Combined Public Employees Benefits Board and School Employees Benefits Board Meeting Minutes

September 17, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
2:45 p.m. – 4:45 p.m.

PEB Board Members Present:
Sue Birch
Tim Barclay
Carol Dotlich
Myra Johnson
Tom MacRobert

PEB Board Members Present by Phone:
Yvonne Tate
Harry Bossi
Greg Devereux

SEB Board Members Present:
Lou McDermott
Pete Cutler
Sean Corry
Patty Estes
Katy Henry
Dan Gossett
Terri House
Wayne Leonard

SEB Board Member Present by Phone:
Alison Poulsen

PEB Board and SEB Board Counsel:
Katy Hatfield

Call to Order
Sue Birch, Chair, called the meeting to order at 2:47 p.m. Sufficient members were present of both the PEB Board and SEB Board to allow a quorum. Board introductions followed.

Agenda Overview

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda. Today's meeting is a special joint meeting of both Boards to discuss one topic, the Retired and Disabled School Employees Risk Pool Analysis. Under legislation, this agency is to consult with both Boards. The ultimate decision that the Legislature may or may not make based on the report that the Health Care Authority produces could impact either or both programs. This is not the first step on a journey of consolidating the programs. This is a discussion because of a specific legislative report about where K-12 retirees should be housed within the various programs and risk pools created under current state law. This is a special meeting under the Open Public Meetings Act. I make this point because we need to stick to the topic on the agenda.

Retired and Disabled School Employees Risk Pool Analysis

Kayla Hammer, Fiscal Information and Data Analyst, Financial Services Division, HCA. Today we'll talk about the legislative reports. We'll discuss background, what is the report and its purpose, the anticipated 2020 risk pools, 2018 PEBB Program enrollment, PEBB Program non-Medicare risk pool data and information, PEBB Program Medicare risk pool data and information, and the retired and disabled school employees risk pool scenarios and their implications.

Slide 3 - What is the Report? RCW 41.05.022(4) requires the Healthcare Authority, in consultation with the PEB and SEB Boards, to complete and submit an analysis of the most appropriate risk pool for the retired and disabled school employees. This is our second round of consultation with both Boards. This report is due to the Legislature on December 15, 2018. Comments and feedback from this Board consultation and the previous consultation will be documented. It's my intent to share it as an appendix to the report in regards to the most appropriate risk pool, cost impacts, member experience, state and federal laws and regulations, implementation, and administrative complexity.

Dave Iseminger: The legislation did not outline the criteria. What Kayla just described is what we see as high-level categories for potential impacts. It is not described in statute.

Tom MacRobert: I'm curious. Could you give me a little more explanation on what you mean by member experience? I'm assuming you're referring to people who have gone through some type of situation comparable to this.

Kayla Hammer: What I mean by member experience is if we were to make changes to the current risk pools that exist, how would they be affected? Would that result in having to choose new plans? Would it impact their cost personally or as a group? Those are examples of what I mean by member impact.

Tom MacRobert: Then also, implementation and administrative complexity. Are you anticipating that if you make changes, there will be overarching concerns in making those changes?

Kayla Hammer: Yes, that's correct. We will go into more detail in this presentation. But, yes, there are some overarching things that would change should risk pool changes be suggested.

Dave Iseminger: Tom, an example would be if the K-12 retirees were moved into the SEBB risk pools, there are currently no procurements or Medicare products that have been procured. There would need to be additional procurements. The SEB Board would have before it the task of authorizing similar or different product offerings. That would be an example of administrative complexity. We might have Medicare plans for PEBB and different Medicare plans for SEBB, as an example.

Kayla Hammer: Slide 5 – Insurance Risk is the likelihood that an insured event will occur requiring the insurer to pay a claim. In health insurance risk, it's viewed on more of an aggregate level instead of the singular example seen on this slide. The amount of risk would be measured by the likelihood that the total claims cost would exceed what was expected.

Slide 6 – What is a Risk Pool? A risk pool is a group of individuals whose medical costs are combined and evaluated to calculate premiums. It's also a means to organize legislative funding for the different pools. Regardless of personal circumstances, if you are part of a risk pool, you will pay the same rates for the same plans as everyone in your pool. Pooling risks allows costs of the less healthy to be offset by the relatively lower costs of the healthy. The amount of risk has impact on the premiums.

Slide 7 – Risk Pool Dynamics. Although the risk within a pool impacts the rates, risk pool changes would not result in aggregate cost savings as the risk pools are not the primary driver for rate setting. There will be individual impacts that can vary dependent upon the changes proposed because when you are moving risk around, you would be reducing or increasing subsidization between individuals. Combining people with different levels of health risk into a single pool increases the level of subsidization from the relatively healthy to the relatively unhealthy. Currently, in the PEBB non-Medicare risk pool, the employee population is subsidizing the non-Medicare retirees, as an example. If you were to combine people with a similar health risk, there would be the opposite effect. There would be little to no subsidization.

Dave Iseminger: The Board will see examples of what Kayla just described in later slides with numbers. We'll be coming back to this concept with tangible examples. I think the first bullet on Slide 7 is a profound piece that changing risk pools doesn't change the aggregate cost to the system. Let's say a billion dollars is being spent right now. If you mix up the population into different pools, you're still spending a billion dollars. It’s what individual people are paying. I think some people believe that changing around the risk pools could create money in the system, but the reality is that it's still the same total amount of money. It's how different people are pooled. The system isn't creating, losing, saving, or generating money with the idea of changing risk pool arrangements.

Kayla Hammer: Correct. Slide 8 – Anticipated 2020 Medical Risk Pools, is an example of anticipated risk pools for 2020. Each one of these pools is legislatively mandated and the way the Legislature funds each pool is different. There is the non-Medicare community-rated risk pool under PEBB. It consists of state and other employees, non-Medicare state retirees, and non-Medicare school retirees. The PEBB Program Medicare risk pool consists of Medicare-enrolled state and school retirees. The SEBB risk pool is solely a school employee pool under the SEBB Program, which is separate from the PEBB Program.

