

Public Employees Benefits Board
Meeting Minutes

June 9, 2021
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
12:00 p.m. – 3:30 p.m.

The Briefing Book with the complete presentations can be found at:
<https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials>

Members Present via Phone

Sue Birch, Chair
Elyette Weinstein
Tom MacRobert
Leanne Kunze
Yvonne Tate
John Comerford
Scott Nicholson
Harry Bossi

PEB Board Counsel

Michael Tunick

Call to Order

Sue Birch, Chair, called the meeting to order at 12:02 p.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, the meeting was telephonic only.

Meeting Overview

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

Today's Washington communities highlighted are Pend Oreille County, Stevens County, and Ferry County. Between the PEBB and SEBB Programs, in Pend Oreille we serve a little over 8% of the population; and similar levels, 8% and 7%, in neighboring Stevens and Ferry Counties. For Medicaid, it's roughly 30% to 32% of each county population served. Roughly 40% of the residents in this three-county region are served by programs at the Health Care Authority.

In this region there are noticeably higher rates of the residents living in poverty in each county, generally somewhere between 20% to 25% in each county, whereas the statewide average is 15%. There is a slightly lower than average rate of unemployment, between 6% and 7% in each county, whereas the statewide average is around 8%. There is a higher percent of uninsured individuals in the region, between 7% and 7.5% in each county, whereas the statewide average is a little over 5%.

Approximately 60% to 65% of the entire population in the three-county region is covered in some way by either Medicare or Medicaid, which heavily influence provider rates in the region.

While all three counties are considered rural, there are noticeable referral and utilization patterns from Stevens County to the Spokane region. We also see a lot of referral patterns from the Pend Oreille and Stevens County area into the Idaho panhandle for non-primary care services.

A long-standing challenge in northeast Washington is the recruitment of physicians, Advanced Registered Nurse Practitioners (ARNP), causing lower access to primary care rates in that part of the state. It's estimated that roughly a third to a half of the population of this region doesn't have easy access to a large grocery store in their community. HCA is in the business of providing access to quality health care, but there are all these other factors influencing our members' lives daily. It was a stark feature I learned about this region as I've gone on this journey of highlighting communities we serve. It highlights some of the challenges that exist in different parts of our state.

We acknowledge our meeting is being supported physically here in Olympia on the traditional territory of the Coast Salish people. This area was a primary portage way to and from the Puget Sound. These lands were shared by several tribes, including the ones known today as the Squaxin Island Tribe and the Nisqually Tribe. HCA honors and thanks their ancestors and leaders who have been stewards of these lands and waters since time immemorial.

Follow Up from May 12, 2021 Meeting

Dave Iseminger, Director, ERB Division responded to a question from the May meeting. There will be answers to other questions either today in later presentations or at a future meeting.

Slide 2 – May 2021 Medicare Member Enrollment responds to a general question of the current enrollment. This slide provides that information. It includes subscribers and their dependents as of May 2021.

Slide 3 – Medicare Out-of-pocket Maximums are listed.

Executive Session

Pursuant to RCW 42.30.110(1)(1), the Board met in Executive Session to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased healthcare services as provided in RCW 41.05.026.

Back to Public Meeting

2022 Annual Procurement Update

Beth Heston, PEBB Procurement Manager and Kaiser Account Manager, discussed proposed changes to PEBB's medical benefits for 2022.

Slide 2 – Medical Procurement Work Plan lays out the annual procurement process culminating in a final vote on the renewal in July.

Slide 3 – Changes for All PEBB Consumer Directed Health Plans (CDHPs). There is a change for all subscribers. Kaiser Northwest, Kaiser Washington, and UMP all three offer a CDHP. The IRS usually announces changes to high-deductible health plans after HCA begins the renewal process and rate negotiations and we expected to see an increase to the minimum deductible. However, the IRS left the minimum deductible for CDHPs the same. No change has been made to minimum deductible for the CDHP since its introduction in 2014. HCA anticipates the minimum deductible topic for the CDHPs to be in next year's procurement process. Instead, we are announcing the annual maximum a member may contribute to their Health Savings Account is being raised for 2022, increasing to \$3,650 for subscriber-only accounts and \$7,300 for all other tiers. That is approximately \$50 for single subscribers and \$100 for all other tiers.

Dave Iseminger: It can be confusing to know who gets to vote on what and who gets to make what decision when. This is one we're telling the Board about because the authority for making this change is in the Cafeteria Plan, which the agency is charged under state law to administer. There will be no vote by the Board on this change because it's the agency's responsibility to manage this part of the portfolio.

Beth Heston: Slide 5 – Uniform Medical Plan (UMP) 2022 Proposed Benefit Changes. The first proposed change is mental health parity and addiction, in response to a law passed in 2008 that had multiple modifications over time. All plans in the HCA portfolio are required to meet parity and continually assess and make changes as interpretant to the requirements that evolve. We are removing coinsurance for the mental health and substance use disorder inpatient professional services in UMP Classic, Select, and UMP Plus. No change needed for the UMP High Deductible. As a result of our most recent review to meet parity, we're removing inpatient physician coinsurance for network facilities for all plans except UMP High Deductible. Bullet #2 - removing the coinsurance, does not apply to facility fees.

Dave Iseminger: This is informational. There won't be a Board vote because it's required by federal law and HCA is required to comply. We are implementing the minimum requirement to comply with other laws.

Beth Heston: Slide 6 – UMP 2022 Proposed Benefit Changes (*cont.*) – UMP Accumulators. UMP accumulators are a matter for Board approval. A medical insurance accumulator is a running total of money a member has paid towards out-of-pocket maximum for covered services. It includes copays, coinsurance, and other health care costs outside of monthly premium payments. Accumulators also count towards the number of allowed provider visits within a calendar year. Currently, when a member changes plans during a special open enrollment, their accumulators do not follow them when they switch to a different Uniform Medical plan. HCA is recommending the Board allow accumulator rollovers between Uniform Medical plans.

This benefits the member going through a special open enrollment and it aligns with our fully insured plans.

Slide 7 – Proposed Resolution PEBB 2021-16 UMP Accumulators. This change requires action from the Board.

Dave Iseminger: I want to highlight the distinguishing part of this resolution, which is this is only for UMP plan changes within the PEBB Program. HCA administers two programs, PEBB and SEBB, and they both have Uniform Medical Plan options. This accumulator rollover is if you're switching UMP plans within the PEBB Program. If, because of your marriage to your school employee spouse, you decide to waive your UMP coverage in PEBB and go into SEBB, the accumulators don't cross programs. We'll be able to evaluate that cross-program accumulator question another day, but we wanted to recommend resolving the internal program situation now.

Beth Heston: Slide 8 – Proposed Change to UMP Plus – Puget Sound High Value Network. There are two UMP Plus providers, the Puget Sound High Value Network and the University of Washington Medicine Network. Today, we're talking about Puget Sound High Value. For 2022, they will no longer be in Thurston County. There are issues with provider contracts, adult primary care contracting was challenging, and recently ownership relationships have shifted towards the UW Medicine UMP Plus Network. This change impacts about 472 members in the PEBB Program.

