Public Employees Benefits Board
Meeting Minutes

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

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

Members on the Phone:
Tim Barclay (Via phone until arrival)
Yvonne Tate

Member Absent:
Marilyn Guthrie

PEB Board Counsel:
Katy Hatfield

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

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

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

Legislative Update

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

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

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

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

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

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

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

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

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

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

Yvonne Tate: Thank you.

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

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

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

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

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

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

Greg Devereux: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

Greg Devereux: Thank you.

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

Kim Wallace: That is underway right now.

Annual Rule Making

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

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

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

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

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

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

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

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

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

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

2018 Policy Resolutions

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

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

Lou McDermott:

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

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

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

Dave Iseminger: I would agree with that.

Greg Devereux: Thank you.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0

Lou McDermott: Policy Resolution 1 - Season passes.

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

Lou McDermott:

Policy Resolution 2 – Surviving dependent eligibility
Resolved, that the surviving dependent of an employee who receives a monthly retirement benefit no later than one hundred and twenty days from the date of death of the employee satisfies the requirement to immediately receive a monthly retirement benefit.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0

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

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

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

Lou McDermott:

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

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

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

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0

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

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

Lou McDermott:

Policy Resolution Number 4 – SmartHealth

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

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 0

Lou McDermott: Policy Resolution 4 – SmartHealth passes.

2018 Procurement Overview

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

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

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

Tim Barclay: Thank you.

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

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

Lou McDermott: Thank you.

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

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

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

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

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

Greg Devereux: Okay, thank you.

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

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

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

Beth Heston: Yes, maximum out of pocket.

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

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

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

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

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

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

Beth Heston: Right.

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

Dave Iseminger: Kim will cover that.

Tim Barclay: Thank you.

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

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

Greg Devereux: Thanks.

2018 Non-Medicare Rates

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

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

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

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

Tim Barclay: It does.

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

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

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

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

Kim Wallace: Yes. Actually the tiers are aligned.

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

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

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

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

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

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

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

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

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

Tim Barclay: Thank you.

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

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

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

Tim Barclay: Okay.

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

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

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

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

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

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

Kim Wallace: Yes.

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

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

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

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

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

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

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

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

Tim Barclay: Thank you.

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

Kim Wallace: Yes.

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

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

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

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

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

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

Lou McDermott: Understood.

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

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

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

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

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

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

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

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

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

Dave Iseminger: We'll definitely follow up.

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

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

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

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

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

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

Kim Wallace: Well, let's try again.

Gwen Rench: No, that's okay.

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

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

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

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

Kim Wallace: Yes, it is.

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

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

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

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

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

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

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

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

Kim Wallace: New for last year.

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

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

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

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

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

Dave Iseminger: For dental.

Kim Wallace: For dental, for all tiers.

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

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

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

Lou McDermott: Thanks Kim.

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

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

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

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

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

Meeting Adjourned.