Slide 9 – Anticipated 2020 Risk Pool Considerations. Assuming no changes in 2020, this slide lists considerations about the scenario that currently exists. In the PEBB non-Medicare risk pool, it combines the employees with the retirees. The risk pool is community-rated across plans. Rates are based on the level of risk within the entire pool. State active premium contributions are a portion of the community rate. The non-Medicare retirees pay the community rate. In the PEBB Medicare risk pool, it combines the state and school retirees that are eligible and enrolled in Medicare. The plans offered to that pool are not the same as the non-Medicare pool. The plans are rated separately based on member experience, and the state premium contributions are a portion of the plan rate up to a monthly limit.

Lou McDermott: I noticed you said member experience. I want to make sure what you're referring to is claims experience. Two different ways to interpret member experience.

Kayla Hammer: Yes, that's correct. Now we'll look at and discuss data. The next few slides show PEBB Program enrollment data. Slide 11 – PEBB Program Member Enrollment. This data is enrollment by group as of August 2018. The member count is accountable subscribers and dependents. There's an asterisk next to state employees and state retirees with notes below. On this table, state employees also includes others. It includes political subdivision or employer groups. There's also the K-12 current people that are in the PEBB Program in this count, COBRA, and others. The state retiree asterisks includes state retirees and those employer group or political subdivision members.

Dave Iseminger: When a political subdivision joins and contracts with the Health Care Authority for PEBB benefits, not all of them bring retirees with them. It's a subset of political subdivisions. I want to be clear that not everyone who joins the PEBB Program includes retirees. As a reminder, there are about 72 K-12 school districts with some or all of their bargaining units in PEBB benefits. But, come 2020, they get moved out of PEBB risk pools and put into the SEBB risk pool.

Kayla Hammer: There is a significant difference between these populations. If you look at the state employee count, for example, that's a lot of employees versus the non-Medicare retirees that are within that pool.

Dave Iseminger: Employees and dependents.

Kayla Hammer: Yes. Slide 12 – Subscriber Enrollment is member count. The dependents accounted for on the last slide are not on this slide.

Slide 13 – 2017 PEBB Program Non-Medicare Risk Pool Data. Now we will discuss data specific to the PEBB Program Non-Medicare risk pool. This is 2017 claims data. We'll talk about relative risk scores, average monthly paid claims, and total annual paid claims separated by group.

Dave Iseminger: This discussion is about the first box on the left side of Slide 8.

Kayla Hammer: Yes. Slide 14 – What is a Risk Score? A risk score is a calculated number reflective of the risk within a population or morbidity. Morbidity is the rate of disease in a population, or how unhealthy is that population, and a measure of that. Risk is calculated based on demographic information, diagnosis codes, drug codes, and utilization. Population groupings with higher average risk as expected to have higher claims cost due to that high morbidity.

Slide 15 – Non-Medicare Relative Risk Scores. This data is based on 2017 claims data.

Pete Cutler: On the risk score, is this used for risk adjustment within the PEBB Program or is this risk analysis being used just for purely analytical reasons? I'm curious how it connects to the rate setting process.

Kayla Hammer: The risk scores that I'm sharing today were a separate analysis and not necessarily what we use for rate adjustment. I would have to double-check that to be completely sure.

Pete Cutler: But the PEBB Program still does use some type of risk adjustment process for the populations?

Kayla Hammer: Yes. That is correct.

Carol Dotlich: You're talking very quickly for me to keep up. My question is back on the other two slides where you had program member enrollment and subscriber enrollment. The totals are quite different. Can you define what the difference is between the two total numbers?

Kayla Hammer: Yes, I can. Slide 11 is member enrollment. It has the subscribers and any dependents on their account. It's a significantly higher number. Slide 12 is looking at subscribers, which is just the employee or retiree, who are eligible and able to enroll in the medical benefits. No dependents.

Slide 15 shows risk scores relative to the statewide PEBB non-Medicare average of 1.0. Any amount above or below 1.0 is the percent of utilization expected compared to the average. An example would be, if you look at the table and see the school retiree non-

Medicare at 1.682, their expected utilization is 68% higher than the statewide average of 1.0.

Sue Birch: Average in this pool?

Kayla Hammer: Yes, average to this pool. Slide 16 – Average Monthly Non-Medicare Paid Claims per group. This is also 2017 PEBB Program claims data. The dollar amount shown is per adult unit per month (PAUPM) and is relative to the statewide average of $535. The monthly average paid claims is based on utilization and is impacted on plan selection. If a specific group was prone to selecting a specific plan that paid at a higher level than other plans, that can have an impact on what is shown here in the average paid claims. If you think about the last slide with the risk scores and connect those to what you're seeing here in average monthly paid claims, the groups that had the higher relative risk score tend to have, on average, a higher paid claims amount per month. The enrollment slide you saw earlier had over 100,000 subscribers in the state employee group. The numbers are much smaller, only a couple thousand, in the high utilizing groups. That helps create balance across the pool as far as overall cost.

Pete Cutler: On the paid claims, is that affected by whether somebody's seeing a consumer directed or a high deductible plan versus one of the other plans?

Kayla Hammer: Yes, the plan selection does impact that. Without having it in front of me, I couldn't say which group chooses certain plans more often than others. But that definitely does impact the cost of what's paid.

Pete Cutler: Am I right that the risk adjustment would not be impacted by that because it would look at how many tendency of what drugs you use, what kind of diseases you had, whatever factors that are not keyed by what your point of service cost share is?

Kim Wallace: Correct. The risk adjustment that we do as a regular matter of course in the PEBB Program to establish the ultimate premiums and rates does not adjust for differences in plan design.

Pete Cutler: Okay. That would make sense because the factors mentioned on Slide 14 were diagnosis codes, demographic information, drug codes, those kind of things, which really are not tied to what kind of out of pocket cost you have in your plan. Thank you.

Kayla Hammer: Slide 17 – Annual Non-Medicare Risk Pool Paid Claims. This slide also based on 2017 claims data. This is looking at all members. You may notice the percent of enrollment does not equal 100% because there are other groups in the non-Medicare pool, the employer groups. They are not part of this state employee line in this particular table, which is strictly state employees. There are other people within this particular risk pool and they account for about 12% of the enrollment.

Now we will talk about the middle column on Slide 8, the PEBB Program Medicare Risk Pool. Slide 19 – Medicare Risk Pool. Medicare data is shared separately from the non-Medicare data because the risk pools are separated in statute and funded differently by the Legislature. The insurance plans offered to the different groups are different. The Centers for Medicare and Medicaid Services (CMS) regulates the kind of insurance plans that can be purchased by people enrolled in Medicare. And then because of the differences in the insurance types, the reimbursement is different between the two populations.