Slide 9 – Proposed Change to UMP Plus – Puget Sound High Value Network (*cont.*). There will be a robust communications plan in place to let those members know of the changes so they can switch coverage during open enrollment. Other available plans in Thurston County include UMP Classic, CDHP Plus with the UW Network, and UMP Select, as well as Kaiser Washington Classic CDHP, Value, and SoundChoice.

Slide 10 – 2022 UMP Plus Network Coverage. This slide is a map of the new coverage network.

Slide 11 – UMP Coverage. This map shows the entirety of the coverage for the Uniform Medical Plan in the state of Washington.

Slide 13 – KPNW 2022 Proposed Benefit Changes – Naturopathy benefits. Kaiser Northwest is fully insured and like an HMO plan. It offers services in Clark and Cowlitz Counties in Southwest Washington and some counties in Oregon. The change begins with an alternative health bundle that Kaiser Northwest is offering, which changes benefits around naturopathy, acupuncture, massage, and rehabilitation therapies. This will allow members more autonomy in choosing and using those benefits and is part of the core benefit of the base plan for Kaiser Northwest. This slide shows the changes to the naturopathy benefits for 2022. There is not currently a dollar maximum per year in PEBB, but in SEBB the massage and naturopathy share a \$1,000 maximum deductible limit. Many members prefer to have naturopathic providers for the primary care they are permitted to get from those kinds of providers.

Slide 14 – KPNW 2022 Proposed Benefit Changes (*cont.*) – Acupuncture benefits. Currently acupuncture is physician-referred only with unlimited visits, and it's a specialty care copay of \$35. Kaiser is proposing to add self-referral 12 visits per year with the

specialty copay of \$35. In addition to a physician referral, you also have 12 visits that you can choose yourself.

Slide 15 - KPNW 2022 Proposed Benefit Changes (*cont.*) – Massage benefits. Kaiser Northwest has not offered covered massage therapy under the PEBB Program. This year, they are suggesting we add a massage benefit to all our plans as part of the bundle. The combined amount is in the SEBB Program.

Slide 16 - KPNW 2022 Proposed Benefit Changes (*cont.*) – Rehabilitation services. This will allow self-referrals and will no longer require prior authorization. There will be outpatient physical, speech, and occupational therapies combined into a 60-visit per-plan-year limit with a \$35 copay.

Slide 17 - KPNW 2022 Proposed Benefit Changes (*cont.*) – Dental services for potential transplant recipients. This dental services change is provided under the medical benefit. The focus is changing dental services allowed for potential transplant recipients. Effective January 1, 2022, Kaiser Permanente will begin to cover under the member's health plan a common set of routine dental services for members who are potential transplant recipients and require pre-transplant dental evaluation and clearance before being placed on the transplant waitlist.

Slide 19 - Kaiser Washington has proposed adding home-infusion therapy to their plans. Associated medication costs will still apply, but the administrative costs will be waived. To receive the network benefits for the administrative selected infusion medications at home, the member must get the specialty medication through the KPWA home infusion pharmacy. They'll receive services through a preferred home infusion provider and/or network of home infusion providers, which is the health plan that contracts with them directly. You must get it from a Kaiser-approved provider, the specialty home infusion formulary, and get it mailed to the house. Out-of-network providers will not be covered under this proposed benefit change. For CDHP members, the annual deductible must be met before the coinsurance can be waived.

Slide 20 – KPWA 2022 Proposed Benefit Changes (*cont.*). This change is to remove cost shares for two urine drug screenings per plan year.

Slide 22 – Kaiser 2022 Service Areas – No Changes. There are no changes to service area this year.

Tom MacRobert: I want to go back to the alternative care proposals. I'm not familiar anymore with Kaiser Permanente. Once upon a time, I was a member when it was Springfield's. If my recollection serves me, for example, to go to a massage therapist, you used to have to be somebody that was in-house at the Group Health facility. With all these naturopathic doctors, massage therapists, acupuncturists, physical therapists, chiropractors, how is that network going to work? Is it something like what we have with Uniform Medical where you can go remote?

Beth Heston: No, Tom. First, it's not Kaiser Washington, it's Kaiser Northwest. It's just two southern Washington counties. And because KP Northwest is an HMO-like plan, you must go to in-network providers. They have a contracted provider for massage, acupuncture, and chiropractor. If you call Kaiser, they'll be able to set you up with an in-

network massage therapist or acupuncturist, but you cannot go to someone outside the network and get it covered. That's the way with all their benefits, as well. On the SEBB side, we have Kaiser Washington that offers several PPO plans. But in the PEBB portfolio, those are all HMOs, so you must stay in-network to get coverage.

Tom MacRobert: Okay, thank you.

Beth Heston: Tom asked to compare the Kaiser Northwest coverage for providers to the UMP coverage where there were lots of providers. That's what I was explaining. You must be in-network, and they have those providers through contracts. They do have some Kaiser-employed providers.

Tom MacRobert: Thank you.

Dave Iseminger: Thank you, Beth.

2022 PEBB Medicare Rates

Tanya Deuel, ERB Finance Manager, Financial Services; Sara Whitley, Fiscal Information and Data Analyst, Financial Services; and Ryan Pistorosi, Assistant Chief Pharmacy Officer, CQCT Division.

Sara Whitley: Today we will review the various types of Medicare plans that exist within the PEBB portfolio of plan offerings. Slide 2 – Medicare & the PEBB Portfolio. This slide was presented last year and provides a good foundation for future slides in this presentation. Listed are: 1) Coordination of Benefits (COB) with Original Medicare (UMP Classic Medicare); 2) Medicare Advantage (Kaiser WA and Kaiser NW MA); 3) Medicare Advantage Plus Part D (UHC MA-PD Plans); and 4) Medicare Supplement (Premera Plans F &G).

1) The coordination of benefit with Original Medicare, which you will hear me refer to often as a COB plan, coordinates payment of medical claims with Original Medicare. In Original Medicare, it's defined as Medicare Part A or Hospital and Patient coverage, and Medicare Part B Outpatient or Professional coverage. Medicare is the primary payor of medical claims for the course due to medical benefits, and UMP pays any remaining claim amount which often leads the retiree enrolled in the Uniform Medical Classic Plan with very minimal to no out-of-pocket cost for their medical portion of the benefit. Pharmacy claims, on the other hand, are **not** coordinated with Original Medicare and UMP is the only payor for our pharmacy claims in the pharmacy portion of the benefit.

