Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

June 19, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 4:00 p.m.

Members Present:
Lou McDermott, Chair Pro Tem
Yvonne Tate
Harry Bossi
Greg Devereux
Myra Johnson
Carol Dotlich
Tom MacRobert

Members Absent:
Tim Barclay

PEB Board Counsel:
Michael Tunick, Assistant Attorney General

Call to Order
Lou McDermott, Chair Pro Tem, called the meeting to order at 1:32 p.m. Sufficient members were present to allow a quorum. Audience and Board self-introductions followed.

Meeting Overview
Dave Iseminger, Director, Employees and Retires Benefits Division (ERB), provided an overview of today's agenda.

June 5, 2019 Meeting Follow Up
Dave Iseminger: We had a request for a Centers of Excellence presentation, which we've scheduled for July 10.

There was a question about nutritional visits. The Uniform Medical Plan with the rates you see today includes a change from three lifetime visits to 12 lifetime visits. No referral is needed in the Uniform Medical Plan to get nutritional counseling visits.

Tim asked questions about aspects of long-term disability. A long-term disability presentation is coming in July to wrap up those questions.

2020 Rates Overview

Beth Heston, PEBB Program Procurement Manager, Employees and Retirees Benefits Division. I will be talking about changes to the Uniform Medical Plan (UMP). Slide 2 – Uniform Medical Plan. To meet federal requirements, we are pointing out an out-of-pocket maximum for prescription drugs of $4,000. For the Classic, Plus, and Medicare plans, the individual out-of-pocket maximum is $2,000. During the year, IRS and Health and Human Services made changes to the pharmacy and maximum out-of-pocket amounts. Late last year, while we had an individual out-of-pocket maximum posted as $2,000, we discovered that in larger families, there was a chance a family could exceed the family out-of-pocket maximum if they all needed expensive drugs. We monitored it to make sure families didn't pay more than $4,000. This year, we recommend making it explicit by putting the $4,000 maximum on the Classic, Plus, and Medicare plans.

Greg Devereux: Was there a family maximum prior to this?

Tanya Deuel, ERB Finance Manager, Financial Services Division. There was no family maximum. There was an individual maximum of $2,000 each. If seven people in the family all hit that $2,000 individual maximum, they would have paid $14,000 out-of-pocket. The $4,000 as a family puts HCA in compliance so we won't exceed the $4,000 maximum. This is not a takeaway or an increase.

Greg Devereux: It certainly sounds like a takeaway.

Tanya Deuel: Now the member is only responsible for a total of $4,000 versus the example of a potential $14,000 cost. The member out-of-pocket cost on a family account now stops at $4,000.

Greg Devereux: Okay, you're right.

Lou McDermott: Is the definition of family more than one? Is it two or is it subscriber, spouse, and a dependent? I guess what I'm getting at is subscriber and spouse the $4,000 maximum? Before it was $2,000 and now it's capped at $4,000?

Tanya Deuel: I believe so, yes. Capped per family.

Dave Iseminger: Still with an embedded $2,000 each. It's a scenario where if you have a family that consists of three or more people, your maximum combined will be $4,000 with an embedded individual maximum of $2,000 each.

Lou McDermott: So a single person is still $2,000. A single person and a spouse are $2,000 each, but capped at $4,000. Add one child and it's up to $2,000 each, but capped at $4,000 for the family.

Tanya Deuel: Exactly.

Dave Iseminger: This was actually a change late in 2018. Our fully insured carriers accounted for this federal requirement. As Beth said, we monitored the charges over this plan year to make sure if anybody in UMP started to hit the maximum, HCA would have taken care of and contacted the member to ensure they didn't exceed the federal

cap. We're just now memorializing in writing this change to comply with federal law. Even though it wasn't in writing, we were complying with federal law.

Lou McDermott: So we took care of everyone in plan year 2018. No family paid more than $4,000 for drugs in 2018.

Dave Iseminger: Correct. HCA monitored costs over the appropriate period to ensure we complied with federal law.

Lou McDermott: Did we monitor this year as well?

Tanya Deuel: Correct.

Beth Heston: Another UMP change was the number of nutritional counseling visits. They are going from 3 to 12 per lifetime. This change better aligns UMP coverage with the United States Preventative Services Task Force (USPSTF) recommendation. Studies show that comprehensive high intensity nutritional counseling services are among the most effective interventions for diet-related chronic disease.

Lastly, the Board voted to add the value formulary to UMP.

Slide 3 – No New Benefit Changes. There are no changes for 2020 for Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington (formerly known as Group Health), Uniform Dental Plan, DeltaCare Dental Plan, and Willamette Dental Group. However, as a reminder, last year there was a change to Kaiser Northwest's durable medical equipment (DME) charges. HCA asked them to step that change. They added a 10% coinsurance and this year they will add another 10% coinsurance to reach the agreed upon level.

To comply with Senate Bill 6219, Kaiser Northwest will cover male contraceptives and sterilization, such as condoms and vasectomy benefits, at zero dollars after reaching the $1,400 deductible for self-only high deductible health plan (HDHP), or what we call CDHP plans. If they are meeting a family deductible, it's $2,800. The Senate bill says members must meet their minimum deductible before they pay zero dollars for contraceptives.

There is a typo on Slide 3. The Willamette Dental Group rate guarantee runs through December 31, 2022, not December 31, 2021. The dental plans all have rate guarantees so there are no changes to the plans.

Tom MacRobert: Excuse me, Beth, I just want to make sure. The rates for Uniform Dental, DeltaCare, and Willamette are the current rates we have in 2019 which will continue through 2022.

Tanya Deuel: On the Uniform Dental Plan, our self-insured dental plan, the third party administrative (TPA) fee we pay is in a rate guarantee. Because it's self-insured, we go back and look at claims experience. The rate does have a slight change in the overall rate that retirees would pay. But the TPA fee is in a rate guarantee. I have that in my slide a little bit later to show you.

Tom MacRobert: Okay, thank you.

Beth Heston: Slide 4 – Service Area Changes. Kaiser Permanente of Washington will no longer be covering San Juan County pending federal approval, or Grays Harbor County.

Lou McDermott: How many members does that effect?

Dave Iseminger: It's approximately 250 to 275 members.

Lou McDermott: I know we previously had experience with a county being dropped. I assume there will be a communication plan, talking to members, making sure they understand open enrollment and signing up for different plans.

Dave Iseminger: Yes to all of those. About four or five years ago, especially in Southwest Washington, we communicated with members as coverage must be on a county level, not on a zip code basis. HCA went through an exercise of working with individuals in Pacific, Wahkiakum, Lewis, and Skamania Counties, and maybe one other county, helping them understand their options. We will do the same outreach to the members in these counties for transitioning to other options. It means that going forward, San Juan County would be a UMP only county. The only plans available will be UMP.

