Public Employees Benefits Board
Meeting Minutes

July 19, 2017
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 3:30 p.m.

Members Present:
Harry Bossi
Gwen Rench
Mary Lindquist
Myra Johnson
Greg Devereux
Yvonne Tate
Tim Barclay

Members on the Phone:
Marilyn Guthrie

PEB Board Counsel:
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 1:33 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Agenda Overview
Dave Iseminger, Acting Director, Public Employees Benefits Division provided an overview of the agenda.

Approval of June 21, 2017 PEBB Meeting Minutes
It was moved and seconded to approve the June 21, 2017 PEB Board meeting minutes as written. Minutes approved by unanimous vote.

July 12, 2017 Meeting Follow-up
Kim Wallace, HCA Financial Services Division Section Manager: I want to share information in follow-up to three questions or issues that were discussed at the July 12, 2017 Board meeting. Specifically, I will first reaffirm and provide additional information regarding PEBB plan actuarial values and the assignment of metal tiers; second, I will

share information that we gathered from Kaiser Permanente of Washington regarding their rate development assumptions; and third, attempt to provide a clearer response to Gwen's question regarding the UMP Plus employee contribution and the non-Medicare retiree premium.

First, the actuarial value and metal tiers. The actuarial value (AV) is an estimated percentage of a typical member's medical bills that a plan is expected to pay. The labels of platinum, gold, silver, and bronze are designations for plans offered on Affordable Care Act (ACA) exchanges across the country. The purpose of the ACA metal tier designations is to help people choose plans. In other words, they can choose to pay higher premiums for richer plans. Currently, the platinum label refers to plans with AVs that are, per the federal AV calculator, at 90%, plus or minus 2%.

Dave Iseminger: That's one of the things I learned in the last week. I thought it was just 60%, 70%, 80%, 90%, but there's actually de minimis variance that gives a plus or minus factor. That is something we wanted to make sure the Board was also aware of.

Kim Wallace: At the platinum level, the AV results from the calculator are 88% to 92%. For 2018, there's a change and the minus is going to 4% and the plus is remaining at 2%. So now platinum is down to 86% or up to 92%. Some of the PEBB plans have AVs in that range.

Currently, gold label plans, per the AV calculator, are 80% plus or minus 2%. For 2018, that's changing the same as the platinum. It's going from -4 to +2. You can see the pattern.

The silver and bronze tiers follow the same pattern around the 70% and the 60%.

You may be wondering about AVs that are in between 82% and 86%. The ACA metal tiers are deliberately separated by this gap so consumer A doesn't select a platinum plan with an AV of 86.1 and consumer B selects a gold plan with an AV that is lower by a minuscule amount such as 85.9%. One of the consumers is buying the platinum plan and paying more for that and one consumer is paying for a gold plan and paying less. It doesn't create sufficient separation for clear and reasonable purchasing on the exchanges.

The key point I want to make is that associating PEBB plans with metal tiers is done for general reference purposes as a way to comment on our plan richness. The metal tier labels were specifically created to be applied to plans offered on the exchanges. The better way to talk about PEBB plans is to use the actual AV percentages. The draft 2018 federal AV calculator results I referred to last week are in the process of being finalized. These numbers indicate that the 2018 AVs are going up slightly for Kaiser Washington's SoundChoice and the three PEBB CDHP plans, each of them going up approximately one percent in the AV calculation and down slightly for Kaiser Washington Classic and Kaiser Washington Value, each about one percent. The other

plans are essentially staying the same. With that additional information, do you have further questions about AVs and the calculator and metal tiers?

Greg Devereux: Kim, could you repeat the very first thing you said? It sounded like, "estimated cost the consumer is expected to pay."

Kim Wallace: That the plan is expected to pay. Yes. The AVs in the 80%; 82%, 83%, 84%, 85% range mean that a typical member with that plan would experience the plan paying for that percentage of their bills.

Greg Devereux: Thanks.

Lou McDermott: Kim, does that include your initial deductible and premiums and things like that or is that excluding that?