2) Moving to the Medicare Advantage box, Medicare Advantage plans are reflected in our portfolio via our KP Washington and KP Northwest Medicare Advantage Plans. Medicare Advantage Plans and group coverage for all benefits that are covered under Original Medicare, and rather than coordination of claims payments, the plans receive risk adjusted federal subsidy dollars from CMS to administer the medical portion of the benefits. These types of plans are popular options among retirees interested in alternative benefit offerings that aren't traditionally covered by original Medicare, such as gym memberships, over-the-counter drug offerings, world-wide travel benefits, some supplemental benefits that aren't included as part of the core medical benefit offering. The Kaiser MA plans also include creditable drug coverage for the pharmacy portion of the benefit.

Creditable drug coverage is defined as drug coverage that is at least as rich as a Medicare Part D benefit, and HCA receives retire drug subsidy (RDS) dollars for plans that administer pharmacy benefits under creditable drug coverage for our members. These RDS dollars are deposited into the state general fund.

3) Medicare Advantage Plus Part D plans or MA-PD plans are reflected by the new UnitedHealthcare PEBB Balance and PEBB Complete plans, which went live as of January 1, 2021. Like the MA Plan type just discussed, MA-PD plans also receive federal subsidy dollars for the medical portion of the benefit, but they receive additional revenue for the Part D portion of the benefit, as well. These subsidies and revenues include drug manufacturer discounts, rebates, and CMS reinsurance revenue for high-cost claimants.

4) Our Medicare Supplement Plans or Medigap plans are represented in our portfolio by Premera Plans F and G. Supplement plans are intended to help Medicare members cover the out-of-pocket costs associated with Original Medicare. There's no underlying benefit design, and these plans do not include drug coverage.

Slide 3 – PEBB Medicare Portfolio. This slide provides a graphical illustration of everything we just covered. The Medicare explicit subsidy applies to all members enrolled in our Medicare plan offerings. It's currently proposed at \$183 or 50% of the retiree's premium, whichever is less.

The medical portion of the benefit, UMP Classic is a COB plan. KP Washington, KP Northwest, and the United plans are Medicare Advantage offerings. The Medicare Supplement plans are often referred to as Medigap plans to help cover the member cost share associated with Original Medicare.

The pharmacy portion of the benefit, UMP Classic and the KP Washington and KP Northwest Medicare Advantage offerings include creditable drug coverage for which HCA receives RDS revenue. The UHC MA-PD plan features Part D drug coverage which was designed and customized for our PEBB Program members specifically. The supplement plans do not offer drug coverage. The first two slides are intended as an overview of the types of offerings included in the PEBB portfolio.

Slide 4 – Retiree Enrollment Summary gives the retiree enrollment summary across our plans for the 2022 plan enrollment. The majority of our plan enrollment resides in the UMP Classic Medicare offering with just under 50% of our members enrolled in that plan, followed next by the KP Washington Medicare offering. Typically, when we speak to the KP Washington Medicare offerings, we generally refer to the Medicare Advantage plan. However, KP Washington does offer a COB-type plan that operates in the background. KP Washington Medicare plans are only offered in a handful of counties across the state, some of which don't feature the MA product. Therefore, when a member selects the KP Washington plan offering, Kaiser enrolls them in the plan that applies to their county of residence. There is a small portion of our KP Washington members enrolled in their Original Medicare plan. As of May, I believe it was around 2,500 members, but the majority of them reside in the KP Washington Medicare Advantage offering with about 21,000 members.

Another highlight I did want to point out is we did get modest enrollment into the new United plan with just over 2,000 members switching into these plans. We hope to see additional members switching to these plans when in-person benefit fairs become available. Retirees prefer that one-on-one aspect of being in-person asking questions and feeling confident in their decisions.

John Comerford: Can you go back to the last slide? When you look at these various plans, can you tell me off the top of your head what the total cost is on each of these plans relatively?

Sara Whitley: John, when you say total cost, do you mean cost to the state in terms of the Medicare explicit subsidy or cost to the member?

John Comerford: I've seen the explicit subsidy, but the difference between the explicit subsidy and the actual cost of the plan per employee.

Sara Whitley: Tanya is actually going to walk through that in just a moment. We have a table to outline the total plan cost, the Medicare explicit subsidy, and the retiree premium.

John Comerford: I've had talks with David before about this on the private side. It seems a lot less costly than it does on the public side. I'll look forward to listening to this.

Tom MacRobert: I'm curious if you could explain. You say that UMP and Kaiser have what you call creditable drug coverage and UnitedHealthcare has Part D drug coverage. Can you explain what the difference is?

Sara Whitley: Creditable drug coverage is pharmacy coverage for a Medicare plan that is defined by Part D, it's as rich as Part D drug coverage. That's how HCA is eligible for the retiree drug subsidy. We're in full control of the formulary, member cost share, and how the pharmacy benefit is structured. Part D plans are certified by CMS as a Part D plan and eligible to receive the subsidies they receive to administer the plan. There is a unique structural difference and I think Ryan can provide additional detail on top of what I just described.

Ryan Pistorosi: I can look into it and see if I can provide a little more information about how that "as rich as" is defined by CMS.

Tom MacRobert: Thank you.

Dave Iseminger: One other piece is my understanding of creditable drug coverage is it's at least as rich as Part D. It can be richer, and I believe as we peel back that onion layer, we'll find that UMP is richer than Part D coverage.

Sara Whitley: Yes, and to clarify even further, that's the Standard Part D coverage. When we talk about the Part D coverage that's included as part of the United plan, the formulary and the benefit were customized for our members as an employer group plan, which gives us that room to customize for our members. The formulary was based off the UMP Classic formulary so there should be very little deviation from that formulary.

The cost shares were also developed to mirror what our retirees are experiencing in UMP Classic. When we say, “as rich as” Part D drug coverage, we’re talking about Standard Part D drug coverage, not necessarily what our members are receiving under the MA-PD plan because we’ve negotiated the formulary and customized that portion of the benefit for our members specifically.

Elyette Weinstein: How did the federal government justify giving a subsidy to private plans that self-insured government plans don’t have?

Ryan Pistori: This is going back to about 2003-2004. One of the original compromises private groups and labor unions were advocating for, with Congress looking at the Part D adoption, was to allow these plans to still have their own control over the formularies and their drug benefit design for their employees or their members, but still qualify for federal assistance outside of the Part D CMS structure. As it evolved, there was the Part D route, which obviously was very popular, and we see a lot of the country move towards that, but then there’s also the private plans that grew up at the same time and continued to receive these subsidies. I think we have a little more information on how this evolved since 2006 later in this presentation.

Elyette Weinstein: Thank you. That was very helpful.

Dave Iseminger: Ryan, you did a great job. Elyette, sometimes there are just grand bargains at the federal level.

Sara Whitley: Slide 5 - Retiree Premium Calculation, is a walkthrough of how we get from a plan bid rate to a retiree premium. It’s the total plan bid rate, which reflects the total cost of the plan and is bid by each carrier during our annual procurement process; then subtract the Medicare explicit subsidy, which can be considered the employer or state contribution to the retiree’s premium, and this amount is calculated as either \$183 or 50% of the total bid rate, whichever is less. The result is the retiree premium.