Once the SEBB Program launches, we are hopeful there will be opportunities to bring additional competition and choice to members in many of those UMP only counties in future years, but not in 2020. SEBB Program service areas for 2020 have not been announced.

Lou McDermott: I assume Kaiser Permanente (KP) will put extra attention around our members who might have complex medical conditions so the transition of care goes well.

Beth Heston: Yes, we're somewhat handcuffed at the moment because of the need for federal approval. HCA and KP have action plans to reach out to members. We used it last year with the change in Lewis County for retirees. We have a strong communication plan in place.

Slide 5 – Network Update – Puget Sound Health Value Network (PSHVN). There will be changes to UMP Plus. HCA has new partners for 2020. For the PSHVN, those include the Rainier Health Network, which includes CHI Franciscan, Pediatrics NW, and others belong to that network. We also have the Physician Care Alliance at the Poly Clinic, and then the exiting partners for 2020, Multicare and Eastside Health Network.

Dave Iseminger: When we launched UMP Plus, the original term of the contract went through December 31, 2019. In the last week, HCA finished negotiations and executed one contract. The other contract is in the inking process, but we have the handshake agreement. This will extend UMP Plus through December 31, 2024. With this transition from the original term to the extension is where the significant network aspects are changing. We wanted to highlight those.

The loss of Multicare is because they're going to be exclusive to the UW network.

In Pierce County, CHI Franciscan is coming on and the Rainier Health Network continues to address provider access in Pierce County for the PSHVN network.

Beth Heston: Slide 6 – Network Update – UW Medicine. Multicare will be an exclusive partner to the UW network. HCA will let members know of this change and what plan they can choose to continue to see Multicare doctors, particularly in Pierce County. Also, Eastside Health Network is exiting the UW network.

Slide 7 – Spokane County Update. Beginning in 2020, Spokane County Multicare is partnering exclusively with UW. The Puget Sound High-Value Network served Spokane County through Multicare, but UMP Plus will only be available through the UW network in 2020. Members will be notified of that change. Slide 8 – UMP Plus – UW Medicine Accountable Care Network (ACN) 2020 Counties Served is a visual representation of the counties covered by the UW CAN. Slide 9 – UMP Plus – PSHVN 2020 Counties Served is a visual for the PSHVN.

Dave Iseminger: Spokane County is switching from being a Puget Sound High-Value Network county to a UW county, in part because of the exclusivity of Multicare being in UW. It looks like a big transition but it's not as profound a transition as you might think. HCA will make sure to communicate to members the need to switch plan names to continue care and do the similar outreach described for KP.

Carol Dotlich: I'm afraid I'm quite lost. I basically don't understand what you're telling me. If somebody has UMP today, they cannot use Multicare unless they switch to a different plan? Is that what you're saying?

Dave Iseminger: We're talking about the Uniform Medical Plan Plus, which is the more coordinated care network embedded within the UMP network umbrella. For the general UMP Classic population, nothing is changing. It's specific to this Uniform Medical Plan Plus, which has core providers that have coordinated care systems and a different in-network, out-of-network pricing structure for the members' out-of-pocket expenses for visits. We're saying that embedded network within the Uniform Medical Plan Plus treats Multicare differently between the networks going forward in 2020 versus today in 2019.

If an individual wants to continue in Uniform Medical Plan Plus in Spokane County and see Multicare providers, they will no longer be able to enroll in a high-value network. They need to choose the UW network. HCA will communicate with them to help ensure a smooth transition for them.

Carol Dotlich: Does this have an impact on the Centers for Excellence plan?

Dave Iseminger: No, it has no impact on those Centers of Excellence, total joint or spine bundle. It's solely with the UMP Plus networks.

Tom MacRobert: Just to make sure I understand this, let's say I am a Uniform Medical Classic member and I get all of my health care through the Overlake Hospital and Overlake network surrounding that area. I am not affected. It would only be if I'm UMP Plus.

Dave Iseminger: Correct. If you are in UMP Plus and you go to Eastside after January 1, 2020, that will be treated out-of-network. If you're in UMP Classic, you're in-network because UMP Classic is the broad PPO versus the embedded network in UMP Plus.

Lou McDermott: That's a good message for our members when they do sign up for a limited network. Because of contracting, negotiations, market share, and all the things that happen in our community, things change year to year. If you're in a limited network plan, you should always contact the plan to make sure your doctor is going to be in that network next year. That communication is a little bit tricky and I think the last thing we want is members showing up in January to their doctor they've seen for years and find out they are no longer in their network. That's going to be key.

Dave Iseminger: To be clear again, none of the service area changes described impact UMP Classic, which is the plan most people are in.

Beth Heston: Slide 10 – Premera Plan F and Plan G. We've spoken to you before about the required change from our Medicare Supplement Plan F to Medicare Plan G. These are Medigap or Medicare Supplement plans. Our Plan F will close after January 1, 2020 to future enrollment. The Medicare Supplement Plan G will open to replace Plan F. Plan G will be identical to Plan F, except subscribers must pay the Medicare deductible. The calendar year 2019 deductible is $185. The Centers for Medicare & Medicaid Services has not released what the 2020 deductible will be, which could change depending on what the federal government does.

Dave Iseminger: Importantly, no one is going to be required to change from Plan F to Plan G. It will be important for members in future years to watch the pricing because since future enrollment is closed, over time fewer and fewer people will be in that plan, which will drive different pricing structures within that plan. They can stay in Plan F as long as they are satisfied with the premium associated with that plan.

Tanya Deuel: Slide 11 – Employee Premiums. I'm going to walk through the plan year 2020 proposed premiums and rates. I will start with state active employees. I think it's important to revisit how the state calculates the state index rate, which is basically the employer's portion of the medical contribution set in the Collective Bargaining Agreement. It's set currently at 85% of the total projected health care costs.

Slide 12 – Calculating the State Index Rate. Going across this slide, starting at the top, it says "Plan Bid Rates." These numbers are illustrative only. I made these up for easy math. In the green box is Plan A at $550, tan box is Plan B at $500, and the blue box is Plan C at $450. We project what enrollment will be across these different plans (Adult Units). In Plan A, there are three adult units, Plan B, one adult unit, and Plan C, six adult units. The math for Plan A is $550 x 3, Plan B is $500 x 1, and Plan C is $450 x 6 that equals the total monthly cost. Add the total cost for all three plans and divide by those ten projected adult units to get a weighted average of $485. Take $485 times the state's contribution per the Collective Bargaining Agreement of 85% to get a state index rate of $412. Remember, $412 is just illustrative. The actual number is more likely $571, which you will see in a couple slides.

Dave Iseminger: This is all related to the employee contribution. This doesn't impact retirees.

