes new definitions such as "school employee" and "School Employees Benefits Board Organization."

In regards to implementing recent legislation, we are making changes based on Engrossed Substitute House Bill 2140 to include non-represented Educational Service District employees into our rules. We will amend the federal Family and Medical Leave Act rule to incorporate information on the new Washington Paid Family and Medical Leave Program and to describe options when an employee is approved for the federal FMLA and state Paid Family and Medical Leave Program.

We clarify if an employee is eligible for COBRA, they can continue Medical Flexible Spending Arrangement (FSA) contributions if they have a greater amount in remaining benefits than remaining contribution payments for the current year.

Slide 7. We clarify National Medical Support Notice requirements that a dependent can be removed from a subscriber's PEBB Program insurance coverage prospectively when the coverage for the dependent is provided as required by the National Medical Support Notice.

We are aligning with the federal requirement for adding a newborn or a child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption. Currently, a subscriber has 12 months to submit required forms if adding a child increases the premium. To align with the federal requirements, it's being amended to 60 days.

Slide 8 – Amendments within HCA Authority. We are amending PEBB Program rules to implement changes within HCA's authority. However, there is an error on Slide 8. The error correction identified on the slide is not within HCA's authority and is within the Board's authority. That's why the Board was asked to take action regarding this in the previous presentation.

An example of an amendment that falls within HCA's authority is in our special open enrollment rule that a special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB Program benefits.

Sue Birch: Our next agenda item is an update on the Uniform Medical Plan third party administrator implementation by Shawna Lang, our Senior Account Manager for UMP. I want to acknowledge Shawna who the Governor and the leadership at the Health Care Authority recognized as being one of the outstanding leaders in our state.

Uniform Medical Plan (UMP) Third Party Administrator (TPA) Implementation Update

Shawna Lang, UMP Senior Account Manager, ERB Division. Slide 2 – UMP Implementation. I'm here to update you on the UMP third party administrator procurement that first started and was released in November 2016. We signed a contract in early 2018. Implementation began in early 2018 and we go live with a new contract on January 1, 2020.

Slide 3 – Implementation Stages. There were four stages of implementation: Alignment Stage Gate, Definition Stage Gate, Delivery Stage Gate, and Transition Stage Gate.

For alignment, we took the contract and broke it down into initial implementation plans and baseline scope. We took the implementation plan and defined all the deliverables, which took almost nine months because we had to take each line of the contract and really understand what it was as a deliverable and how long it was going to take. We made sure we knew the deliverables and the implementation plan.

We are currently in the Delivery State on all deliverables. We will then go through open enrollment and all the materials must be ready by September 1, 2019. This involved combining materials for both the PEBB and SEBB Programs. The new procurement for

this UMP contract includes both populations. Once we are done with the delivery phase, we will transition to maintenance and ongoing processes and procedures.

Dave Iseminger: Remember the Health Care Authority used to do the direct administration of all parts of the Uniform Medical Plan until approximately 2011. HCA was directed to do a procurement that resulted in the Regence third party administrator contract we have today. That contract expires at the end of 2019. That's why we went through this multiyear procurement and implementation effort. The contract that was just executed, the initial term of it is for the entire decade of the 2020s. It goes from January 1, 2020 through December 31, 2029. It also has a possibility for extensions until the mid-2030s. HCA has been working on implementing this contract, which is valid for 17 or 18 years if it goes to its maximum contract length.

As HCA transitioned from its direct administration of all aspects of UMP, the Board and the Legislature added the high deductible health plan and UMP Plus. We are rebooting the whole thing. When you reboot, you find more efficiencies and better ways to build things and make operations better. This started from the ground up even though it's with a partner we've already been working with. It was also doubling it at the same time because the SEBB Program came on board at the same time this was happening.

Sue Birch: Between Dave and Shawna, they've made this look so easy but it has been extraordinarily complex and detailed. Kudos to you and the whole team because this really is a remarkable achievement.

Dave Iseminger: Shawna first came to me four jobs ago here at the Health Care Authority saying we need to starting working on this procurement. That was six years ago. Here we are nearing the finish line on implementation.

Shawna Lang: Slide 4 – UMP Implementation. HCA started out with 13 work streams. The Account Team Infrastructure over the current and ongoing reporting, the operations manual, which takes the contract and breaks it down into the daily processes and procedures. An additional layer defines what that layer does. It defines accounting, invoicing, claims adjustments, reporting, etc.

ACP Reporting goes into what is in the UMP Plus account. HCA has over 72 reports on a monthly basis to review. This stream makes sure all of those reports have processes, file layouts, and ensuring everything is updated and has a maintenance schedule.

Dave Iseminger: The 72 reports don't sit on a shelf and collect dust. These are reports giving real time information to providers. The contracts are designed to coordinate care management. They are the types of data flying over to the providers to help them coordinate and improve health conditions. Providers use them to network on a real time basis to improve the quality of care members receive.