Slide 6 – State Medicare Explicit Subsidy – Illustration. This slide provides illustrations for the calculation on Slide 5.

Tanya Deuel: Slide 7 – Medicare Retiree Proposed 2022 Rates are the Medicare retiree proposed rates for plan year 2022. We walk through this slide every year. The left column are the plan names categorized by color for each of the carriers. The first top column is the single subscriber premium, second column is the Medicare explicit subsidy that the state is contributing towards your premium, and the far-right column is the composite rate. John, this is the rate you were looking for. When we say composite rate, this is the rate that is bid by our carriers. HCA goes through multiple rounds of negotiations with all of our carriers, as well as developing our own assumptions for our UMP Classic Medicare bid rates. This far-right column is the total rate we’ve negotiated. If you work backwards, the total rate less the Medicare explicit subsidy results in the single-subscriber premium. Sara just walked through that dynamic.

John Comerford: Sara, do you ever price these on the outside market? In other words, as an individual, my buying Plan F, for instance, I paid personally less than this for Plan F. Not with this carrier but with another carrier, and when I added on Part D, I still commit less than this overall. That’s been my concern. I’ve raised it with Dave in

the past that when I see these rates, they are much higher than are offered in the outside market. I'm wondering if there's a reason for that, or am I missing something?

Tanya Deuel: So typically, on the non-Medicare portfolio, we do compare because we can measure things by actuarial value, and we can make sure we are comparing an apples-to-apples cost projection. On the non-Medicare side, I don't know that we have done that this most recent year, but it does come down to coverage levels, too. The deductible makes a big difference, the maximum out-of-pocket, the pharmacy coverage. All those things make a difference in how the cost of the plan is derived. We would have to find an apples-to-apples comparison in our plan design on the individual market. And I know our Medicare offerings are fairly rich. Does that answer your question, John?

John Comerford: Yes, it does. I'll take it up with you guys later offline. It's just something that concerns me a little bit, that when I see premiums from private companies that are lower than this, and they seem to have the exact same benefits on the Medicare supplement side.

Tanya Deuel: We're definitely available to look into that. We would need a little bit more information around the plan, the offering, the benefit design to be able to really do an apples-to-apples comparison.

John Comerford: All right. Thank you.

Dave Iseminger: We've done individual plan comparisons over time as this question has come up, so we're more than happy to do a review of a specific plan to identify what the differences are or elucidate something new that we need to understand about our comparison to the individual market.

Tom MacRobert: Another clarifying question. If we look at Kaiser Washington Medicare Advantage Original Medicare, the composite rate on the right side. The \$346.39 is the bid rate they gave you or that you negotiated. Is that correct?

Tanya Deuel: Yes, the composite rate includes our \$5 administration fee, so it's the composite rate less \$5 would be their bid rate.

Tom MacRobert: Okay. And then it's either \$183 or 50%. In this case with Kaiser, it was \$170.70 and that's how you arrive at the \$175.69.

Tanya Deuel: Yes. Unless their bid rate is, if you do the opposite \$366, it's less than \$366. They're only going to get 50% of that bid rate towards the Medicare explicit subsidy.

Dave Iseminger: Tanya, could you clarify is it 50% of the bid rate or 50% of the composite rate?

Tanya Deuel: It's 50% of the bid rate.

Dave Iseminger: And not considering the administrative fee?

Tanya Deuel: Correct, 50% of the bid rate.

Elyette Weinstein: This is to follow up on what John Comerford said. I would like to know the results of that comparison, as well. I'd appreciate being informed of it.

Tanya Deuel: Elyette, we did a couple of years ago when we were looking through what to do with the overall portfolio and what sort of plan offering to add, where we derived on adding the Medicare Advantage Plus Part D plan. We did do a thorough analysis of pricing and what exists on the market and what our members could pay. We did that a couple years ago, but we can look again. Like I said, there is going to be some sort of comparison. We'll have to make some assumptions to make sure we're finding like plans.

Slide 8 – Medicare Retiree Proposed 2022 Premiums looks at comparing our single-subscriber premiums from plan year 2021, the rates our members are currently paying, to what is proposed for calendar year 2022. The same plan names down the left-hand side, followed by the single-subscriber premiums for 2021 and 2022 and the columns showing a change year over year as measured in a percentage and a dollar change. While we are seeing mostly negatives, there is an increase in our Uniform Medical Plan of about 9%, as well as a decrease of about 5% on our UnitedHealthcare, with everything else remaining fairly stable.

We want to talk about the UMP Classic Medicare. The entire crux of this presentation is to get a good understanding by the Board and our members of why that's different, why is UMP having an increase, and what can we do about it versus, let's say, our Medicare Advantage Plans and the way those plans are structured. Like Sara described, we're going to go into further detail, and she and Ryan will walk through some of the pricing and why the formularies are different, or how they behave, and why some of that federal revenue really has an impact.

Sara Whitley: I want to level set where we're going to take our presentation next. We started this discussion with a review of the PEBB Medicare portfolio offering, then dug into how they're both similar and different with respect to the underlying benefit structure, mechanisms for payment, and planned interaction with Original Medicare. We now want to switch gears and spend time walking through Slide 9 - The Medicare Pharmacy Landscape, and take a deeper dive into how our plan, specifically the United MA-PD Plans, are able to provide such a rich benefit design with lower premiums for our members when compared to our UMP Classic offering.

Slide 10 – Part D Plans Are Insulated from Rising Drug Costs. The main point we want to drive home today and throughout the next few slides is that Part D plans are insulated from rising drug costs, whereas the UMP Classic is not. As the pharmaceutical industry has shifted to specialty drugs, the costs of those drugs continue to trend upward. While pharmaceutical innovation targets often unmet medical needs, the FDA has allowed for accelerated review and approval of specialty drugs that offer enhanced therapy at 60. These drugs provide enhanced innovative therapies, but they're also set at a price point the market will bear. We know from general utilization data in our UMP Classic Medicare plan that our Medicare members are the highest utilizers of specialty drugs in our PEBB UMP portfolio when compared to the non-Medicare plans. UMP absorbs the full impact of rising drug costs as the only care for

UMP Medicare pharmacy costs, whereas Part D plan, on the other hand, and as we'll walk through in great detail in a moment, is insulated from those rising drug costs by supplementary sources of revenue to include, but not limited to, Part D reinsurance revenue provided by CMS to cover high-cost claimants, manufacturer drug discounts, which are provided by drug manufacturers when cumulative drug spend reaches a certain level, drug subsidies from CMS, and other sources of revenue.

Ryan Pistori: This has always been around specialty drugs, especially since the late 90s. What changed with the adoption of Medicare Part D is granting retirees in our country drug coverage and helping the federal government pay for these drug costs for our seniors. Prior to this, drug companies were setting prices that the uninsured-- at that point, many retirees didn't really have drug coverage—couldn't afford and since then, we've seen steadily rising drug costs, especially with the advent of drugs targeting these populations. We have a graph later to help illustrate what has happened within this market from 2006 onward.