Tanya Deuel: It doesn't impact retirees at all. We will go through those in a few slides. Slide 13 – Determining Employee Premiums. Now we take each plan bid rate, Plan A at $550, Plan B at $500, and Plan C at $450, and subtract $412, the 85% weighted average employer's contribution. That makes the employee contribution for Plan A $138, Plan B $88, and Plan C $38.

Dave Iseminger: One disclaimer because I know many people are paying attention to both the PEBB and SEBB Programs. This math formula is not applicable in the SEBB Program population. It's very different in the SEBB Program.

Tanya Deuel: Slide 14 – Determining Employee Premiums by Tier. This slide shows how we develop premiums by Tier. The single employee contribution for Plan A is $138. For Tier 1, it's $138 x 1 (single subscriber) = $138 monthly premium. For Tier 2, it's $138 x 2 (subscriber plus spouse or state-registered domestic partner) + $10 admin fee = $286 monthly premium. For Tier 3, it's $138 x 1.75 (subscriber plus child(ren) = $242 monthly premium. It doesn't matter how many children you have, it's still just .75. For Tier 4, it's $138 x $2.75 (subscriber, spouse or state registered partner, child(ren) + $10 admin fee = $390 monthly premium. The math is the same for Plan B and Plan C.

Harry Bossi: The plus $10, like the surcharge, adjustment, whatever you want to call it. How long has it been $10? How many years?

Tanya Deuel: A very long time.

Harry Bossi: I didn't know if going forward, it needs to be considered for an adjustment.

Tanya Deuel: I can follow that up next time.

Harry Bossi: That's okay. It just wasn't new this year.

Tanya Deuel: No. Slide 15 – Employee / Employer Premium Contribution. This slide shows the breakdown of the employee and employer split for a single subscriber. I'll orient you to each slide as we move through. The dark blue column on the left lists the plan names and they will stay in the same order throughout the slides. The next column over is the proposed plan year 2020 employee contribution for a single subscriber. The middle column is the state index rate or the employer's contribution of $571. It is the same amount for all plans. The far right column is the proposed plan year 2020 composite rate.

The composite rate, if you work backwards, for example, on Kaiser Northwest Classic, the composite rate is $711. If you subtract the $571 employer contribution, the single tier subscriber only rate is $140.

Dave Iseminger: I want to explain the very last sub-bullet in the footnote area. About three or four years ago, the legislature changed the rules for political subdivisions contracting with the agency to join PEBB Program benefits. There used to be a function to determine if an entity was riskier than the PEBB Program pool. If they were, they

couldn't come in and make rates worse. The Legislature flipped it and let anyone join, but provided the ability for HCA to evaluate the political subdivisions as a whole to determine if they had a rate risk impact than the rest of the pool. If they did, HCA could charge back that impact via a surcharge. A surcharge for political subdivisions results in an offset here for the pool of $1. The surcharge itself is more than $1, but the offset to the pool is $1.

Lou McDermott: Does it go the other way? If they were less risky and healthier, would we write them a check?

Dave Iseminger: No.

Tanya Deuel: Haven't had that happen yet either.

Slide 16 – Employee Contributions by Tier. This slide walks the single subscriber rate through the math of all of the tiers. Again, the plan names are on the left and there is a comparison of the plan year 2019 versus the proposed 2020 rate. As you move across the top, there's the subscriber tier, the subscriber and spouse tier, the subscriber and child(ren), and the full family tier (Subscriber, spouse/state-registered domestic partner, and child(ren)). On the far right is a comparison of plan year 2019 to 2020 as far as a percentage and dollar change. The percentage change is solely on the single subscriber rate. While these rates are smaller, the percentage change may look higher. In a couple slides, we'll look at the overall rate, which will have a different percentage because it's off of a bigger number. The numbers in red are a decrease so the rates are going down.

Lou McDermott: I know we had a conversation before the Board Meeting about the increase in UMP Plus and I was part of the new negotiations. I understand why this is happening. Do we want to provide that explanation?

Tanya Deuel: The change in UMP Plus is due to the recent contracts Dave referenced. Due to the nature of the accountable care plans, there is risk assured between the network and HCA. There are changes to that methodology in those contracts we are executing and waiting for signatures. I cannot discuss those details here in a public meeting.

Dave Iseminger: Tanya can't discuss the level of detail of the methodology changes but we did have financial changes within the methodology. It's important to note that from the beginning, we've been trying to target at least a 30% premium spread between UMP Classic and UMP Plus. Last year, the claims suggested a different rate that grew to approximately a 45% change. This year, with claims experience and changes in some of the financial methodology, we're closer to getting back to our 30% target.

Lou McDermott: To extend those contracts through 2024 and maintain the favorable benefit design, there were concessions made, the nature of the contract change. That's what's bringing the rate back to the 30% range. In our negotiations, our goal was to maintain the target of 30%. A correction has to happen between the 2019 rates and the 2020 rates to get it back to 30%, which is unfortunate.

Dave Iseminger: HCA would not anticipate a 38% increase every year. This is a one-time correction.

Tanya Deuel: The 38% is just on the employee contribution. 38% on $50 is $69. It's a higher percentage than the total rate in a slide or two.

Slide 17 and 18 – Non-Medicare Retiree Rates and Non-Medicare Retiree Rates by Tier. Non-Medicare retirees pay the full plan cost. In the column on the far right, there are smaller percentages of change. Typically, there is a 3% to 5% increase year over year. What we see here is on the lower end of an increase.

Dave Iseminger: Many times when you see reports from the Office of the Insurance Commissioner talking about rates year over year, this rate is what they're talking about. The overall plan cost. They're not talking about the individual employee contribution from our prior slide. When the Commissioner talks about the commercial market, rates are either going up or down a percent or two. This is the comparable metric to be looking at for the PEBB Program.

Tanya Deuel: This rate does not receive any contribution from the state towards their premiums. It is the actual bid rate plus an approximate $5 admin charge.

Slide 19 and 20 – Medicare Retiree Rates. This is the Medicare retiree premium, not the overall rate. This slide looks like the slide we saw previously for the actives with the plan names down the left. The single subscriber premium, in the next column is after the subsidy. The subsidy column is the employer's contribution towards medical for our Medicare retirees, which was increased in plan year 2020 to $183 from $168 in plan year 2019. The 50% language still exists. The subsidy is set at $183 or 50% of the premium, whichever is less. As you look down the middle column, Medicare Explicit Subsidy, only two plans have the Medicare explicit subsidy listed at $183 because the total composite was not over $366 (2 x $183).

Slide 21 – Medicare Retiree Premiums. This slide takes the same plan year 2020 rates and has a comparison of plan year 2019 to plan year 2020. There is a percentage and dollar change for the single subscriber premiums. The numbers in red parentheses are a decrease. Where you see Premera Medicare Supplement Plan F Disabled, it actually goes down $10.53.