Dave Iseminger: As an example, on the Medicare pool for pharmacy benefits, the UMP benefit in the PEBB Medicare pool pays primary for pharmacy but it pays secondary for medical. In the non-Medicare risk pool, the UMP pays primary for everything. That's an example of the reimbursement model being different.

Kayla Hammer: The PEBB Medicare plans are either secondary to Medicare or they are Medicare advantage plans. This results in the two populations cost data not being comparable since Medicare is picking up the bulk of the allowed costs for the Medicare pool on medical.

Slide 20 – Medicare Risk Scores. Based on our research, the K-12 retirees currently enrolled in the PEBB Program are slightly more healthy compared to the PEBB Medicare risk pool as a whole. However, K-12 retirees have significantly higher morbidity than active employees and early retirees. There are challenges and complexities with comparing the risk scores and associated costs of the Medicare and non-Medicare risk pools due to some of those things I mentioned on the previous slide, primarily, the way in which the plans reimburse based on the different types of plans offered to those two populations.

Lou McDermott: On your second bullet, could you say the PEBB Medicare retirees also?

Kayla Hammer: That's correct. Both or all the populations in the Medicare pool have higher morbidity than the active.

Lou McDermott: I just wanted to make sure we weren't calling it out because it wasn't similar in the other pool.

Dave Iseminger: As a reminder, the context of this report is what to do with K-12 retirees. The information, if it's silent for other parts of the retiree population, it's because the question being answered is what to do with K-12 retirees. The absence of information about other parts of the pools doesn't mean that it's similar, different. It's because we're trying to focus on the simple and straightforward K-12 retiree piece. We're trying not to introduce even more complexity within the description.

Kayla Hammer: Slide 21 – Annual Medicare Risk Pool Medical Benefit Costs by group. It's important to point out that the benefit cost amount is a combination of things. It is

self-insured claims cost, administrative fees, and fully insured medical premiums. This is not strictly claims costs as it was on the previous slide when we were talking about the other risk pool within PEBB. The total medical benefit costs between the groups is similar. There is some increased cost in the school retiree group within that risk pool, but they also have a higher percentage of member enrollment.

Dave Iseminger: Again, we tried to spend a lot of time with the titles of these slides because I know as you flip back and forth between medical benefits cost and claims cost, you'll start to think that they're the same thing but they really aren't. Claims cost is just claims cost. This is titled medical benefit cost and that description at the bottom indicates it's more than just claims. I just want to remind you about that difference.

Sue Birch: Could you share a little more information about administrative fees, if that is a blended rate? And could you give us a little more context about administrative fees?

Kayla Hammer: We pay a fee to Regence for managing this for us. It's related to having a self-insured program.

Sue Birch: Thank you.

Kayla Hammer: Slide 22 – Scenarios: Implications and Considerations. I want to discuss the scenarios that we presented previously and talk about implications and considerations. Slide 23 – Create SEBB Program Non-Medicare Risk Pool, is a slide you've seen before. This is a scenario that would create a non-Medicare risk pool under the SEBB Program and we would remove the non-Medicare school retirees currently in the PEBB Program and move them into a community pool with the school employees under the SEBB Program. The school Medicare retirees would remain in the PEBB Program Medicare risk pool.

Kim Wallace: Kayla, I think what this is showing is that on the left-hand side in the green is the current PEBB Program non-Medicare risk pool without the non-Medicare school retirees. We move them over to the far right and essentially create the same type of non-Medicare risk pool for SEBB as there would be for PEBB.

Kayla Hammer: That is correct, Kim. Slide 24 - Considerations. Any risk pool changes that we discussed today will require changes to state legislation and likely changes in the way the Legislature funds each of those risk pools. The non-Medicare school retirees could have the same plan options they use prior to retirement in this particular scenario, which would result in a positive member experience for many. This could also lead to a negative member experience for the PEBB participating school non-Medicare retirees currently in the PEBB Program having to move over and to potentially having to switch insurance again. There are impacts on the employee populations as well. By removing some of the higher utilizing population currently in the PEBB non-Medicare community-rated pool, there could be a slight reduction in premiums for employees, assuming they were having a high impact on the current pool. By adding higher utilizing

population to the SEBB employee pool, there could also be an increase to premiums for school employees. These are potential impacts.

Dave Iseminger: Just a couple of additional examples of what this would really feel like to a member. The second bullet, for example, non-Medicare school retirees could have the same plan options they used prior to retirement. Let's go forward in our time machines, and it's now April of 2020. The plans that the SEB Board is currently talking about creating and are now in place in January 2020, at the end of that school year, Katy Henry retires from her teaching job. Now she can continue to have the same plans versus right now what would happen is she would come over and be in the PEBB plans. She would pick up on PEBB plans that are similar to those that state employees have. The example we're trying here is Katy gets to have the same plans she had as a school employee. She would have to probably pick up more of the premium, but the plans that she's already begun experiencing as a K-12 employee in SEBB, she would be able to maintain that experience and wouldn't switch plans until the point she reached Medicare age.

The third bullet is really describing, on Slide 11, the number of people that are non-Medicare school retirees currently in PEBB, about 4,000 members. Those are the members that, if the pool switched and you move that purple box to the far right, if this were the scenario the Legislature picked, those 4,000 people would have an affirmative plan switch that would have to happen.

Wayne Leonard: The K-12 remittance that we currently pay, does that subsidize both the non-Medicare retirees and the Medicare retirees? Or is it primarily one group?

Kayla Hammer: It's both.

Tom MacRobert: I want to make sure I understand this. So on the one hand, non-Medicare school retirees could have the same plan options, meaning if you have Kaiser Permanente, Uniform Medical, those remain the same, correct?

Kayla Hammer: What I meant by having the same is actually speaking as of 2020. Let's say you are in SEBB in 2020. You enrolled, you're working. You sign up for X plan. Then next year, 2021, you retiree. You would potentially be able to keep whatever you signed up for in 2020. In 2021, you could have that same plan. But for people that are already retired and under the PEBB Program right now, they may not have access to the plans that they've become accustomed to over the last two years of their retirement.

Tom MacRobert: So, that's the third bullet then that you were referring to. They might have to switch in that scenario.

Kayla Hammer: Yes.

Tom MacRobert: Okay, thank you.