Shawna Lang: Clinical Management includes the clinical programs Regence has for their commercial book of business in the UMP plans. That's part of the new reboot starting January 1, 2020. It includes customized parts of UMP, such as the Health Technology Clinical Committee (HTCC), disabled dependents, and others.

Dave Iseminger: The Health Technology Clinical Committee makes coverage determinations that apply to state purchased health care plans on emerging technologies.

Shawna Lang: Communications incorporates the certificates of coverage, which are contracts with the members that tell the member exactly what benefits are available. As part of this contract, Regence is taking on the actual operations of the UMP public website. The authenticated website goes along with UMP. Once you're a UMP member, it includes all of the personalized information that goes into signing on and seeing your claims, which is also being updated.

Medical Pharmacy Management includes all of the medical drugs administered at hospitals or at doctors' offices. We have rebooted to ensure an extensive list of what those are, as well as rebates coming in and out of that category.

OCIO Design Review is the IT oversight of all the data that goes back and forth to ensure we have privacy, data regulations, and state oversight.

Operations – high priority areas and Operations – other functional areas includes making sure open enrollment, claims, customer service are updated, defined, and specifically scoped for both the PEBB Program population and the SEBB Program population, and knowing the differences between them. We have defined escalation teams at Regence so when we have escalated issues, we have someone defined for UMP only.

Performance Guarantees. There are a lot of performance guarantees on this contract. 40% of the annual administration is at risk on this contract. We want to make sure our TPA is performing. HCA is able to track and audit all of those things.

Provider Management comes to network adequacy, access, and making sure we have not only met the Office of the Insurance Commissioner (OIC) standards, but have internal standards within the contract.

Provider Search. We are upgrading the provider search option to better identify primary care providers for UMP Plus plans and others. We are also customizing the provider search tool.

Reporting and Benchmarking is documenting every report that's coming to us and knowing the layout, the owner, what system it's coming out of, the owner at HCA, and making sure we have documented changes of each of those.

Value-Based Programs is about the total cost of care, the Medicare LAN charts, making sure we have measurements of how we're paying for value, and how we're measuring that in a performance guarantee throughout the contract.

Dave Iseminger: OCIO Design Review is the state security requirements that are important with the level and type of data flowing throughout the different information systems. It's often a security review process we go through for any of our IT work streams and Pay1. When we get to Pay1's replacement, will be subject to that. For everyone, Pay1 is our backend accounting function that invoices, does the invoicing

process with employers, and provides the carriers the enrollment files. It's from 1977. It's as old as the LTD basic life insurance benefit and just as antiquated.

Shawna Lang: Slide 5 – New UMP Clinical Programs Implemented. Radiology Full UM / Advanced Imaging Authorization (AIM) is offered through advanced imaging or AIM. We'll have preauthorization on Computed Tomography (CT), Nuclear Cardiology Echocardiography (SE), and Magnetic Resonance Imaging (MRI). It takes the current utilization management program and makes it a requirement. This is an actual preauthorization for every one of these.

Sleep medicine is actually through AIM not EviCore, as noted on the slide. That's a mistake. Preauthorization is required for site testing, where the sleep study will take place, if it's at home, sleep center, in-patient, or out-patient; the equipment and supplies; and for the first 90 days for a C-PAP machine. They want to make sure the member is using the equipment on a regular basis and checking in on a case management level.

Physical Medicine is through EviCore. This is preauthorization of pain management, joint surgery, back surgery, physical therapy, speech therapy, and occupational therapy. In this program, the consult and first six visits don't require a preauthorization. After that, the provider, it's not on the member, needs to make sure the member has submitted a preauthorization for the rest of the visits. It is also a provider write-off. It doesn't get billed back to the member.

Dave Iseminger: What we found is over the years, Regence has other parts of its book business and it will develop utilization management techniques for other programs and other benefit offering suites. What we negotiated in our contract is that as they develop those, we have the right to include those, and they are already included within our payment structure. We don't have to go back and ask for additional funding to implement other great ideas that they have already been implemented across their book of business. It's already going to be included. We will roll those into our plan as we go forward. Shawna is highlighting several of them that have been in Regence's other administrative services contracts that will be incorporated by the nature of what I just described.

Shawna Lang: Slide 6. 24-hour Nurse Advice Line (excluded for UMP Plus plans). This is a toll-free number that members can call any time and get advice.

BabyWise is available to our pregnant members over age 18. It's maternity management, support, and education. There's also an application with information on the first trimester, second trimester, and education of the pregnancy phases.

Carol Dotlich: What if this is the daughter of a member who's below the age of 18?

Shawna Lang: There are privacy issues for members' dependents between the ages of 13 and 18. That's why we've chosen to offer it above the age of 18.