Slide 22 – Impact of Medicare Explicit Subsidy. This slide shows the impact of the Medicare explicit subsidy on rates. Moving from the far left to right, you see plan year 2016 through play year 2020. These are UMP Classic rates with plan year 2020 being the proposed rate. The number on the top is the total rate. The orange box is the retiree premium with the blue box being the Medicare explicit subsidy. As you look at plan year 2018 versus plan year 2019, $483 versus $481, they are relatively flat. The Medicare explicit subsidy increased from $150 to $168. The orange box decreased slightly because the member pays the full rate minus the Medicare explicit subsidy. When there are extreme rate increases and the Medicare explicit subsidy doesn't increase at the same trend, the Medicare retiree absorbs the increase.

Carol Dotlich: These increases in cost, are they due to the increasing pharmaceutical costs?

Tanya Deuel: A good portion of it is pharmaceutical costs. Our Medicare rates, as a whole, are over 61% in pharmacy costs and the rest are medical based on the nature of how UMP works.

Dave Iseminger: It's fair to say the structure of the Medicare plan is the UMP pays primary on pharmacy but secondary to Medicare for medical. The vast majority will always be driven by pharmacy costs because of the structure of the plan itself inherently as a primary payer of pharmacy. HCA will always pick up the first dollar coverage as an insurer on drugs compared to the medical. Pharmacy always is going to be a predominant driver of any rate change, up or down.

Greg Devereux: Why is that, Dave? Why is PEBB primary on drugs?

Dave Iseminger: It's almost like asking why the sky is blue. It's fundamental to the relationship that the plan has --

Greg Devereux: Why is the sky blue? [laughter]

Dave Iseminger: I could actually answer why the sky is blue better because of the refraction of light. But for your Medicare question, we take on a credible plan that qualifies under the Medicare rules. It comes with federal requirements. You can have a plan that has prescription drugs; and if it does, it has to meet certain requirements. Fundamentally, the way a plan is packaged under the federal rules, it does inherently require you to be a primary payer on pharmacy. If you include prescription drug coverage, it comes with different requirements such as offering and ensuring the plan is at least as good as part D. Part D would be the primary payer if it was your only plan. If you are picking up drug coverage, you are picking up being the primary payer of pharmacy.

Beth Heston: In many cases, our prescription drug coverage is much richer than Part D.

Carol Dotlich: I'm going to make a statement. Because you implemented the value formulary, you've heard this from me before, I don't think our rates should go up because by implementing the value formulary, which I didn't agree to, but your plan is to keep the cost of the drugs low. Since you've implemented that plan, I think the premiums should stay the same for retirees because you're going to recover that cost with your value formulary.

Dave Iseminger: One of the challenges we have, Carol, is we are about to implement it, but the way it's being implemented, for the most part, will impact future diagnoses and future drugs people will take. There's a lot less disruption for the current member. Because we build our rates based on prior claims experience, we don't have a way to do the projection for the exact way the formulary is being implemented. A year from now, we'll have more experience to factor into the process. The way it's being implemented, we aren't anticipating or able to quantify a specific attributable savings to bank on for purposes of setting rates for 2020.

Tanya Deuel: The costs we're expecting for the value formulary, the savings will increase as the years go on because in the beginning, there'll be more exceptions. We will realize those savings starting in next year's rate build.

Dave Iseminger: For example, Carol, if the value formulary had passed two years ago, it would've been able to be accounted for in these rates. It just can't be done in the rate setting process for 2020.

Lou McDermott: One thing we always run into, is the balance between taking care of our members and making sure they have continuity of care, continuity of medications, and wanting to implement new things. When we go back and do our modeling, if we make sudden dramatic changes, we don't grandfather people. We create no exceptions. We can achieve immediate savings and we know that. But at the same time, these are our members. We care about these people. They're taking these medications for chronic conditions, for acute conditions, and we take it into consideration. It is always a struggle to try and find that balance between taking an action, which eventually will save money and make sense clinically to do, and yet taking care of the member. In my conversations with staff about the savings assumptions, because it's very unpredictable how many people are going to get the exception, how many people are going to come in and start new medications, and start at the medication within the Preferred Drug List (PDL). That's a tough one. It is a tough balance, but there will be savings achieved. It will take time, unfortunately.

Carol Dotlich: I would like to push back on that. I could agree or accept what you're saying better had we adopted a plan where we grandfathered the patients on their drugs currently and just moved on new diagnoses and outcomes rather than taking existing patients off of their existing meds and putting them through the value formulary process. That's not what this Board voted to do. We voted that there was no grandfathering of those people. To get an exception, they had to go through this whole different process. They're not grandfathered. That's my objection. I could understand your point of view if you had agreed to grandfather but the Board did not agree to that.

Lou McDermott: Ryan, do you want to come up and talk about implementation and medications that folks are probably going to be filling at the end of the year that are going to go for 90 days and all the different things that are going to cause us not to get the full financial impact of the change?

Yvonne Tate: I have a comment. Just because they weren't grandfathered doesn't mean they're going to be thrown off the drug. They're going to go through a process. If the only thing that works is that drug, they're going to keep that drug. It isn't a fait accompli that they're not grandfathered.

Harry Bossi: I want to check in, too. This is a cost containment process we're going through. The cost containment doesn't start until 2020. You're not likely to see savings right away. Hopefully, this will help offset for 2021. I think the whole idea is long-range and not short-term benefit for our plan members.

Ryan Pistoresi: We have been working closely with Moda. We've had weekly meetings and will continue to have meetings throughout the rest of the year about the implementation of the 2020 UMP PDL. We are going through and trying to identify

members currently taking these medications that may qualify for an exception. There are patients that have already gone through some of these drugs and progressed to other drugs. We are trying to reach out to them to let them know about the process early on. We are going to work with the existing claims history to identify those members and start the process so there is no disruption for them on January 1, 2020. They can continue to get their medication if they qualify. For members that don't qualify, we will reach out to them and identify alternatives so they can start the process this year so there is no disruption for them at the start of the next plan year.

Carol Dotlich: Are you saying you've implemented the value formulary this year already?

Ryan Pistoresi: No, we haven't implemented it yet but we're starting the process to implement. There's a lot of work between now and then to identify members to get the drugs set up correctly in the different tiers because for certain medications, two or three may move to Tier 2 based on experience that MODA has recommended from when they implemented their preferred drug list for Oregon Educators Board (OEB) and Oregon Public Employees Benefits Board (OPEBB). We're still in the process of implementing. We're looking at ways to mitigate some of the potential disruption at the start of the next plan year.