Sara Whitley: I want to note that what you'll see might not initially make much sense. It's a lot of information but stick with me as we walk through. I think at the very end I'll be able to paint the picture and complete the story that we're trying to tell during today's progression.

Slide 11 – Standard Part D Plan Payer Structure. This slide serves as a foundation for the next two slides. It's an illustration based on a Standard Part D plan, one that might be offered on the individual market and not a plan that is included in our current PEBB Medicare portfolio. While the information doesn't directly apply to our PEBB offerings, it's important in providing the underlying foundation upon which we'll build. I'll use this slide to walk through certain definitions, specific dollar amounts, and where these phases fall within the Part D world so that when we get to those types of specific illustrations, you'll understand where we are in the graphic.

Slide 11 is two-dimensional, moving horizontally and vertically across the graphic. If we start in the lower left-hand corner and move from left to right horizontally, the relative width of the bar represents the portion of cost paid by that applicable payor. We'll illustrate this as a percent of total drug costs in the Deductible Phase of coverage. A phase of coverage is listed vertically from top to bottom. As we move vertically up the figure, accumulative drug costs will increase as the member continues to receive fills on their prescription. For this illustration today and for all subsequent slides, we're going to assume a member is utilizing a high-cost specialty drug, one that's going to have them move through these phases very quickly as they fill prescriptions. If we start at the bottom of this figure in the Deductible Phase, the member is responsible for 100% of the cost associated with their drugs up to the Part D plan deductible. For a standard individual market Part D plan, the 2021 plan deductible was set at \$445.

After the member satisfies their deductible, we move into what's referred to as the Initial Coverage Phase. In this phase, the member continues to pay any associated cost-share for their drugs, which is typically around 25% per plan on the individual market. The Part D plan represented by the darker turquoise color pays the remaining portion of drug cost. The members in the Initial Coverage Phase pays their portion, whereas in the Part D plan it is the plan that pays their portion until cumulative drug costs reach

about \$4,100. Specifically, it's \$4,130 as defined by Part D, but we'll refer to it as \$4,100 for simplicity's sake.

After cumulative drug costs reach this level, they then move up into the next state of coverage. Moving vertically on the graph, which is called the Coverage Gap Phase. Members are in the gap phase of coverage. For Standard Part D plan, members continue to pay their associated cost-share of 25% for coverage in the Gap Phase, but rather than the Part D plan covering the remaining portion of costs that we saw on that Initial Coverage Phase, the plan now covers a smaller portion and drug manufacturer discounts kick in to help offset those costs. This is the first stage that we see where Part D plans are insulated from those rising drug costs. As cumulative costs increase, the member pays their portion, the plans pay their portion. As we reach the Coverage Gap Phase, drug manufacturer discounts kick in and offsets those cumulative costs, reducing the amount the plans are responsible to pay in this phase.

It's worth noting that Standard Part D plans don't typically provide coverage in the gap. This results in member out-of-pocket costs reaching considerably higher levels than what we would see in our PEBB Medicare portfolio. I want to qualify that before we move onto the next illustration. Coverage in the gap is something individual market plans do not typically offer.

So, moving forward, as this hypothetical member's cumulative drug costs increased above \$10,048 specifically, again for simplicity's sake, we'll say \$10,000, they enter what's called the Catastrophic Coverage Phase as defined under Part D. In this phase, members' cost shares drop significantly down to around 5% and Medicare reinsurance revenue kicks in, which is represented by the dark green bar where we see Medicare pays and then the plan pays their portion of costs. Medicare reinsurance payments are intended to cover approximately 80% of costs in the Catastrophic Coverage Phase. Again, we're seeing as cumulative costs increase for a member receiving a high-cost specialty drug, the Part D plan is insulated from those increases in cost by these additional supplementary sources and revenue.

Slide 11 laid our foundation based on a standard individual market Part D plan offering. I walked through what the coverage phases mean in a Part D phase. Slide 12 – Part D Plan Payer Structure, will walk us through the same illustration, but it's based on the customized employer Part D plan benefit design for members who select our UHC MA-PD plan. I want to note that the Part D plan structure is identical for both the PEBB Balance and PEBB Complete, so we'll talk about it uniformly as the Part D benefit design for the UHC plan.

We'll begin in the lower left-hand corner and move from left to right horizontally with the bar representing the proportion of cost the applicable payor will pay in that coverage phase. Again, for the purpose of this illustration, we'll assume the member is utilizing a specialty drug. Starting at the bottom of the figure, the Deductible Phase, the member is responsible for 100% of costs associated with their drugs, up to the plan deductible. The UHC plan deductibles are set at \$100 for drugs in the specialty care. Members would pay a \$100 deductible and any associated cost-share for their drugs after the fact, which per drug in the Tier 4 for specialty care on our UHC Plan is a maximum of \$100. After the member satisfies their \$100 deductible, we, again, move into the Initial Coverage Phase. In this phase of coverage, the member continues to pay any

associated copay for the drugs they are filling, which is \$100 again for a Tier 4 specialty drug, and UHC pays the remaining portion of drug cost. The member is in the Initial Coverage Phase until their drug costs reach a cumulative of around \$4,100 as we mentioned on the previous foundational slide when they then move into the Coverage Gap Phase.

I want to pause before we move forward to qualify and make two important notes about this plan's specific illustration with respect to the UHC Plan. The first thing on the previous slide, Standard Part D plans, members enrolled in those plans continue to pay their associated cost-share, which is higher than what we see in our UHC MA-PD Plan and is around 25% of their total drug costs into the Coverage Gap Phase. The UHC employer group plans are not standard plans. They were customized for our members to provide coverage in the gap, which results in no member out-of-pocket cost above the plan maximum out-of-pocket of \$2,000, which is why, for the purposes of this illustration, we have the member only paying in the Initial Coverage Phase, because I needed a way to illustrate a cap on member out-of-pocket costs while also illustrating that we have coverage in the gap for our members. To say that in a different way, while the member out-of-pocket costs might not exceed \$2,000, based on the richness of the plan benefit and how we structured the copays and maximum out-of-pocket for the UHC MA-PD Plan, it is possible their cumulative drug spend exceeds into the Coverage Gap Phase and the Catastrophic Coverage Phase before the member has reached their maximum out-of-pocket. In these phases, the plan can realize these additional subsidies and additional revenue from drug manufacturer discounts and from CMS reinsurance revenues that offset the Part D plan costs.

To speak to a more specific example, we know that a member reaches the Catastrophic Coverage Phase when cumulative drug spend reaches about \$10,000. For a high-cost specialty drug that costs around \$5,000 for a 30-day supply, which is not uncommon for a specialty drug, the member would reach the Catastrophic Phase of coverage after the second fill of that prescription. While the plan might be realizing the Medicare reinsurance revenue, the member is still paying their associated copay and has not reached their \$2,000 plan maximum. Again, that is a testament to the richness of the plan design we negotiated and customized for our members with the UHC MA-PD Plan and the additional revenue that is afforded to these Part D plans provided by CMS, which is why they're able to offset those pharmacy costs and provide us lower premiums in the long run.