Kim Wallace: Premium? I believe it is not the premium. It is the cost sharing, but it is all cost sharing associated with receiving services.

Dave Iseminger: And just to reiterate that those AVs are the typical member, not every member.

Kim Wallace: Thank you. There was an interesting and meaningful discussion about the metal tiers and AV percentages and we wanted to get a little bit technical and provide this clarification.

The second item that I have for follow-up is regarding Kaiser Permanente of Washington's 2018 bid rates and premiums. In follow-up to the questions posed last week about the drivers of the Kaiser Permanente of Washington employee premiums, we discussed this with them and can share the following. The composite trend rates used in 2018 rate development were down about 0.1% from last year. The composite trend rates were generally just under 8%. The Kaiser acquisition of Group Health did not affect the development of the 2018 trend rates. Specifically, assumptions used were not more conservative for 2018 and they did not include additional administrative load.

Dave Iseminger: And that's related to the acquisition, right?

Kim Wallace: Yes. The percentage increase for the 2018 bid rates is actually lower than their composite trend rates. Now that said, these bid rate increases are higher than the increase in the state index rate and higher than the increases in UMP bid rates because of these relative differences. Kaiser Washington's employee contribution amounts are going up significantly and you saw the percentages. I believe one of them was 10.2%, which I think elicited the question.

The dynamic, between the bid rates and employee contributions takes us to the third follow-up item I have prepared. The third is in response to Gwen's question about how the UMP Plus employee contribution is going down by quite a bit, while the non-Medicare retiree premium for UMP Plus is going up slightly. This is the point in the meeting last week when I said we really want to figure out how to describe this in the most accessible, reasonable, and accurate way.

I am going to share from a different vantage point than I think we have in the past. I actually drew a picture, so you may want to draw a picture as I go along. If you imagine two vertical bars, side by side, that represent the UMP Plus total premiums for 2017 and for 2018, the 2017 bar is $591 and the 2018 bar is slightly taller at $596 dollars. You have the two bars side by side and 2018 is five dollars higher than 2017. This five dollar difference is the premium increase that the retirees will experience, just less than 1%, but you can see it is going up.

For active employees, the state paid $525 of the $591 in 2017, leaving $66 to be paid by the employee at the single tier. All but $66 of that bar of 2017 is state paid. You can shade in that portion of the bar. The state paid 88.8% or $525 worth of the bar. Moving to the 2018 bar, the state will pay $551, over 92% of the total bar, leaving only $45 to be paid by the employee. If you shade in $551 worth, or 92% of the 2018 bar, the state paid portion of the UMP Plus premium is going up more than the total premium is going up. The state paid portion of that premium is going up by $26 while the total premium is only going up by five dollars. That creates the difference between what state employees are experiencing versus what the retirees are experiencing.

When we calculate the state paid portion, or the state index rate, the $525 and the $551, we do that using all the final bid rates for all the plans together, and we calculate a weighted average bid rate and multiply that by 85% to get what the state will pay. The state's responsibility went up by 26% from 2017 to 2018, but the total UMP Plus premium only went up by five dollars. For UMP Plus subscribers, the state will be paying a greater share of the premium in 2018 compared to 2017 and the employee will be paying a smaller share of the premium.

That is true, while at the same time, in aggregate, the state is meeting its 85% of total premium responsibilities and employees are not paying more than their 15% share in aggregate.

Greg Devereux: But doesn't that drive the cost up in UMP Classic?

Kim Wallace: We do have a dynamic where people with higher or lower risk are choosing different plans. If a plan like UMP Plus, with a relatively high actuarial value, is perceived that it costs less for members to join, then they will have a type of incentive to switch into UMP Plus. I think that's what you're asking about, the degree to which members are leaving. The risk score could actually get higher in the UMP Classic as people who are able to leave to UMP Plus, or feel that it's a good deal for them do.

That is something that we watch on a regular basis by measuring and watching which enrollees are in which plans.