Dave Iseminger: Once the SEB Board voted, because they were the second of the two Boards to vote, that started an implementation project at HCA. That project began in late May and now goes through and ensures implementation goes into effect January 1, 2020. That requires the identification and outreach to members. When Ryan says we're implementing, we're working on that implementation project and informing people about the change that is coming. The effective date of that change is in the resolution, which is January 1, 2020. Ryan's not talking about implementing today. He's talking about the steps necessary to implement the policy effective January 1, 2020.

Tom MacRobert: I don't want to revisit all of our arguments about it in the past. I do have one comment and one question. The comment, basically, is there is going to be some disruption to people moving off drugs they currently are taking if it's a drug affected by the value formulary. Even though, as Yvonne pointed out, they will have the ability to go through the appeal process, that doesn't mean they won't have to leave the drug they're taking to try generic alternatives. If those don't work, they go through the appeal process. We're talking about a process that could have some very long-term effects on those people affected by it. That's just the point. The question I have is, moving forward, if this value formulary is to have a positive monetary effect for the Health Care Authority, how are you going to present that information to us such that we understand where those savings are coming from as we go forward?

Dave Iseminger: Tom, as we get into next year, that is the prime question people are going to ask. As HCA is presenting rate information, what would the table have looked like if that wasn't there? We know there's a vested interest from everyone in a lot of different arenas, but in particular, the Board as to what really can we attribute to that piece. Again, I want to make sure the Board realizes in future years, the further out you go, the more we would anticipate seeing savings. Just like any time you make a stab at trying to bend trend. I can't commit to the exact way we're going to visually represent it. It depends on how everything shakes out. I anticipate we would proactively bring

forward information about what the attributable savings is in a future projection and a future rate development.

Tom MacRobert: Okay, thank you.

Lou McDermott: At the end of the day, by not having aggressive savings targets associated with the plan, it gives the clinical folks an opportunity to implement it to the favor of the member, trying to make sure we take care of our members. The harder line we put on the fiscal implications of the change, the more we hold their feet to the fire and the more they have to make tougher and tougher decisions with regard to our members. They're going to ease into this program and over communicate with members. Some members will see the writing on the wall and get a 90-day refill in December. You can't do anything until April anyway. Those things are going to happen because when you make a change, people react. We're trying to give the clinical team room to do their thing. We will start seeing positive effects on this. We can parse that out financially and during the next rate-setting phase, some of those will come to fruition and be baked into the projections for the next year. We'll get to reap the benefit of that without an extreme cutover.

Dave Iseminger: I appreciate your comments, Tom, about the impact individual members will have. I don't want to leave the other side of the story on the table. The generic equivalents are supposed to be just as efficacious and cheaper. Those who do try another generic drug alternative that works for them as it is anticipated, would have a positive impact of paying less out-of-pocket month over month going forward. There will be positive out-of-pocket savings that people will realize by going to the lower cost, equally effective drug.

Yvonne Tate: The point I was trying to make is this decision is on an individual basis. For example, there may be members who have already tried all the generic equivalents. They're not going to go through that again if they can document it. They've tried them and they didn't work. That's all I'm saying is it's an individual case-by-case basis as to what the path they take. They will look at their medical records and consult with the third party administrator and their medical doctors as to where it's going to go. The only other thing I'd like to say is just reminding the Board Members that with any kind of rate setting, generally what happens is you look backwards to project forward. You have to have trend in order to project future rates. With this change, there is no trend right now. That's part of the dilemma. The longer this change is in effect, the more trend data we'll have.

Carol Dotlich: I would just like to say from a consumer point of view, what it's going to look like to people with these rate increases is they're paying more for less choice, for less opportunity. That's my objection to the increase in rates.

Myra Johnson: What I'm hearing is I think the key to this is truly going to be about communicating and a transparency of how this came about to the membership and the end user. I am hoping a lot of the generics work, but I also going with what Yvonne says in that members will know if they've tried something and it didn't work. Their primary care provider will also know and help the member walk through this process quicker because they already know. I think if that's a win for anybody, that's a plus. I'm hoping, as we look deeper into pharmaceutical costs and how that impacts the end user

and as long as we're communicating that effectively, there's not going to be 100% win on any of this, but I think I'm happy we're going in the right direction. Thank you and that's my comment.

Dave Iseminger: I'll add one more piece related to specialty drugs. We've said these numbers before but I was in an annual meeting with Moda earlier this week. For 2018, 54% of the drug spend was driven by .3% of prescriptions. That was a growth from .24% specialty prescriptions in 2017. A growth of just .06% drove an additional 4% to 5% in overall drug spend. That is what's also factored in here driving rates up. It continues to be specialty drugs and that small utilization has profound cost.

Another piece the value formulary is attempting to smooth out is the future volatility in the market that comes with specialty drugs. Although Ryan and Donna try to have crystal balls, we don't all know exactly what's going to come down the pipeline, how clinical trials will work, which drugs will tank in the clinical trial process, and which will ultimately get approved.

With our rates, there's at least three or four major drivers. You have your explicit subsidy and what portion the state picks up. You have drugs overall, but in particular, specialty drugs that are driving trend. There are small changes in percentages within specialty drugs that end up driving huge increments in the dollar-for-dollar increase in rates. Those things all come together into the rates.

Tanya Deuel: We are also trying to be aware of being too aggressive that we don't have the yo-yoing in rates between years, like you can see on this chart between plan year 2017 and 2018. That was a $55 increase to the member, a 20% increase. We don't want that to happen in the future where we're too aggressive and then next year's rates go up because those savings weren't actually realized.

Greg Devereux: On page 16, I assume this is because of the waiting, but the subscriber, spouse, and children for UMP Classic, that's the only one that -- let me look for a second.

Tanya Deuel: UMP Classic is going down on the single subscriber.

Greg Devereux: All four go down, correct?

Tanya Deuel: Right, because the single subscriber goes down by $3. We then work through the math of times 2, 1.75, or 2.75. They all go down.

Greg Devereux: All right, thank you.

Tanya Deuel: Slide 23 – Dental, Life, and Long-Term Disability. Slide 24 – Dental Premiums. These dental premiums have rate guarantees, which Beth referenced earlier. The plan names are on the far left and the subscriber comparison rates for 2019 and 2020 are in columns 2 and 3 for the single subscriber. The Uniform Dental Plan is in a rate guarantee for our TPA, our third party administrator. We actually do a full rate build on this like we do on the medical. We look back to 2018 actual experience and trend it forward. This rate actually has a slight increase where the other two rates do not. As a reminder, this is 100% paid by the employer for state active employees.

Retirees pay these rates. If a retiree enrolled only in dental but not medical, there would be an admin fee charged. Retirees are charge the admin fee once if they are in medical and dental. If they're in dental only, it's still charged only once.