Dave Iseminger: Sara, one more piece for the puzzle. You may, as members of the public or the Board, be asking, "Why do the drug manufacturers have a piece they have to pay as a condition of CMS?" As part of the CMS agreement, the drug manufacturers must do their part in the Coverage Gap Phase. That's something that can't be accessed in the self-insured UMP COB setting. I want to drive home why drug manufacturers are paying a piece of the puzzle. CMS requires it as a condition of their agreement.

Ryan Pistorosi: Right. That is a requirement. The manufacturers, in order to participate in Part D, need to sign an agreement, and they must supply this discount when members hit this phase. If they don't and they don't want to supply that discount, they're not eligible to be covered by Part D. You can imagine that virtually every drug covered by Part D has this manufacturer discount as a part of the plan.

Sara Whitley: That's an important piece to the story, as well. So again, with this graphic, we see how the Part D plan, illustrated by the light turquoise color, is insulated from those drug costs as cumulative drug costs increase vertically across this graphic.

Slide 13 - UMP Pharmacy Benefit Structure will piece the story together. We see how UMP is not insulated from rising drug costs. This illustration is based on the UMP Classic Medicare plan design. And again, we're assuming Medicare is using those high-cost specialty drugs. Starting at the bottom of the figure, the Deductible Phase, the member is responsible for those costs. After the member satisfies their deductible, we move into the Initial Coverage Phase, then onto the UHC Plan where the member pays their associated cost share, which is a maximum of \$75 for a 30-day supply in our UMP Classic plan, and UMP picks up the remaining cost. As we move vertically up the graph and those cumulative costs increase, UMP remains the only payor for the pharmacy benefit. There is no offset to revenue. The Plan picks up and absorbs the full cost of those drugs. This is how we wanted to illustrate why you're seeing the differences in premiums and why the Part D plan and the UHC plans can offer just as rich of a benefit to our Medicare retirees as UMP can, but at a much, much lower price point.

Ryan Pistorosi: Slide 14 – Catastrophic Coverage and Part D is what I alluded to earlier in the presentation around what has been changing with the Medicare prescription drug coverage since Part D came into effect in 2006. The far-left bar shows the distribution of how federal funds were paid for our seniors through the federal government, through CMS, through the different plans. The orange is the reinsurance, and if you recall back to the slides that Sara was just presenting, that's the very top bar where Medicare pays approximately 80% of the drug costs once someone reaches the Catastrophic Phase. As the drug costs continue to accumulate in that phase, their percentage stays the same.

The green is the direct subsidy, the darker blue is the premiums, and the lighter blue is the low-income subsidy. If you think about members that have a low income, who may even qualify for Medicaid as dual eligibility for Medicare and Medicaid, you can see the retiree drug subsidy there at that 9%. Through the years, and if you think about what has changed since 2006, such as the Affordable Care Act being passed in 2010 and some of the other changes in health care delivery and new technologies, you can see these proportions changed over time such that the orange bar, that reinsurance is now by far the greatest percentage. In fact, is almost the entire cost through all the sources from 2006.

When we look at 2009, as you can imagine, it's continuing to grow to this day. You can see some of the other bars shrinking. Of note, the low-income subsidy has remained relatively flat throughout, and the retiree drug subsidy has gone from about 9% in 2006 to 1% in 2019. If you recall back to the earlier question where the employer groups and the labor unions wanted to negotiate and to have these plans be available to them when Part D came into effect, that was about 9% of that. As time has gone by, we've seen these members move from these plans into other options, and Part D reinsurance has taken the bulk of the federal costs.

If you think about the incentives from the manufacturers like we touched on at the very beginning of this Medicare pharmaceutical landscape, they really are incentivized to set prices at what the market will bear. And if you think about the diagram Sara was

presenting where the manufacturers are having that discount in the Coverage Gap Phase, those manufacturers are not getting any income on their drugs when they're in that phase. They only really get their income on the prior phases, which are set much, much lower, or in the Catastrophic Phase which is where Medicare pays 80%. If you think about a drug manufacturer that may set a drug price at \$5,000, like Sara's example, and they stepped through it and hit it at their third fill, then they're getting their revenue through that and it's at 80%. If you think about them setting a drug price at potentially \$50,000, they'll quickly step through that, and Medicare will still pay the same rate of 80%. There really is an incentive for these manufacturers to continue to charge these higher prices and to collect their revenue through this reinsurance. As you see what happens with that Medicare Part D Standard coverage, there really is an incentive for manufacturers to set that price. If you think about how that price is reflective with UMP, you can see why UMP is taking the brunt of these drug price increases, especially around specialty drug costs.

There's another slide that helps illustrate what we've seen over the last few years around the rise in specialty drug costs as a component of our Medicare Pharmacy Spend that Sara will share.

Sara Whitley: Slide 15 – UMP is Not Insulated from Rising Drug Costs. To put a bow on the underlying story, we now understand why UMP absorbs the full impact of rising drug costs as the only payor for the UMP Classic pharmacy offering. While we continue to take proactive and innovative approaches in efforts to maintain costs via the value formulary, which is decreasing the rate at which the pharmacy trends increase, the overall general trend for the Medicare pharmacy benefit will continue to rise over time. As these costs continue to rise, UMP members will realize any impact in an increasing UMP bid rate. The next few slides will walk through additional illustrations of Medicare bid rate and premium development, and then we'll pull together some specific drug next slide for our Medicare plan, as well, as we wrap up our discussion today.

Slide 16 – Medicare Bid Rate Development has two sets of bar charts. Hopefully, bar charts are a little less spatially confusing and provide an illustrative example of how a COB with Original Medicare bid rate is developed and translated into a retiree premium. This will be the two bars on the left-hand side. There is a separate illustrative example to contrast with how a Medicare Advantage Part D rate might be developed. The numbers you see were created for the purposes of this illustration.

The far-left bar represents the total benefit rate for the COB plan, which encompasses both the medical and pharmacy total costs. We know that CMS is the primary payor for medical claims, which is illustrated by the gray offset you see at the top of the bar. The value of these primary claims from Original Medicare result in a reduction to the total medical costs that UMP is responsible for, which results in the total medical costs bar at the very bottom in the dark turquoise. We then stack the total pharmacy costs on top of that, the lighter turquoise box, which comes to the total bid rate, and for the purposes of this illustration is \$600. We shift to the two brighter blue boxes. As seen in previous illustrations and calculations, the Medicare explicit subsidy is then calculated, which in this case is \$183. That is the lesser value of 50% of the premium or \$300 and \$183, which results in a retiree premium of \$417. That's the illustration for a Coordination of Benefits plan similar to what our UMP Classic bid rate, or how our UMP Classic bid rate is developed.