Greg Devereux: Maybe I missed it in the presentation, but why are folks moving to Plus versus Classic in UMP? What are the drivers?

Dave Iseminger: I think there are actually a couple different incentives within the plan design structure to keep in mind. One of those would be that there is no cost share for members for primary care visits. There's also a lower deductible. It's $125, and then if you tack on the wellness incentive, it becomes a zero deductible plan. Those are a couple of other features beyond just the premium differential that also may incentivize individuals to go to UMP Plus.

Greg Devereux: What has been the migration from the first year to this year into UMP Plus? How much has it grown?

Dave Iseminger: At the end of 2016, we were at approximately 10,000 covered lives. We're now between 16,000 to 17,000 covered lives.

Greg Devereux: Thank you.

Lou McDermott: Dave, it seems like we have a younger, healthier population going into the Accountable Care Program (ACP); but it also seems like the benefit design for the ACP lends itself well to people who are sick and have chronic conditions and need to see their doctor often. Is there any plans on trying to encourage folks that have more chronic conditions to take another look at ACP in our marketing and the other things that we do to try and let people know? I think at the end of the day, they're trying to keep their flexibility because they do have medical issues and they want to make sure they can go anywhere they need to go, but I think the benefit design lends itself to folks who have more medical needs.

Dave Iseminger: I think we're fortunate in the PEBB Program that we have a variety of products that can meet a variety of different people's needs. One of the things that is in the works is a more targeted communication campaign so that people are looking and actively reviewing the plan designs and evaluating their circumstances with those plan designs. For some people that will be UMP Plus, for some that will be UMP Classic, and for some it will be Kaiser Permanente SoundChoice. We really are working on a communication campaign to get people actively thinking about the different parts of their circumstances so they make sure they're picking the right plan design for themselves.

Harry Bossi: I think your presentation was really good. I understood all of it, but you can only get a certain saturation point in the Plus plan that revolves around the Puget Sound area without expanding the network. Anybody who lives east of the mountains or outside the metro-plex area doesn't have that opportunity or choice. I think it's obviously something to keep in mind moving forward with the Classic plan and the

others, if they are viewed as attractive as possible, and not that they're less of a plan than the ACP.

Dave Iseminger: I would just remind you, Harry, that this year the UMP Plus did expand into Spokane County, Yakima County, Grays Harbor County, and Skagit County. There is a little bit of expansion east of the mountains that we have. There isn't any particular planned expansion for calendar year 2018, but we're hoping to continue working with our partners in the networks to see what other expansion opportunities there are.

There is actually one more follow-up piece. There was a question about the Kaiser Washington network change for their consumer directed health plan and whether there would be a continuity of care consideration for those individuals who have providers who would now be out of network. The answer is yes, there will be continuity of care factored into those situations where an individual has a provider that would now be out of network as of January 1.

Lou McDermott: Dave, is that going to be communicated with members?

Dave Iseminger: Yes, it will be.

2018 Non-Medicare Premium Resolutions

Lou McDermott: Kim will review the 2018 Non-Medicare Premium Resolutions that were introduced last week and are up for vote today. Kim's materials are behind Tab 4. As a reference, behind the goldenrod papers in Tab 4 is a one-page list of the resolutions, selected pages from Kim's presentation from last week, and a copy of the 2018 medical plan benefits summary that Beth Heston said she would provide.

Kim Wallace: I want to make sure that you're also able to reference the one-page table of rates titled, "Revised Non-Medicare Retiree Rates by Tier."

Lou McDermott: Kim, can I just check to see if Marilyn has joined us yet via phone?

Marilyn Guthrie: Yes, I have.

Lou McDermott: Thank you, Marilyn.

Dave Iseminger: Kim's referring to a tab that is embedded within the second goldenrod sheet. There are a couple slides that were presented last time about the non-Medicare rates and premium increases. As you flip through those, you'll see that Slide 8 is in there twice because one is labeled "Revised Non-Medicare Retiree Rates," and the other one is the original. Kim will provide a brief update on this chart.