Slide 25 – Life, AD&D, and LTD Premiums. Basic life, AD&D and LTD are employer-funded and there's no rate change for 2020. However, the optional and LTD is employee funded. While there are no rate changes for 2020, the individual rate you may pay if you're paying optional could change if change your waiting period or your age band changes. If you get older, the age band rate changes slightly.

Slide 26 – 29 - Proposed Resolutions. There is one resolution for each carrier. They are grouped by non-Medicare, both active and retiree; and Medicare following. I'll read the first one so you can see what we have.

Slide 27 – Proposed Resolution PEBB 2019-07 – Non-Medicare Premium. The PEB Board endorses the Kaiser Foundation Health Plan of the Northwest employee and Non-Medicare retiree premiums.

This is what the resolution will look like for each carrier.

Slide 30 – Proposed Resolution PEBB 2019-10 – Medicare Premium. I want to draw your attention to the Medicare explicit subsidy resolution. It reads: The PEB Board endorses the monthly Medicare Explicit Subsidy of $183 or 50% of premium, whichever is less.

The Board has the authority to set this lower if you choose. We have written it at the full amount, thinking that's what you want.

Dave Iseminger: We are assuming you would exercise your discretion to give retirees the maximum allowed in the budget. But you do have to formally ratify that amount because in theory, you could lower the subsidy. You can't raise it but you can lower it.

Tanya Deuel: Slides 31 – 24. The next resolutions are by carrier for the Medicare premiums. The first one is Proposed Resolution PEBB 2019-11 - Medicare Premium. The PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare premiums. Following that are resolutions for Kaiser Permanente of Washington, the Uniform Medical Plan, and Premera.

Slide 35 – Next Steps. We plan to bring these resolutions to you for action at the July 10 PEB Board Meeting.

Eligibility and Enrollment Policy Development

Rob Parkman, Rules and Policy Coordinator, ERB Division. Slide 2 – Introduction of Policy Resolutions. I am introducing one policy resolution today. Proposed Policy Resolution PEBB 2019-06 - Tobacco Use Surcharge.

Slide 3 – ESHB 1109 (Budget Bill). This slide is an extract of the current budget bill that goes into effect July 1, 2019. Included is relevant language from the bill for you to have available as we talk about the policy related to the tobacco use surcharge. Prior budget language expressly stated $25 is the amount of the monthly surcharge. The language

changed in the state operating budget that starts on July 1, 2019. The Board can establish the amount of the surcharge provided it is not less than $25 per month. Because of this change, we're bringing a policy resolution to you for consideration.

Dave Iseminger: Rob will review considerations and share why HCA recommends leaving the surcharge at $25. If the Board wants to have the agency consider additional points, we will. The spousal surcharge had similar language when it was originally enacted that said it must be at least $50 so we brought you a resolution to set it since you have discretionary authority. We've never brought you a tobacco surcharge resolution because the original budget language effective until this July expressly set the surcharge at exactly $25. Now that the language changed, we're asking you to take action once you have authority, which is after July 1.

Rob Parkman: Slide 4 – Considerations. This slide presents considerations for the Board. Approximately 26% of employers with 500 or more employees have a tobacco surcharge according to a survey conducted by the Mercer consulting firm. The median differential payment for smokers and nonsmokers is about $600 a year, or about $50 per month. The $25 surcharge is comparatively low.

Currently, about 3% of PEBB Program members pay the surcharge, compared to a national average of about 15%.

The American Lung Association is opposed to tobacco surcharges. They feel they're ineffective in causing smokers to quit, and in fact, there's evidence that if they're high enough, people will forgo insurance altogether so they don't have to pay the surcharge. While surcharges have not proven particularly effective, there are other methods that have worked, including taxing tobacco products, adopting smoke-free laws, both of which Washington State has done, as well as making tobacco cessation treatment accessible, which the Board has done by including the most effective programs within medical plans offered by HCA.

Slide 5 – Proposed Policy Resolution PEBB 2019-06 – Tobacco Use Surcharge. Beginning January 1, 2020, the tobacco use surcharge will be $25 per month for a subscriber with a member enrolled on their medical plan that uses tobacco products.

Carol Dotlich: Currently, are the Medicare population included in the surcharge and would this resolution change that?

Rob Parkman: No.

Greg Devereux: I've always been opposed to both the spousal surcharge and the tobacco surcharge. This just gives further evidence there's no real need for the tobacco surcharge. To me, these are simply taxes on state employees, both of them, and when 88% of state workers are behind their counterparts in the public and private sector in terms of wages, I think it's ridiculous the state exercises this and takes more money back from them. I know we can't do anything here but I think it's ridiculous to take it out of people's paychecks.

Tom MacRobert: I have one question. If the data shows surcharges are not effective, why are we doing it?

Dave Iseminger: There is definitely data that says there are more effective tools and a fair amount of data that questions surcharges. We have a relatively small surcharge compared to others. There is definitely a deterrent effect. We can't exactly attribute a specific correlation, but when the tobacco surcharge was originally implemented, there were more people paying it than are paying today. Either they're accessing tobacco cessation programs so they can appropriately attest they are trying to seek better lifestyle choices that can decrease their tobacco usage, or they've actually quit. I guess they could not be telling the truth on their attestation, which gets us to if you were to raise it, you might incentivize potential false attestations. I think there is some data, although it might not be perfect, that says surcharges are not effective. In fact, it might be a significant amount of data that says overall surcharges aren't the best tool. It is something that can at least create a deterrent effect. Having something that's lower than the rest of the market, continuing forward and promoting healthier lifestyle choices, or accessing tobacco cessation is at least a tool.

Lou McDermott: I think there's a camp out there that's suggesting people who smoke have higher health care costs and this is to help offset some of those costs. I think that's the rationale. But is it a deterrent? I don't think so.

Tom MacRobert: I'm not arguing that. I'm just arguing that based on what Rob said, not only is it not a deterrent, but you used the example of people actually sometimes will forsake other things that would be healthily effective so they can continue. That doesn't sound to me like it's a program that works effectively. I'm just pointing out the logic behind it.

Greg Devereux: I appreciate your answer, Dave, but to me, a more accurate answer is the state senate in a particular year decided they needed different ways to raise money. They decided the spousal and tobacco surcharges were ways to get money for the state budget. I don't think it was based on policy considerations. They hid behind policy considerations. But it was simply a money grab to get from the state workers in my opinion.

Dave Iseminger: One thing I'll add, Tom, at some point, it can become a deterrent to accessing insurance at all. I believe under federal law you can add an additional cost up to 50% of the premium. You can increase the premium by 50% solely for tobacco users. States have the authority to set different parameters. I can't remember what our state's commercial market insurance laws allow. There are instances across the country where a premium might be 50% more, not $25 a month, but a total 50% of the premium added on. That could be what's driving the statements about deterrence of accessing insurance. I would say in the grand scheme of 50% of a premium addition versus a $25 a month charge, there is definitely a gradation there. I don't want us to say because we have it, some people forego coverage. We're not saying that in the PEBB Program population. That's from a national perspective. Keep in mind the ceiling at the national level is up to 50% of additional cost associated for tobacco use.