Kayla Hammer: Slide 25 – Create SEBB Program Non-Medicare and Medicare Retirees Risk Pools. In this scenario, there would be the non-Medicare risk pool created under SEBB, like on the previous scenario. But in this, we would also create a Medicare pool under the SEBB Program. That would remove the Medicare school retirees from the PEBB Program into their own pool that would be managed by SEBB. The same considerations would exist as on the previous scenarios slide, as for the non-Medicare risk pool under SEBB. In this scenario, though, the HCA may need to procure a Medicare portfolio for the SEBB Program. Current PEBB Medicare school retirees would then maybe have to select new plans. This could impact up to 34,000 subscribers. It also could lead to a divergence of rates, plan offerings, member costs, and subsidy amounts.

If the pools were separate, there's no guarantee the Legislature would award the same Medicare explicit subsidy for both populations. We talked before that the K-12s currently in PEBB Medicare were slightly healthier than the Medicare pool as a whole. There would be assumed savings if you were to move them into their own pool. But it's not guaranteed that they would receive the same subsidy amount they were awarded previously under PEBB. There could be savings, there could not be. It depends on what the Legislature would decide to do. There's also additional administrative and program costs associated with this scenario. The implications for the Medicare retirees is that reducing the population can impact the risk of the pool, which would then impact the rates. The school Medicare retirees could end up with some savings, potentially. And then there is also the potential for the state Medicare retirees who were slightly less healthy to have an increase in their premiums.

Dave Iseminger: There's a lot to unpack on this slide. I'll share a couple of examples. I want to level set for each of the Boards. I want to make sure the SEB Board realizes when the agency goes to the PEB Board, we present both non-Medicare plans and Medicare plans. We talk about both risk pools and both plan options and premium setting at the same time for both of those risk pools. In this scenario, that would be done at the SEB Board, as well. Because right now, the agency is presenting the SEB Board with plans on, if I were wearing my PEBB hat, we'd be talking about the non-Medicare risk pool. We would have to very likely go forward and do procurements and bring other plan designs forward to the SEB Board for this second risk pool the Board would manage, the fourth risk pool for the agency, but the second risk pool for the SEB Board. It's not a given that we'd be able to procure the same carriers, the same plan design we've seen as we've presented different benefit options to the SEB Board that your demographics are different. There could be a different rating if the pool is split apart. That would be a whole other function and work stream that would be generated under this scenario to the SEB Board is procurements for Medicare plans, authorizing of Medicare plans, rate setting for Medicare plans. We would be doing everything just like we do for the PEB Board twice. HCA would be doing it twice for the SEB Board.

The third bullet means that if you have separate Boards, separate plans, and separate risk pools, things could diverge in a variety of different ways. It's no guarantee that any of those divergences would happen, but it's certainly possible, given that the

populations would be rated and assessed differently by the carriers. You very well may get somebody who says they used to pay less with them, or, now they are paying more. There's going to be that comparison between two separate Medicare risk pools that are described here in a way that doesn't exist today.

Kayla highlighted the subsidy amount and how the Legislature could handle that differently. I'm not as confident that the SEB Board understands the funding mechanism that happens for retirees and how it differs from employees. For employees, there's a state contribution where the employee pays the difference between what is the total cost from the carrier minus the state contribution. There's an amount the carrier agreed to that is the total plan payment rate to carriers. You subtract the state contribution and the difference is what the employee pays.

On the retiree side, there's the payment rate for the carrier and then the state Legislature has set for next year, the state will contribute $168. There's a flat amount put in the state budget that is paid. The difference is then paid by the employee. Of course, I'm oversimplifying because it's not really $168. It's $168 or 50% of the premium, whichever is less. But in effect, there's a flat dollar amount put directly into the budget. On the employee side, it is negotiated. There's Collective Bargaining Agreements. On the retiree side, it's a flat amount the Legislature puts in the budget.

Kayla Hammer: That's specifically for Medicare retirees.

Pete Cutler: My understanding is in the HCA statutes, there's a provision that, in essence, requires the premiums for non-Medicare retirees to be based on the average claims experience of those non-Medicare retirees plus active employees. Is there a similar type provision in the language dealing with setting premiums in the SEBB Program?

Kayla Hammer: There's no language now because at this time, the SEBB Program is strictly an active pool of school employees.

Pete Cutler: Okay, that would make sense now that you mention it. And there's nothing about that in the future if there is a change, it's just silent?

Kayla Hammer: This report is the next step for the Legislature to evaluate if they were going to make any changes.

Pete Cutler: Great, thank you.

Carol Dotlich: I would like to explore a little bit the impact of the Medicare explicit subsidy if the two groups, the Medicare eligible were separated.

Kayla Hammer: As of right now, for the PEBB Medicare risk pool, which has the school retirees in it now, there is a set amount for the explicit subsidy. I believe it's going to be $168 in 2019 or 50% of the premium, whichever is less. If they were to separate, there

is nothing in statute about what the subsidy amount would be for the SEBB Medicare risk pool. That would be up to the Legislature to decide and reevaluate. I can't speak for what they would do or if they would make any changes to the PEBB pool with it being sliced pretty much in half. We do know that there is nothing written for the SEBB, if there was a SEBB Medicare pool.

Patty Estes: When we talk about procurements, I know we've talked a lot about our timeline for SEBB and launch. What's the timeline if we were to try to procure Medicare plans?

Dave Iseminger: I'll answer this two different ways. This is all hypothetical as to when any changes would go into effect. If scenario two were selected by the Legislature, the earliest they could make any changes would be during the 2019 Legislative session. It would be very challenging and I'm pretty sure the agency would explain why implementing for plan year 2020 would be particularly challenging. It would be on a 2021 timeframe or later. It would depend on what the Legislature set as the timeline.

For doing the actual procurement process, we actually haven't done a full evaluation as to the Medicare procurement options. I'll give an example. When we did our life insurance procurement on the PEBB side and rebooted that product from beginning to end, procurement all the way through implementation was just under a year. When we are working on the SEBB procurement currently, the SEB Board in the March meeting authorized and directed the agency to go forward with a disability procurement, as an example. We've gone through that procurement and today brought you some preliminary benefit design pieces, asking you to take action soon. We're in contract negotiations and then the plan would go into effect in 2020. It really depends. I would say anywhere from a year and a half to two years is average. The more complicated the procurement, like our third party administrator for Regence, that took three and a half years plus two years of implementation. The less complex procurements can be under a year from beginning to end. But it's typical that it's somewhere between a year to two years.