Kim Wallace: We prepared this replacement slide because when we were finalizing the Medicare rates and working in the model that we use to establish rates, we identified a

column of hard coded numbers where there should have been a formula. When we re-implemented the formula, the non-Medicare retiree rates changed slightly to what you now have in front of you marked "Revised." This affected only the non-Medicare retiree rates. Six of the rates have changed slightly. The range of the change is a decrease of $6 in SoundChoice up to an increase of $3 on Kaiser Washington Value plan.

Dave Iseminger: Kim, are you describing the range at the single subscriber level? And those ranges would also be multiplied out by the multiplier across the tiers?

Kim Wallace: Yes.

Lou McDermott: Can I ask one question, Kim? When the error was discovered and the change was made, was the information shared with our partners to make sure they understood the change?

Kim Wallace: It went out to our authorizing environment partners and shared with Kaiser Washington.

Dave Iseminger: Kaiser Northwest was not impacted. We did not share with them.

Lou McDermott: Okay, I just wanted to make sure.

Kim Wallace: Yes. We have many different partners, and yes, we shared. As I mentioned, six of the rates have changed slightly. I do want to apologize for presenting this change as you are getting ready to vote. The rates are not changing significantly, but please do feel free to express any concerns you have about proceeding to the vote or to ask any questions you have about the rates.

Lou McDermott: Are there any issues from the Board on voting on these rates with the changes that have been presented today? I think we can proceed.

Kim Wallace: 2018 Non-Medicare Premium Resolution 1: **Resolved**, that the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Non-Medicare employee and retiree premiums.

Dave Iseminger: Kim, if the Board members are looking for a reference, that would be the top two rows of the chart on Slide 8, Tab 4?

Kim Wallace: Kaiser Northwest. Are there questions or comments?

2018 Non-Medicare Premium Resolution 2: **Resolved**, that the PEB Board endorses the Kaiser Permanente of Washington Non-Medicare employee and retiree premiums.

2018 Non-Medicare Premium Resolution 3: **Resolved,** that the PEB Board endorses the Uniform Medical Plan Non-Medicare employee and retiree premiums.

Lou McDermott: Thanks Kim. We will now vote.

2018 Non-Medicare Premium Resolution Number 1: Resolved, that the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Non-Medicare employee and retiree premiums.

Moved. Seconded.

Greg Devereux: My concern, I understand a number of the plans don't have changes, especially the CDHPs, but I do have concerns about the inflation within a number of the classic and that will be reflected in my vote.

Lou McDermott: Understood, thank you, Greg.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 1
No Vote: Greg Devereux

Lou McDermott:

2018 Non-Medicare Premium Resolution Number 2: Resolved, that the PEB Board endorses the Kaiser Permanente of Washington Non-Medicare employee and retiree premiums.

Moved. Seconded.

Tim Barclay: Lou. I share Greg's concern, particularly the rate increases on the Kaiser Washington plans. For me it's disappointing that our managed care organization (MCO) is trending higher than our broad UMP PPO plan that's statewide. I also think it's inconsistent with the objective. I think that the SoundChoice plan is going up by 10% for our members. I think the whole goal of that was an ACP look-alike whose specified objective is to manage trends. I think at this hour, I'm still going to vote yes to pass these this year; but I think I would like to put on our Board agenda next year, maybe in our April meeting a conversation about how the MCO plans fit into the portfolio and what our objectives are. Whether that needs to be an executive session or not, I don't know, but I think we need to have a conversation about what our expectations are for the MCO plans as part of the portfolio.

Lou McDermott: All right, thank you, Tim.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 1
No Vote: Greg Devereux

Lou McDermott:

2018 Non-Medicare Premium Resolution Number 3: Resolved, that the PEB Board endorses the Uniform Medical Plan Non-Medicare employee and retiree premiums.