Lou McDermott: Rob, I think you're hearing the Board say to go with the minimum $25. Thank you for bringing us this information.

Rob Parkman: Slide 6 – Next Steps. I will take your feedback, hearing a $25 surcharge, and bring it back to the next meeting.

Emerging Medications

Ryan Pistoresi, HCA Assistant Chief Pharmacy Officer, Clinical Quality and Care Transformation Division. Today I have one medication to share with you, onasemnogene abeparvovec, also known as Zolgensma, which is the new gene therapy approved late last month.

Slide 2 - Spinal Muscular Atrophy. This slide is background on the disease. Spinal muscular atrophy is a rare neuromuscular disorder characterized by muscle weakness. The neurons do not function correctly. Over time, the neurological function begins to degrade and fail, which leads to progressive muscle weakness. This is a rare disease and it affects approximately four to ten patients per 10,000 live births.

Dave Iseminger: To skip to a much later slide, we have about 2,500 births per year in the PEBB Program. This is something we would project to happen once every three or four years in the PEBB Program population.

Ryan Pistoresi: There are a few different types of spinal muscular atrophy within this umbrella of a disease. As you see listed here, the different types of the disease depend on when the symptoms manifest in the different patients. It also depends on the number of copies of an SMN 2 gene that we all have in our bodies. The disease is caused when the SMN 1 gene, also known as survival motor neuron one, is either mutated or deleted and it doesn't function properly. These patients need to rely on these SMN 2 genes in order to have these neurons survive.

Just looking at the list from Type 0 to Type 4, patients with Type 0 typically have zero or one copy of the SMN 2 gene and that's why they usually die within weeks to months after birth. If you go down to Type 4, those are usually patients that may have upwards of eight to ten copies of this SMN 2 gene, and they usually don't even know they have spinal muscular atrophy because they have ambulation throughout all of life and have normal life expectancy. Unless you had a genetic test for this specific gene, you wouldn't know because you don't suffer any of the symptoms known for spinal muscular atrophy. The ones we'll be talking about for this presentation are Types 1, 2, and 3 because those are the ones that have onset of symptoms usually early in life or around the teenage or early adulthood.

Type 1. These children are never able to sit unsupported. They usually have to be put on permanent ventilation between year one to 15 months. They usually don't survive past their second birthday.

For Type 2, the symptoms usually appear between three months to 15 months. They are able to survive a little bit longer but many have to have permanent ventilation in their 20s. One study showed about 70% of patients with Type 2 were alive at 25 years of age.

Type 3 patients usually manifest more mild diseases, usually losing ambulation and requiring a wheelchair, but their life expectancy is about normal.

In terms of the different types relative to the number of live births, about 60% of all births are Type 1 and 30% are Type 2. Type 0 and Type 4 are the least common forms of spinal muscular atrophy.

Slide 3 – Spinraza (nusinersen) is the first medication approved for spinal muscular atrophy just a few years ago. This was a medication approved by the FDA in 2016. Prior to this treatment, there were no pharmacological therapies for spinal muscular atrophy. It was just supportive care and making sure the patients are comfortable. As of 2016, there is an approved therapy. This medication requires about six doses in the first year and then three doses every subsequent year. You begin doing doses a few weeks apart. After that, you progress to every couple of months. This is a medication that costs about $750,000 in the first year and $375,000 every subsequent year.

I am going into detail because it's challenging to compare between Spinraza and Zolgensma. Spinraza was studied in symptomatic patients, which is analogous to Type 1 spinal muscular atrophy and the pre-symptomatic patients, which are types two and types three. So on the genetic test they were identified to have spinal muscular atrophy but because they didn't develop symptoms at the time of the trial, they were considered pre-symptomatic but were likely to develop symptoms in the next couple years of life.

In one of the trials, about 50% of Type 1 patients that received Spinraza achieved motor milestones relative to 0% of the placebo. It shows there is this difference from when the medication is administered to when it isn't. It is worth noting of the 73 patients who received Spinraza in the trial, six were able to sit independently and one was able to stand. These patients were never expected to sit unassisted.

I want to touch on the motor milestones. These patients had at least one improvement in one category of a specific motor neuron test and more categories of improvement than no improvement. When you think about this drug, there is a wide spectrum from patients, how they respond. On one end, you have a patient that is able to stand and a couple patients that are able to sit. You also have about 49% that really didn't see any improvement with this medication. There is a wide range of how patients respond when they receive this medication.

Very few patients have received this medication under UMP since it was approved in 2016. As Dave mentioned, we don't see many births in the UMP Program population for patients with this disease.

Slide 4 – Zolgensma (onasemnogene abeparvovec) is the drug we're talking about today, the newly approved gene therapy. This is the first gene therapy approved for spinal muscular atrophy and the second gene therapy approved for use in the United States. It's approved for patients who are less than two years of age with certain mutations in SMN 1 and sufficient copies of SMN 2. The Type 0 that don't have enough copies are not eligible for this drug. Theoretically, any other type of SMA could be eligible for this gene therapy. So far, only one published clinical trial studied Zolgensma in patients with Type 1. Only 15 patients were in the trail that received this medication.

The published data includes outcomes on survival ventilation status, sitting independently, healthcare utilization, looking at how these patients may utilize in-patient hospital visits or other healthcare services, adverse events of the safety of the

medication and a few other things. It's worth noting the Spinraza trials looked at motor milestones, whereas this trial only looked at safety, were there any deaths, or any need for permanent ventilation. Permanent ventilation requires ventilation for at least 18 hours per day. There are no outcomes for us to look and compare between these two drugs since they were studied in very different ways, even though they were studied for the same population.

It is worth noting that all 15 patients were alive at 20 months, compared to about 8% of the historical control. Following the end of this trial, about 40% did begin to use Spinraza. It looks like there is potential transition for these patients to go from this gene therapy to Spinraza. There is not much data on why or who transitioned over, but it looks like there may be need for additional medication to improve mobile milestones and other functional assessments for these patients. There is going to be a 15-year follow-up study. Since this was just finished earlier this year, we won't know until about 13 years down the road what the long-term outcomes are of these gene therapies.

Slide 5 is SMA Type 2. There is no published data on this type. Type 2 is for those pre-symptomatic patients I mentioned for Spinraza. These patients develop symptoms later in life, may live into their 20s or live a normal life expectancy, and may require a wheelchair. What's interesting about this study is they use a different route of administration. It's interesting that this gene therapy was approved for all types of SMA when it was only studied in Type 1. But all studies in Type 2 are using different methods of administering the medication. We are closely monitoring that to understand why there is a difference in how this drug is used for these types of patients. Unfortunately, there won't likely be published results for this until approximately April 2023. There's not much data on this new gene therapy, or Spinraza in general, just because of the rarity of this disease.