Sue Birch: I think it's important to note, you referred to it as scenario number two. I believe you're referring to Slide 25 and now you're referring to scenario one on Slide 23. Is that correct?

Dave Iseminger: I was trying not to number them. And now you're saying I'm numbering them in voice.

Sue Birch: You numbered them. I just wanted to clarify for everybody.

Dave Iseminger: Yes.

Kim Wallace: I wanted to add also that when we're thinking about a procurement related to Medicare plans, that also introduces CMS and Medicare. The overarching

environment in regulations, etc. One of the things that HCA is researching and is aware of is that there's an added set of deadlines and considerations when entertaining the idea of offering new or different Medicare plan options. That would be another factor that comes into play as we would be planning a Medicare related procurement.

Wayne Leonard: A quick question to clarify my understanding. I think you just said when the Legislature makes this decision. Is this just informational for us or are we going to make a recommendation to the Legislature?

Dave Iseminger: You could use "when" or "if." There were 20 years of legislative reports about K-12 benefits consolidation and then the official recommendation wasn't what was passed in the House Bill 2242. When and if, let me correct that part on the record. The second piece is, we're here consulting with you, describing the scenarios and what pieces we're seeing as considerations. The agency is charged with making a recommendation on the most appropriate risk pool. The Boards separately or together are not dictated to take a vote. We're asking for your insight so that we can add it into the report. The agency will make a recommendation. Whether the Legislature puts this on a shelf and it collects dust; or they, for ten years, two years, one year, or they act on it in 2019, there are a lot of different factors in the legislative arena as to whether something will be specifically acted on our not. It's the agency making a recommendation and the Legislature taking action one way or the other, or leaving things how they are.

Tom MacRobert: Kim, if I'm understanding what you just said correctly, though, if you were to transfer a large pool like the Medicare retirees from one group to the other group, you could have the potentiality of having to go out and do a whole new procurement of benefits for that group because you've made such a substantial change?

Kim Wallace: I was commenting on the plan offerings that the HCA would be entertaining and wanting to offer across all retirees, both the K-12 and the state retirees. The act of separating them into two different pools suggests that there is a reason to do that. It's part of the analysis that we're doing, looking at that question. Are there compelling reasons to do that? It may be that there are not. HCA is interested in your feedback and views on the desirability of actually splitting the Medicare retirees to separate pools. From our vantage point, we want to highlight that is serious work and it comes at a cost. What we're thinking hard about and inviting you to comment on, is the benefits, what's really achieved by such a separation? What goal would be achieved by separating the Medicare retirees because of the administrative complexity, cost, and timing? We would want to be really clear as to what is being achieved.

Kayla Hammer: Slide 27 – Create Two Additional SEBB Program Risk Pools. In this scenario, the non-Medicare school retirees would be removed from the PEBB Program under the non-Medicare risk pool into their own pool under the SEBB Program. The Medicare school retirees would be removed from the PEBB Program and in their own risk pool under the SEBB Program.

Slide 28 – Consideration. There are similar considerations as previous slides for the non-Medicare and Medicare pools, particularly the PEBB non-Medicare pool. There's likely a small impact to employees in the PEBB Program and SEBB Program based on the risk pool in which the non-Medicare or school retirees are assigned. PEBB Program employees may save by removing the higher utilizing, the small utilizing population, as mentioned previously.

There is the possibility that SEBB Program employees, if Slide 23 scenario was enacted, could have slightly higher rates. But in this scenario, school non-Medicare retirees would be in their own pool. There would be no subsidization situation happening in the SEBB employee pool. However, the small risk pool for non-Medicare retirees would result in increased cost for those early retirees because we would be removing that subsidization talked about previously, the value of a community-rated pool. It's estimated that the premium increase could be as much as 58% to 60% for that small pool of people. That's assuming no legislative subsidy was in place for the non-Medicare retirees.

Dave Iseminger: A big piece of this Kayla is trying to highlight is a lot of these implications and considerations are rooted in the fact that it's such a small number relative to the big picture. Again, if you go back to the earlier slides, we're talking about 2,600 subscribers or 4,000 members compared to hundreds of thousands of individuals in a risk pool. When you get to that small of a pool, it has a lot more volatility.

Sue Birch: Dave, are we worried with these smaller entities, of the plan design and/or the offerings that would be available?

Dave Iseminger: Sue, I do think that's another implication of the scenario on Slide 27. The SEB Board would have to decide, are you going to rate the pools separately for employees and non-Medicare retirees but give them the same plan offerings, or do we do another set of procurements with a different set of plans and have something that's a middle ground between employee plans and full Medicare retiree plans. It would open up the door to that further question in a way that is not present in either of the prior two scenarios, where the non-Medicare school retirees are with the school employees. It doesn't necessarily inherently introduce that. It just means that they would be community-rated separately. The SEB Board could decide to offer the same plans from the employee risk pool or a different set of plans. It would at least create that option.

Kayla Hammer: Slide 29 – One SEBB Program Risk Pool. This scenario illustrates one risk pool under the SEBB Program that contains employees, non-Medicare and Medicare retirees, removing both groups of retirees, the non-Medicare and Medicare from the PEBB Program, all under SEBB.

Slide 30 – Considerations. Further verification is needed on the legality of this scenario. We know it requires changes to Washington State legislation, as this is fundamentally different from the way risk pools are currently funded and managed under statute. Federal law needs further review. The illustration does look like a community-rated pool

but it would not function that way because one thing we do know is that under federal law, no issuer can sell a major medical policy to a Medicare enrollee. That means, regardless of the risk pool, the Medicare retirees will still be purchasing specific plans, which is not the same as people that are not enrolled in Medicare.

Dave Iseminger: If you stay on Slide 29, it looks like everybody's together and being treated the same exact way. But it functionally would not be that way because the bottom purple box would have completely separate plan offerings than either or both of the prior two boxes. The reality is if you were trying to community rate them in a single pool as shown on Slide 29, you would end up immediately having some sort of adjustment factor based on the different plan designs. You would immediately see a different rating structure within what looks like one pool. It would create this plan adjustment factor for lack of a better description that is inherent to the fact that Medicare retirees will have fundamentally different options than non-Medicare retirees. It may look like one pool but it wouldn't function like one pool, which would beg the question, why make it look like one pool.