Moved. Seconded. Approved.
Voting to Approve: 6
Voting No: 1
No Vote: Greg Devereux

2018 Medicare Plan Design Changes

Beth Heston, PEB Division Procurement Manager: Our plan design changes are on the Kaiser Permanente of Washington, formerly Group Health, Medicare Advantage Plan and the changes are to align with Kaiser National coverages and new federal regulations. The additions to the plan will be at no cost share or co-pay. They are: Diabetes Prevention Program; an annual physical exam; telehealth; and a sixth pharmacy prescription drug tier, which is a zero dollar vaccine tier. Those changes were simply put in because of the acquisition of Group Health and the change to Kaiser.

Mary Lindquist: What is telehealth?

Beth Heston: Telehealth is a program that both Kaisers have. Kaiser Washington and Kaiser Northwest have that to enable visits with your doctor via telephone video sharing, for chronic disease management, and sometimes urgent care. They've been available and were introduced for Kaiser Washington in 2016. They added it to the 2017 benefit while they were still Group Health. Kaiser Northwest and Kaiser National have had them for some time.

2018 Medicare Premiums Overview

Kim Wallace: I will share the proposed 2018 Medicare Retiree Premiums. Slide 2 shows the single subscriber premiums by plan. The middle column shows the value of the Medicare explicit subsidy. When you add those together, then you get the composite premium on the far right. You'll notice that the explicit subsidy is $150 for all of the plans except for Medicare Supplement Plan F Retired, and that is because the explicit subsidy is equal to $150 per month or 50% of the total premium, whichever is less. There was a proposal earlier in the budget cycle to increase that but that did not follow through to the final budget. So for 2018 it's remaining at $150 or 50% of the total premium, whichever is less.

Slide 3 shows 2018 compared to 2017 so that you can see the percentage change. Plan-by-plan you'll see that there is a relatively modest increase or, in one case, a very modest decrease in the premium. On the far right, it's the absolute dollar change on a monthly basis for single subscriber. The UMP Classic Medicare premium, in the middle, does stand out with a 20% increase, or a $55.51 increase per month.

I'd like to share some information about what's driving this increase and then respond to questions that you may have. On the UMP Classic Medicare plan, the medical trend over the past couple of years has actually been quite reasonable. 2.7% from 2016 to 2017, and 3.2% projected in these rates from 2017 to 2018.

Lou McDermott: And this is UMP Classic Medicare?

Kim Wallace: Yes. It's very important to recall that UMP Classic Medicare pays secondary for medical care and it pays primary for pharmacy. That's a very powerful factor in what is happening to the premiums. So specifically with regard to pharmacy trends in UMP Classic Medicare, the trend is 13.7% for 2016 to 2017 and projected at 16.2% from 2017 to 2018. Pharmacy claims' costs make up approximately 61% of our total projected claims for this plan. The high pharmacy trend is really the driver of the expected cost increases for 2018. If you think about the pharmacy spend, a lot of people think about specialty drugs. I have a couple of numbers regarding specialty drugs without Hepatitis C. The trend model from our Pharmacy Benefits Manager projects specialty drugs to be 50% of the total pharmacy spend and the specialty trend from 2016 to 2017 at 21.9% and 23.8% for 2017 to 2018. Obviously those trend rates are much higher than what we expect on medical. With regard to specific drug classes and specific drugs that sometimes can be, in and of themselves the primary driver of the high rates that you see, we are doing more analysis and working with Milliman to ferret out some additional helpful data, hopefully by our meeting next week.

Lou McDermott: Kim, I think it's fair to say that a 20% increase is unsustainable. What are some plans for the near future to try and alleviate some of that pressure.

Kim Wallace: Absolutely. I was going to comment that we do want to express that we are extremely concerned about this rate of increase and we have been looking for ways to mitigate this as early as 2018. We were not able to identify actions that could be taken for plan year 2018. We are, however, committed to identifying and reviewing changes that could be made for 2019 and beyond. I think Dave is going to speak to some of those.

Dave Iseminger: There are a variety of ideas that I we'll be bringing back to the Board to talk about. I think we need to look at the entire retiree medical portfolio and present to the Board some options and implications for closing the formulary. That has a lot of different iterations of what that phrase means, closed formulary. If you asked all eight of you on the Board, all of you would give different answers as to exactly what that means, but in some way controlling some of the drugs that are the higher-spend drugs and pushing towards more value-based drugs.