If we contrast that illustration with an MA-PD plan illustrative example, we can again start with the MA-PD total benefit rate, which is the left of the two bars on the right. We know that plans receive CMS revenue to administer the medical portion of the benefit, and we see this represented again by the light gray bar at the top of the total benefit rate. This offsetting revenue leaves the total medical cost illustrated at the bottom of this chart, and just like the COB plan, we then stack pharmacy costs on top of that medical cost. But in this case, we note the total pharmacy costs are lesser than what we see in the COB plan. This is because those total pharmacy costs are offset by Part D revenue, highlighted with the darker gray box with a green bar around it, that matches the total pharmacy costs bar. The sum of these two bars, from these two boxes, represents the two true total pharmacy costs to the plan, gross of any additional revenue. The standalone green box, less the Part D revenue, represents the total pharmacy costs used in development of the plan bid rate. So, again, we're illustrating how an MA-PD plan can offset total pharmacy costs with that additional revenue. Sliding to the brighter blue boxes on the right, under this illustration, the total bid rate for this MA-PD plan results in a \$280 plan cost. We calculate the Medicare explicit subsidy to be \$140, 50% of that premium, provoking a Medicare retiree premium of \$140.

Slide 17 – Impact of Medicare Explicit Subsidy (UMP Classic Medicare). This slide should be very familiar. Tanya often presents this slide during our Medicare rate presentation. It represents the impact of the Medicare explicit subsidy for the Uniform Medical Classic Medicare Plan. The total bar represents the total plan bid rate, which we can see has increased year over year. The blue portion of the bar is the Medicare explicit subsidy, which has remained with a cap of \$183. Because our members are realizing the full value of the Medicare explicit subsidy, any increase in bid rate year over year is fully absorbed in member premiums, which is represented by the light gray bar.

Slide 18 – UMP Classic Bid Rate. Again, as we move forward in the deck and dig a little bit deeper, we can see the UMP Classic bid rate has increased over time on our previous slide, and this slide represents the UMP Classic bid rate of the proportion of total medical versus percent pharmacy. We can attribute a lesser portion of our total bid rate to medical costs and a greater portion, around 60%, to pharmacy costs.

Ryan Pistori: Slide 19 – UMP Classic Medicare Drug Mix (Utilization). These next two slides will look at how the cost and utilization of UMP Classic Medicare has evolved over the last six years. Slide 19 looks at the utilization. The measure we have taken to present this to you is on base supply, which is a standardized measure of how a person may use a drug. This is standardized between drugs that you would take once a day, twice a day, taken once a week. It's measured in how many days a person is using a drug, and it's a very good measure that considers all the different types of drugs being used until you can see the pattern of utilization has been relatively similar over these years, which is primarily driven by generic drugs. These are the drugs that you know as the cheapest ones used to treat a lot of the most chronic medical conditions like hypertension, high blood pressure, hyperlipidemia, high cholesterol, depression. There's quite a lot of drugs.

The bluer bars are the brand, specifically to what we call traditional brand. These are drugs specific to conditions like diabetes, even hypertension or hypercholesterolemia, asthma, COPD, just the traditional drug classes. The specialty ones in the yellow are

for the newer biologic drugs that have high costs, special handling, are used to treat complex medical conditions, but there's a small population and often an unmet medical need by the traditional drugs. Relative to the other drug classes, it's a small day supply in the grand scheme of things. The relative percentage share is increasing steadily as more drugs come to market as more patients develop these conditions in which these drugs treat, and in which there is more competition within this space.

Slide 20 – UMP Classic Medicare Drug Mix (Plan Paid). This slide is the actual costs associated with these drugs. The colors are the same and in the same placement. This slide illustrates where these drivers are in costs. Generics, which accounted for approximately 90% of all base supply utilization for these six years, is less than 25% in 2015 and has continued to decrease. The way this slide is being presented in how the plan is paid is that they're not necessarily decreasing at the rate you see. It's just the component of our generic spend is decreasing relative to brand and specialty. If you think about it in terms of the different bid rates that you saw on Sara's slide earlier, this is slowly decreasing. We are saving some money on generics, but it's not decreasing at the rate you see. I just want to make sure you understand what this slide is representing, which is a component of total drug spend and not the histogram on Sara's slide where it showed the absolute dollar spend increasing over time.

The brand here is slowly decreasing as a percentage of the UMP Classic Medicare spend. It's pretty flat. It's slightly risen in this time. The specialty is continuing to grow at a steady and strong rate over this time, and it's continuing to increase on an absolute dollar value for UMP Classic Medicare through these years. This is to show you this specialty drug cost, even though it's a very small component of our utilization, is one of the main drivers of the drug costs that influenced the UMP Medicare rate. If you think about the value formulary that Sara alluded to earlier, it was one of the strategies we implemented in 2020 that helped us shift from the higher cost drugs to the lower cost drugs within these different tiers. But, as you can see, over time that specialty drug percentage is continuing to increase and outpace the savings realized through that change. That's not to note we are doing other management strategies like using prior authorization to focus in on the preferred drugs, or other utilization management strategies throughout these different classes. It's continuing to rise despite these different tools we use as a plan and wanting to reiterate the message conveyed earlier where the federal government and CMS's subsidies are really helping offset the MA-PD plans or the Part D plans relative to what we see in UMP Classic Medicare.

Dave Iseminger: Ryan, I have one thing for you to clarify. When the value formulary was put in place on this last slide, what part of the drug mix was the value formulary influencing?

Ryan Pistorosi: The value formulary impacted all three phases, but the most significant impact we saw was within that light blue brand phase because members who were using brand name medications had not previously used the preferred ones that are the lowest cost to the member and to the plan. That shift we talked about at the May PEBB meeting was taking the light blue utilization and shifting it within the light blue. We did see an absolute dollar decrease between them. In this representation here, it isn't really being reflected given that we're looking at what specialty is doing in 2020. We tried to describe that in detail at the May PEBB meeting.

Tanya Deuel: Slide 21 – Proposed Resolutions. We are going to walk through our proposed resolutions. Slide 22 – Proposed Resolution PEBB 2021-17 2022 Medicare Explicit Subsidy. We're asking the PEB Board to adopt the calendar year 2022 Medicare explicit subsidy of \$183 or 50% of the premium, whichever is less. This is before the Board because the Legislature sets the cap at \$183; however, the Board could choose to adopt a lesser explicit subsidy. The resolution has been drafted at the full \$183, making the assumption the Board would want to choose the full \$183.

Slides 23 through 27 are proposed resolutions by carrier. When there are multiple plan offerings under one carrier, by the Board adopting the carrier resolution, they are adopting each of the premiums within that carrier as well as any underlying plan design. For example, a KP Northwest plan design change for our Medicare portfolio, by the Board adopting the Kaiser Northwest Medicare resolution, the Board would essentially be adopting the premiums and those underlying benefit design changes.