Dave Iseminger: There are services available to those under the age of 18. It's just not this particular program.

Shawna Lang: Regence would not reach out to those under age 18, but if someone reached out to Regence indicating they wanted these services, that would be different.

Myra Johnson: I was wondering if 18, is it possible to have that go to 16? I know there's the privacy act, but I was just wondering if the programs are available. I heard you say from 13 to 18 they would still be eligible somehow.

Shawna Lang: The algorithms aren't going to identify anyone under the age of 18 and proactively reach out to them. Yes, we can offer these programs, but the member has to reach out.

Sue Birch: I believe where staff is going is BabyWise is independent. You wouldn't want a 13-year-old attaching to a program without parent or household involvement. Thank you for that input. There are all sorts of very specialized programs in the state for that age range, in addition to what we have going on. My guess is we're dealing with that in a different way, but we didn't want that algorithm to create adverse impacts.

Myra Johnson: Thank you.

Medicare Retiree Health Benefits Project Update

Molly Christie, Project Manager, ERB Division. I will provide an update on where we're at with the project and identify next steps.

Slide 2 – PEBB Program Medicare Retiree Portfolio. I want to provide a recap of what we discussed at the January 2019 Retreat. We looked at why we're evaluating the Medicare portfolio; retiree benefit options other states have pursued; results from the Request for Information performed last September on Medicare Advantage Plus Prescription Drug plans (MA-PDs); and HCA's recommendation to the Board to procure at least one national MA-PD.

Slide 3 – Today's Agenda includes: RFI recap, RFP status, Funding, and Timeline.

Slide 4 – MA-PD Request for Information Recap. MA-PDs are private insurance plans that cover all Medicare benefits like Medicare Part A and B covering hospital and then professional services, as well as Medicare Part D, prescription drug coverage under Medicare. Medicare Part D is not necessarily the same as prescription drug coverage under an employer group plan. CMS pays the plan for these at a capitated rate for coverage under Medicare Part A and B. CMS also separates capitated subsidy for Part D coverage as well. MA-PD plans have a lot of restrictions by CMS so they have to cover all of the services covered by original Medicare. They also have to cover at least two drugs in every drug class for those drug classes that have two drugs for Part D coverage.

Where they vary is they can offer supplemental benefits and can change cost-sharing levels. Member cost sharing can be different than it would be under original Medicare. It's usually more generous because these plans are competing for enrollment. Last year we saw CMS expanded the definition of supplemental benefits. The standard supplemental benefits are enhancements over original Medicare that a lot of these plans offer, like vision, dental, hearing, alternative therapies, etc. This expanded definition is looking at non-primary medical benefits, things that will essentially help

keep members in their homes longer and out of the hospital. We are looking at those types of things in the RFP.

Sue Birch: Molly, I would add there are things like transportation services. There are the social determinate type things, and because Medicare Part C is moving in this direction, it's giving lots of opportunity for other partners to start looking at these nonmedical things that save on medical expenses.

Molly Christie: Exactly. Like any private health plan, MA-PDs can operate in different ways. You can see HMOs, PPOs, HMO point of service. There are different variations. Through our RFI process, we also learned that some large Medicare advantage organizations can offer plans under a federal waiver that allows for national PPO coverage. These plans are called different things, non-differential PPO ESAs, passive PPOs, there's all kinds of terminology. Essentially, what it means is the non-differential piece, the members are able to receive care from any Medicare participating provider that also accepts the plans payment terms and the member's cost-share levels are the same. If they see an in-network provider or a Medicare participating provider out of network, it doesn't make a difference in terms of cost sharing.

Slide 5 – MA-PD Request for Proposals Status. We are preparing an RFP for one or more fully insured MA-PD plans, at least one of which operates as a national PPO. Based on our research and analysis, this option aligns best with a goal to transition to a more sustainable and affordable health benefits portfolio that maximizes federal funding. It's that funding for private Medicare plans that covers a lot of the cost of original Medicare benefits and the Part D prescription drug.

Responses to the RFP are due at the beginning of August. We'll provide more details on the range of plan designs and rates as we work through negotiations.

Slide 7 – Evaluate Funding. The RFP timing will provide the opportunity to evaluate specific financial information on regional and national MA-PD plans before the next legislative session. We'll evaluate potential funding needs in the fall. These may be requested as part of the 2020 supplemental budget process.

Slide 8 – Timeline. Our objective continues to be to launch new plan options in 2021. If all goes according to plan, we will release the RFP in June or July and receive proposals in August. Depending on these results, we'll move forward with negotiations between September and December. We'll update the Board on the progress at the January Retreat and potentially present rates for a vote around July 2020.

Public Comment

Next Meeting
June 19, 2019
1:30 p.m. to 3:30 p.m.

Meeting adjourned at 4:21 p.m.