Kim Wallace: I want to circle back to the comment I made a few minutes ago. We're looking at these different options. I think it's important to consider what would be achieved by moving away from what is currently anticipated so that we can be really clear. That's what HCA is seeking in our report. HCA wants to be really clear on the rationale and underpinnings of our analysis of the most appropriate risk pool for the K-12 retirees. We're keeping in mind what would be accomplished. Why? What would be the better outcome from a recommended change? We invite you to share your views on the opportunities to change and why. What are you envisioning accomplishing?

Tom MacRobert: I'll jump in. After you have gone through and given us a really good descriptor of all of these different plans, I can see no benefit to switching. Maybe you could enlighten me as to why that perception is incorrect. I would love to hear it. But as it stands right now, I can't see any benefit.

Dave Iseminger: Several of us around this table went to law school so we can always play devil's advocate. I don't want anyone to think that me saying one way or the other is supporting an option. It's just me being a lawyer. One of the examples would be the member experience of being able to maintain the same plans, especially that non-Medicare retiree. If you were to move them in the way that's described on Slide 23, where you move non-Medicare retirees, school retirees into the school employee risk pool, then those recently retired young retirees or not Medicare eligible retirees, they get to maintain that plan relationship that they've experienced. At least the future new retirees, not the current ones that are in the PEBB pool. That would have a disruption. But future new retirees would be able to have similar plans they experienced as school employees. They only have one switch to the Medicare retirees plans in the PEBB Medicare risk pool when they enroll in Medicare. If you kept the exact system that was in place today that's envisioned for 2020, you'd have a K-12 employee who has SEBB plans, they're an early retiree, they move to the PEBB non-Medicare risk pool plans,

then they become Medicare eligible and have another shift into a completely different Medicare plan. You could eliminate one of those shifts by a future state where the K-12 non-Medicare retirees are able to maintain the same plans they enjoyed as active school employees. That's one advantage to one of the scenarios.

Tom MacRobert: But that would be the smallest group we're talking about, the least number of people that would be impacted.

Dave Iseminger: Correct. That is a small group. It's about 4,000 members and I think it was 2,600 subscribers.

Tom MacRobert: Okay, thank you.

Katy Henry: But it would affect all future SEBB retirees.

Dave Iseminger: Correct.

Dave Iseminger: Katy, another point, for the record, to keep in mind is that with the consolidation of SEBB, as I always say, the bridge to PEBB will become more apparent. There are many school teachers who learn about PEBB very close to retirement and that's the first time they ever hear of the PEBB Program. With one agency administering both programs, that bridge will be clear and that number may get higher as time goes by.

Patty Estes: I just want to make sure I'm understanding the cost to a school employee if we put the non-Medicare retirees into the same risk pool with the school employees, that would increase their cost.

Kayla Hammer: It could impact the cost because you are moving a small group of people that are typically utilizing into --

Patty Estes: With a smaller funding mechanism with a subsidy. Am I understanding that correctly?

Kayla Hammer: With the non-Medicare risk pool scenario, it is assumed there would be no legislatively mandated subsidy for the non-Medicare retirees. They benefit from a blended premium rate by being in a pool with active employees. Does that make sense?

Patty Estes: No, it's okay, though.

Kayla Hammer: It's a lot to take in on one day.

Pete Cutler: Following up on that, in fact on Wayne's questions, the payment that school districts who don't have employees in PEBB currently, which is a great majority of districts, there is a monthly payment, which I think is referred to as a carve out. It

represents the Health Care Authority's estimate of the cost that the PEBB Program plans incur for all the school retirees that's calculated and updated every year. In theory, on Slide 24 where it talks about the impact of moving the non-Medicare school retirees into a single pool with actives, there could be an increased premium for school employees. My understanding and theory, if you're calculating that carve out accurately, it would not have a premium impact because the dollars would now be pulled out and no longer available to school districts - because they're going to HCA to pay for those costs and would no longer be transferred to HCA and they would remain with the school district.

Kayla Hammer: Let me clarify. You're saying that in that scenario, there would essentially be a wash?

Pete Cutler: Right. I think on making a decision on what to recommend here, for me, it's influenced by trying to understand how that carve out funding mechanism would offset premium impacts that would otherwise be expected to occur. I don't need a discussion right now. But it would be useful before we go too much farther.

Kim Wallace: What some people refer to as the carve out, others refer to as the K-12 remittance. One thing I wanted to clarify for the group is the amount of money you're referring to that the school districts pay in the K-12 remittance covers the value of the retiree costs and comes in two flavors: the implicit subsidy and the explicit subsidy for retirees. That amount is financially modeled and calculated by HCA. They are suggested values. I want to make the point that the Legislature does pick a number and they don't have to pick the suggested value.

Pete Cutler: Thank you for that clarification. In my prior role, often reviewing those numbers, that's an important part for the record. It's actually a legislative decision based on analysis provided by the Health Care Authority.

Kim Wallace: Right. The reason that's important is how much of a wash would occur. It's a funding decision about that retiree subsidy amount. I think none of us know what exactly would come of that calculation of that implicit subsidy.

Dave Iseminger: As we're moving on, I want to say even though this presentation didn't really get into the inner workings of the K-12 remittance or carve out, they'll certainly be described in the report about the implications. There were too many variables, especially with how Kim just described it for it to be as fruitful of an add-on to this presentation. It certainly will be discussed in the final report.

Pete Cutler: Dave, I think it would be useful to have something written up available to Board Members. Maybe just post it on the web. I think providing feedback on different options for pooling, unless you understand the mechanism for the remittance, it really is hard to make an informed point of view. I hope we can get something in writing before December. Thank you.

Carol Dotlich: I wanted to clarify, under this scenario on Slide 23, can you foresee the impact on the PEBB non-Medicare risk pool costs?

Kayla Hammer: Potentially. We talked about relative risk scores previously. And we talked about how in the Medicare pool under PEBB, currently, the K-12 retirees are healthier than the pool as a total. So there is the potential that by removing a, maybe slightly healthier -- they are mostly comparable. But there could be a negative impact, I suppose, on the PEBB Medicare pool. It would depend on the number of people removed and the overall effect on the rating of the plans that happened after the fact. I could say yes, there could be. But it's hard to say.