First is Proposed Resolution PEBB 2021-18 KPNW Medicare Premiums, followed by 2021-19, Kaiser Washington Medicare Premiums, followed by 2021-20 UMP Medicare Premiums, followed by the 2021-21 UnitedHealthcare Medicare Premiums, and last would be 2021-22, Premera Medicare Supplement Premiums.

Slide 28 – Next Steps. These resolutions will be brought back to the Board for action later this month.

Elyette Weinstein: Thank you for referring to that Kaiser Foundation article in your materials. I see on page six it refers to the federal government's efforts to reduce program costs associated with expensive specialty drugs. Honestly, this article is from 2018. I'm curious. Is anyone familiar with any new efforts to reduce the cost of these specialty drugs? And my second question. In 2019 I think it was House Bill 1224 that passed dealing with drug transparencies. One of you referred to the Health Care Cost Transparency Board, which is also referred to on your website. I was wondering if that has any relation to this problem and is going to help address it? Thank you.

Ryan Pistorosi: I believe when that article was published, Trump had released a paper that detailed four different ways they were going to explore trying to offset drug costs. The ideas were looking at drug importation, reference pricing to international prices, so looking at what other countries were paying for drugs, and then setting the prices like that. There were a few different ideas at that time. I should be up to date on what the Biden administration is looking at in terms of their efforts. I know that Medicare negotiating drug prices has been a popular topic in the last few months. I know that has some broad bipartisan appeal, at least in the public, but I don't necessarily know what that would look like given CMS doesn't have experience in trying to negotiate drug prices, and whether it would look like a European approach like in the UK where they will not cover drugs unless they meet a specific price per quality threshold, or if it'll be like an American payor model in which they will be negotiating rebates and then using that rebate to either be applied at the point of sale to the member buying the drug or apply to what Medicare is paying in reinsurance.

Your second question was about the Health Care Authority's Drug Price Transparency Program, which was a result of House Bill 1224 in 2019. That program is operating. We are looking to publish our first annual report at the end of this year. We do have a

status report on our website detailing the work we are doing in setting up this program, and this will be the first year we are receiving data from the carrier's PBMs, PSAOs, and drug manufacturers. More to come on that. It is separate from the Health Care Cost Transparency Board, which is being set up at our agency, as well. I don't have as much insight into that since I am not directly involved in it like I am with the Drug Price Transparency Program. I do know they, unfortunately, will not be able to use the information we collect from the Drug Price Transparency Program given that there is a requirement in statute that forbids us from disclosing that data, even within the agency, besides what we can publish in the public report. It is firewalled off from the other parts of our agency and is not able to be used by the Health Care Cost Transparency Board.

Tom MacRobert: I want to make sure I have this clear. I had written out when I was listening to the presentation why do UnitedHealthcare and Kaiser Permanente qualify for manufacturer drug discounts, and we don't? I think what you said, Ryan, is because if they want to participate at the federal level, they actually have to sign an agreement that ensures they will comply with the standards set by the feds and at a state level. We simply do not get a Part D reinsurance. Is that correct?

Ryan Pistorosi: The way I would describe it is that UMP Classic is a Medicare Coordination of Benefits (COB) plan without a CMS contract and is self-funded, whereas the United MA-PD plans are contracted with CMS and must follow all the rules required of CMS for Part D coverage. If so, then they can access those CMS funds. Those are the two kinds of differences I would describe between UMP Classic Medicare, which does not get those CMS funds versus the MA-PD options that we are now offering, which do get those CMS funds.

Tanya Deuel: I think that was good, Ryan.

John Comerford: Not being a state employee and being on the Board for two years now, I have lots of questions. This one involves going back to Medicare. If the employee were to pick a Plan F or a Plan G, do they have to take the Part D with the state, or could they go out and privately shop the Part D?

Tanya Deuel: We do not offer a standalone Part D plan, John.

John Comerford: So, if they opt for the F or the G, they are on their own for getting a Part D? There's nothing the state can offer for creditable coverage.

Sara Whitley: No. That's correct. We don't offer a standalone Part D plan. If a member's enrolled in a Premera Plan F or G and they're looking for drug coverage, they would need to go to the individual market and enroll in just that individual Part D plan because we don't have a standalone pharmacy Part D benefit or plan offered within our portfolio.

John Comerford: And you don't offer any subsidies to them for doing that?

Sara Whitley: We do not.

Dave Iseminger: Chair Birch has asked me to wrap up our meeting. I want to thank everybody for the presentations related to the Medicare rates. We will continue that

discussion with a scheduled action on those Medicare resolutions at the next Board meeting.

Public Comment

Fred Yancey: A quick question. The biggest obstacle, and you guys have presented it, that our retirees have is the high cost of prescription meds. Surprise, surprise, and it's a catch 22 for them. Many of them can't afford the high cost of Uniform and yet that precludes them from getting a good deal on prescription drugs. So interesting question that John asked. Could the Health Care Authority offer a Part D plan? Have you ever looked at that? And is there any interest in looking at offering that as a standalone plan? That's all I had.

Dave Iseminger: Thank you, Fred. I will say there were a lot of options evaluated in what culminated in the MA-PD proposal, but it is a constant evaluation process. I will just say there were a lot of options on the table when this ultimately led to MA-PD, and we'll continue evaluating different options because of the structural differences described today between the various parts of the Medicare portfolio. It is an ongoing interesting question. Thank you for that comment.

Fred Yancey: Maybe it's just me and it's maybe out of place, but it would sure be nicer to either have the Exec Session scheduled at the start of the meeting or at the end of the meeting but not midway. You had a couple of important things and then you recessed and then came back. It's a weird arrangement.

Dave Iseminger: I can say that part of the challenge, Fred, is that under the Open Public Meeting Act, it's awkward either way. We must come back to public session to adjourn or come into public session to open. There's an awkward piece no matter how we do it, but we can always evaluate because it kind of relates to the start and end times of the various meetings, but I do recognize it's a challenge. We'll take that under advisement.

Fred Yancey: Again, if you did the meeting overview and then recessed, then came back and followed the rest of the tabs, that would have been better for me. And maybe I'm just being selfish.

Dave Iseminger: Well, we do our best to stick to the agenda.

Elyette Weinstein: This is really a response to be fair to the staff. As a Board member, it made perfect sense the way they proceeded. You would have been here three more hours because of me if they had not gone in the order they went, and I can't speak for the other Board members, but I have to tell you, because of them I understood what was going on.

Dave Iseminger: I appreciate that Elyette, as far as what we can't talk about what was in the Executive Session, the very nature of it. But I appreciate you providing that insight from the Board member standpoint, having attended the entirety of the meetings that the progression worked from your perspective.

Next Meeting

June 30, 2021

12:00 p.m. – 5:00 p.m.

Preview of June 30, 2021 PEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the June 30, 2021 Board Meeting.

Meeting adjourned at 4:00 p.m.