We continue to monitor and evaluate these drugs for use in our patient population.

Lou McDermott: But we do know how much it costs.

Dave Iseminger: Ryan, it still could be administered for these individuals, even though the clinical trial was only on Type 1. Individuals in the US will be able to receive it and we know how much it costs, even if we don't know the full clinical data. We're talking about a $2 million drug that's been in the news after one clinical trial of 15 people.

Ryan Pistoresi: Correct.

Tom MacRobert: Novartis is the company that is going to be at some point, hopefully, in their mind, selling Zolgensma? Are they the ones doing the research?

Ryan Pistoresi: Yes. Zolgensma was developed by AVXS, a small biopharma company. When this drug was going through clinical trials, Novartis bought them out. It's a joint partnership between Novartis and AVXS.

Tom MacRobert: Who pays for the research?

Ryan Pistoresi: This research is being paid for by the manufacturers. They are the ones that fund and design the clinical trials. Once they're finished with that, they submit

that information to the FDA for review for potentially changing the drug label or the prescribing information.

Emily Transue, MD, HCA Associate Medical Director. There is an open question on some of the FDA approval. We would be looking at what we would create in terms of coverage criteria to make sure this was directed at people who could benefit from it.

Ryan Pistoresi: Novartis announced the price of Zolgensma will be $2.13 million per dosing kit. Given that this is a very expensive medication, they are trying to work with payers to set up a pay-over-time option, which would be the first time the US has had that option. It would be about $400,000 per year over the next five years. One of the challenges with that is if a member were to get the drug through UMP, change employers, leave UMP to work in the private world, UMP would still be on the hook for the cost of the drug. There are inherent challenges with this type of payment structure, which is why we haven't seen it before.

Using more than one dosing kit has not been evaluated. During the clinical trials, they were only looking at patients of a certain weight, children six months of age or less. Since this was approved for children up to two years of age, HCA could potentially be looking at patients with larger body weight. The amount of the dosing kit may not be sufficient and may require multiple. HCA is evaluating that for determining the appropriate medical necessity criteria for when these medications should be approved.

Dave Iseminger: I'm curious if those payment plans will be interest-free or not.

Ryan Pistoresi: Slide 6 – UMP Budget Impact. HCA anticipates the budget impact for this new drug would be the $2.13 million, but only once every three to four years. It depends on the incidents of Type 1 SMA in the UMP population. Dave mentioned we have about 2,500 births per year, so we may see one of these every three to four years, once we reach 10,000 live births for our population. Since it is possible, it could be less, it could be more. It depends on our patient population and how this is diagnosed.

To summarize all the 26 medications talked about since the beginning of the year, the anticipated budget impact is $4.4 million. This is easily the most significant budget impact drug of the year.

Pubic Comment

Fred Yancey, Washington State School Retirees. Two basic points and then one opinion as a citizen. I happen to agree with the logic, illogic if you will, behind the issue of tobacco surcharges. If evidence shows it's ineffective, if you're doing it for health reasons, and I never said this, but then why don't retirees pay? They smoke as well. It's illogical. It does not make sense.

Where does the money go? Nobody has said our rates are cheaper in UMP, as an example, because they're offset by X amount of money that we get from the tobacco surcharges. Mr. Devereux suggested it just goes into the state general fund but I think it goes to Health Care Authority. What happens to that money and how much are we talking about?

Ms. Deuel did an outstanding job educating somebody like me on how you get the rates and how it works in terms of the tiers. My only question is, when the Board is asked to certify the Medicare rates, they don't have a tier sheet similar to that for the Medicare rates. What you're given is a sheet showing just the subscriber rates. I think you need to see what a subscriber and spouse pay and family pay and so forth for Medicare because it's pretty shocking premium costs.

Tanya Deuel: I can actually address those now. I saw your email about the retirees by tier. This question was asked last year so I looked at how we addressed this. Just so the Board is aware, with the Medicare premiums by tier, it's not just the four tiers anymore because it's a combination of how many Medicare eligible are on each account. It's not four tiers, it's many tiers because it's a combination of Medicare and non-Medicare. We don't produce this until the Board has adopted the rates because it is a lot of math that's long and we usually don't go through this QA process with the actuary until after the Board adopts the rates. That's the answer to that one.

Fred Yancey: I understand that but the Board is being asked to adopt by resolution the rates and they don't have them in front of them. At least based on current rates, it looks like it's two to three times higher as you go across tiers. I understand your spouse may not be Medicare eligible so that's a certain rate. Maybe both of you are Medicare eligible and that's a certain rate. But I think you need to see the shocking cost of a Medicare insurance coverage for retirees.

Tanya Deuel: It follows the same tiers as the actives that were in the beginning of the presentation where it's times one, two, 1.75, or 2.75 if they're both Medicare eligible. When you add the non-Medicare children in the equation, it becomes a combination.

To follow up on the tobacco surcharge, it's about $3.3 million, based on the last fiscal year.

Lou McDermott: Tanya, is that just tobacco or is that all the surcharges?

Tanya Deuel: That is just tobacco. It's $3.3 million, which is about 11,000 people paying that surcharge. It goes into our general account, not the general fund but our main benefits fund, which is used as general revenue to offset the entire cost of the program. It reduces the cost to the state and everybody.

Fred Yancey: Thank you for your time.

Preview of July 10, 2019 PEB Board Meeting

Dave Iseminger provided an update on potential topics scheduled for the July 10 PEB Board Meeting.

Lou McDermott: I want to recognize and thank Fred Armstrong, our account manager from Kaiser Washington, formerly Group Health, for his years of service working with the Health Care Authority and this Board. Fred is retiring and this is his last meeting today.

HCA would deal with Fred on issues that happen all the time. We have rate season, which everybody is aware of where we're talking benefit design and money. But during

the year, lots of stuff is happening with the OIC, lawsuits are being filed, regulations are changing, the federal government's doing their thing, members are having issues, and Fred was our primary contact. He always did a great job for us and always very responsive. I just want to thank you for all the work you did over the years.

Fred Armstrong: Thank you. It was my pleasure.

Lou McDermott: Am I allowed to share your retirement plans?

Fred Armstrong: You are.

Lou McDermott: Fred is going to be a babysitter to his grandchildren. He is packing up and moving closer to the children to help with daycare. I think that is an awesome retirement. It beats going to meetings all day, Fred. Believe me! [laughter]

Next Meeting
July 10, 2019
1:30 p.m.

Meeting adjourned at 3:16 p.m.