Kim Wallace: I think your comments just now seem to be focused on a change in Medicare retirees and splitting them up. I think Carol's asking about on Slide 23, the movement that's happening is the non-Medicare school retirees leaving PEBB and coming over and joining --

Kayla Hammer: I was looking at the wrong scenario. You were curious about the impact on the PEBB Program non-Medicare risk pool by removing. The non-Medicare school retirees who were slightly healthier, had a slightly better risk score than the non-Medicare state retirees. So you're removing a small amount of people that are still high utilizing but less high utilizing than the other non-Medicare retirees. There is a possibility that the ratio of healthy to less healthy could be disrupted. So potentially, that could result in some increase to that PEBB non-Medicare pool.

Dave Iseminger: Carol, in the non-Medicare risk pool, there's 275,000 state employees. There are 5,300 non-Medicare state retirees and 4,000 school non-Medicare retirees. So a very small portion of when you compare on Slide 15 the relative risk score that's in the middle of those three populations. It's probably going to be fairly small but it could happen. And that would be a slight increase overall because you're taking out some subset of the piece that is on the healthier side of the equation but not the healthiest or largest.

Carol Dotlich: Do you have any sense of percentage or dollar amount that change could be?

Kayla Hammer: I do not have that information. And it wouldn't be something that could easily be measured until you went through the procurement process and looked at the new pool and had conversations with carriers to get a real idea about what that would be.

Patty Estes: Am I correct in remembering that the current K-12 employee population enrolled in PEBB is around 30-35,000?

Dave Iseminger: No, it's 3,500.

Patty Estes: Okay. Taking that into effect, too, there could potentially be about 7,000 that move out.

Tim Barclay: I think you asked for our thoughts and comments on these various options. I'll give that to you. Remember, you asked for it. So just quickly on the four different options, my thought is the fourth one makes no sense. You're bundling people together to bundle them together only to do all the work to separate them to make it sort of functional for others. I don't think the fourth option is really worth a whole lot of conversation.

Sue Birch: Tim, to clarify, you're referring to the one on Slide 29?

Tim Barclay: Yes. The single risk pool of all the different people. I won't spend a lot of time on that.

I think the interesting question is if we start with the first scenario on Slide 23, which I think makes a lot of sense. I agree with Pete's comments earlier that throwing the non-Medicare school retirees in with the school employees doesn't have to have a big impact depending on how the K-12 remittance funding is transferred with it, and how it's administered in the calculation of the premiums. It's a small number of people. You've got some sense of potential for offset, in terms of how they decide to do the K-12 remittance. The administrative simplifications of not making people switch into the PEBB Program, I think this scenario makes a lot of sense.

The second one on Slide 25, I'm struggling to see the value. We're going through some work now in PEBB to restructure the Medicare benefit portfolio. To ask the Health Care Authority to do that twice, present it, and potentially deviate between different boards doesn't make a lot of sense to me. People, no matter what pool they come from, when they become Medicare eligible have to make a choice, have to make a change of plans. It's not going to make life easier for them to go to one versus the other. Furthermore, I think it's a little inconsistent with the whole context of how SEBB was created in the first place, which was to create more consistency between how folks are funded and managed. I think it would be a little bit counter to where the Legislature's trying to go to then take a population that has already combined into a single Medicare benefit package and split it into two and create more administration and more differences. I don't think it makes a lot of sense to split that pool out.

The third one I already commented on. I just don't think those people are big enough or different enough with the K-12 [indecipherable] to justify splitting them into a separate pool. That’s my take on it, when it's all said and done, the only scenario that really makes any sense to pursue is the first one.

Wayne Leonard: I would concur with Tim's summary. If there are going to be any changes, it appears that the pooling on Slide 23 would probably be the only one that makes sense. And even with that, I would hope that we would look at minimizing the

administrative costs of administering all these different pools or plans. If it was going to result in higher administrative costs, I'd probably rather just keep it the same.

Tom MacRobert: You have to submit this to the Office of Financial Management in November? Is that correct?

Dave Iseminger: Yes. All the legislative reports this agency does, this is one of 41 that we're doing this calendar year, or between last session to this session. All of our reports, we do a review through OFM. It's a standard part of the legislative report-making process for this agency.

Tom MacRobert: It's my understanding, unless there's something that comes completely out of whack, that's something they just say it looks good. The numbers look good. The numbers match. It's not an analysis of what you're trying to do but rather it's an analysis of the numbers you're using, right?

Dave Iseminger: I think it varies based on the reports. I've seen reports that the agency's worked on that's had a lot of substantive feedback that has said this needs further clarification. You need more data to represent this piece. Or there's this other part of the equation. That's why it is a multi-week process to really give the best report possible to the Legislature with a critical eye from OFM, outside of the agency to inform that process. I would definitely not describe it as a rubber stamp. It is a substantive process.

Tom MacRobert: At the time you send the report, you're going to have to make a recommendation. You're going to have gone through these different scenarios and come to a conclusion as to which one you think represents the interests of everybody and make that recommendation. Hopefully OFM says yes and it goes to the Legislature.

Sue Birch: Tom, I don't think it's fair to represent that HCA would make the recommendation that represents everyone’s opinion. I don't believe HCA would suggest we represent either the PEB or SEB Board in that recommendation.

Tom MacRobert: No, I wasn't asking that. What I was saying is that you are going to have to come to a recommendation.

Sue Birch: That is correct.

Myra Johnson: First, I want to say thank you. You've clarified the mud just perfectly. Thank you and I appreciate that. I, too, am liking the scenario on Slide 23 with the explanation on Slide 24. My one concern, and I know the answer's probably going to be, "We're trying, we're trying." That last line, “Possible increase premium for school employees." I would like that to be miniscule if even non-existent, which I understand with all the scenarios in play and I understand it is a possibility. If this is the one that you move forward, reiterate that any increase is not a positive.

Yvonne Tate: What I was thinking about is between the option on Slide 25 or Slide 23, I guess the question really is, if you have a [indecipherable] . . .

Sue Birch: Thank you for that, Yvonne. Anybody else on the line? Harry, Allison, or Greg, if you've gotten off your flight?

Harry Bossi: I'm okay, thank you.

Alison Poulsen: I don't have any further questions. I really appreciate the thoughtful discussion. This is a complicated and important decision.

Sue Birch: Thank you, Alison. I have a question I'd like to ask for a little clarification. On scenario one, Slide 23. Is the thought process that by moving the non-Medicare school retirees, even though we might have more uniformity with the types of plans that they're moving onto when they're not an active employee, it's likely that the plans are going to be more similar and so that's the dominant health care motive. Is the thought that the Medicare plans offered to both are state employees PEBB and SEBB members are going to be more uniform throughout the state? Was that some of the thought process you had about the Medicare plan designs that would be available in that middle column?

Dave Iseminger: In this scenario on Slide 23, essentially nothing would change but this wouldn't be something that prompts a specific change in the Medicare risk pool. There are plenty of other pieces the PEB Board's been evaluating as to implications for the Medicare risk pool. But right now, state and school retirees have the same option to the same plans in that Medicare risk pool. If there were any changes to the plan offerings, they would remain equally accessible by both parts of the risk pool because they are in a single risk pool. I think that's what you might be asking.

Sue Birch: It seems to me that the carriers would be able to offer more uniformity based off Medicare.

Dave Iseminger: That's what they do now. There is no distinguishing in the Medicare risk pool based on what kind of retiree you are. You're a Medicare retiree in the Medicare risk pool. The only reason they're different is we were just highlighting K-12 versus state. But from a carrier standpoint, that Medicare risk pool in the middle column, there's no differentiation based on who your employer was when you were an active employee.

Kim Wallace: I want to ask a follow-up question to Sue. I think you're asking a question about the kind of continuity or alignment that people experience when they become a retiree. I think it's a matter of Health Care Authority making a policy decision that gets implemented in terms of managing the Medicare portfolio. There has been historically, care taken to create a logical path for employees covered under the PEBB Program to have benefits or at least carriers that they are comfortable with, familiar with,

etc. when they retire. Currently, in the PEBB Program, the carriers offering Medicare plans to retirees are carriers that are familiar to our offering plans to employees. I think one of the questions with the new SEBB employee program, the question would be then, how is it that there is this logical, reasonable flow and path for them to go from being a K-12 employee with SEBB coverage to being a K-12 retiree with Medicare coverage in PEBB. I think it's a good point. I think it's part of designing and maintaining the full Medicare portfolio that we now, the HCA has an evolving responsibility to consider designing a Medicare portfolio of offerings that makes sense for all the folks that are retiring into Medicare in a new way. We've cared about that for a long time but I think it's part of the review and the new look at the full Medicare portfolio being offered is taking into consideration what do all of the people experience as they come in to Medicare coverage as a retiree. Is that what you were asking about?

Sue Birch: Thank you. That's exactly what I was looking at here. I'm trying to understand how we're stair stepping folks.

Carol Dotlich: I agree with Tim. I think this plan makes the most sense of all the scenarios provided.

Public Comment

Fred Yancey, on behalf of the School Retirees Association. Thank you very much for your attention to this issue. The life of a retiree living on a fixed income, as you know, is a challenge. And our concern really is your perspective of what scenario you pick. Our concern is what we have to pay for insurance. It's a very simple sort of concern. So we want the best scenario that gives a retiree the best insurance at the lowest cost. It was suggested, and I think Ms. Wallace suggested it as well, but I won't put words in her mouth and I may have misunderstood her. But if you look at the number of subscribers and we talk to our seniors that have retired, you only have a fraction of retirees that elect to go into the PEBB Program to begin with. I think it's because there aren't enough offerings to attract enough retirees. I mean, the real question is, you know, should you be out there getting some more options for retirees. The ones I talk to, our own membership, probably, we're guessing only about 40%, you know, belong to the PEBB Program. When I looked at the Medicare offerings because I'm Medicare eligible, you know, I was kind of dismayed at the few choices I had. I'm happy with the choice I made but I talk to my friends that are not even school related and they tell me their Medicare plans. And I'm going, "Boy, there's a wide variety of choices that I didn't see reflected in the PEBB." So again, thank you very much. Our concern and I didn't hear anything about that today other than general comments and it's too bad. I really would like to know what sort of rates we're looking at for retirees. I don't know how -- I understand how hard that can be to find out. Thank you.

Julie Salvi, with the Washington Education Association. Sorry I didn't sign up earlier. So our interest is ensuring that the retirees stay in a robust enough pool, to have the best deal available for them. And I look at the current state of affairs and the first options where a number of your Board Members were also recommending as really being kind of the two options before you that would check off a number of those boxes

for us. The other -- I didn't hear a lot of interest in the other plans and I just wanted to offer an idea, which is I would like to see some entertainment of how a transition plan could be made because I think what we're going to run into is current non-Medicare retirees who are in PEBB who are not going to be interested in moving to SEBB only to move back to PEBB in a few years when they're Medicare eligible. And then once K-12 employees are in SEBB, many of those people who are early retirees, non-Medicare retirees would like to stay in SEBB. And that may be an option. There could be a way to transition between the two and not have current non-Medicare retirees bouncing between PEBB and SEBB. And that may be a more interesting option to consider if you're ruling out some of these other options going forward. So kind of an option of how you might transition with the carve out or remittance that is out there. I think there's a mechanism, financially, to make that work. And that would be a new scenario that would keep the employees in mind for how many changes they're having to go through.

Doug Nelson: Yes. Doug Nelson from Public School Employees of Washington. So on the record, we support Slide 23. I think we're talking about the non-Medicare retirees. And you have to realize, in the K-12 system, we have developed an organically developed insurance industry over 30, 40 years. I think what this whole SEBB Program is about is providing something similar for everybody across the state. And so I recognize that the PEBB or the SEBB non-Medicare retirees will have to change. Join the club. There's about 160,000 K-12 employees who are going to be changing too. So I agree with Julie. If we can figure out an easy transition way, that would be great. But if not, it might be just a bullet that has to be bitten on like everybody else is. Thank you.

Dave Iseminger: I do appreciate the historic nature of bringing both Boards together for a conversation that could impact both. I just appreciate everybody coming together for a special meeting. I appreciate the comments from both Boards in July and particularly today as we were able to get more information to you for your consideration. We'll wrap up all of your comments and insight as an appendix, or as some part of the report, and appreciate your willingness to engage on such an important topic. I was glad we were able to give you about 45 days' notice for this meeting and that everybody could come here to the Health Care Authority. So thank you all.

Sue Birch: Dave, thank you, as usual to you and your team for preparing all of this and getting us all together.

Meeting adjourned at 4:25.