There's another piece that can be looked at by the Board which is driving off of some of Harry's questions from recent Board meetings, which is, "What's the relationship for the drug coverage and the value that's given in UMP Classic versus Medicare Part D plans." We're also at this precipice where under federal law Plan F retires at the end of

2019. There needs to be an evaluation for replacements of supplemental plans. This creates the perfect crucible to bring the Board a systemic approach for looking at the entire portfolio of medical retiree plans. My intent is to have this be one of the major Board topics as we enter the next Board season so that we can get your insight about directions that you would like the product portfolio to go for the 2019 year. Fortunately, under the SEBB consolidation bill, we have to be working on a retiree analysis anyway. This is all dove-tailing well.

Lou McDermott: That was my next question. With SEBB coming in, that's going to be a resource draw. How do we ensure that this work gets done without missing another cycle, so to speak?

Dave Iseminger: As I said, fortunately, there is some pressure within the SEBB consolidation effort to do a review of the retiree portfolio for K-12 retirees and so we can dove-tail that work at the same time. It really is being able to leverage the work that already has to be done as part of evaluating K-12 retiree options and using that to do the same kind of analysis on the PEBB side of the world.

Gwen Rench: I do want to say thank you for having the composite rates without the subsidy. That does help a lot; but of course, I'm very concerned about the vast increase. I think Harry's idea might be a good way to explore because I tried to do some analysis of what we're paying because Medicare retirees are also paying $105 out of their social security, and some people even higher than that. So it comes out that we're paying almost as much as the non-Medicare retirees. It gets real close even with the subsidy. It's only approximately $70 difference for our total medical expenses.

Kim Wallace: Yes, and I just wanted to share one other bit of information. We do have 100,000 retirees in the PEBB Program. We want to acknowledge this is not a small number of folks that we are concerning ourselves with.

Dave Iseminger: Kim, is that covered lives or subscribers?

Kim Wallace: Total members.

Greg Devereux: Is that non-Medicare retirees?

Kim Wallace: No, Medicare and non-Medicare total.

Dave Iseminger: I believe at last month's meeting we had just under 10,000 that were identified as non-Medicare retirees.

Kim Wallace: Yes, 9,643.

Yvonne Tate: So those are all the younger people, right?

Dave Iseminger: They're the non-Medicare eligible folks, yes.

Lou McDermott: Kim, how many people are in UMP Classic Medicare?

Dave Iseminger: The enrollment numbers for UMP Classic are between 55 and 60 percent of the covered lives are within UMP Classic Medicare and then another 25% is approximately in the Kaiser Washington Medicare Advantage Plan.

Kim Wallace: I have an exact number. In UMP Classic there are 52,969 Medicare retirees. In UMP Classic Medicare, essentially 53,000 people and 6,700 people non-Medicare UMP Classic, for a total of almost 60,000 people.

Lou McDermott: Sounds like 60,000 good reasons to get this done.

Dave Iseminger: And 60,000 opportunities to improve this experience.

Proposed 2018 PEB Board Meeting Schedule

Dave Iseminger: The tentative dates for the 2018 PEB Board meetings are behind Tab 7. There are plenty of additional topics for consideration by the Board in the next year. Although you may have become reliant on one or two of those meetings being cancelled in the spring months, I wouldn't be so sure that any of those would be cancelled considering the work that's before us for 2019. Please mark these dates on your calendar.

Harry Bossi: I'd like to second the comment that Tim made earlier relative to more specific discussion concerning MCO and propose that be a good component to include in the January Board Retreat. It does allow a few more months for consideration if there is a direction that the Board would like to pursue in terms of rate development or proposals.

Dave Iseminger: Duly noted.

Gwen Rench: I'd like to put in a pitch again for enhanced fitness to be covered by the UMP. Kaiser covers this and we're increasing the premium so much it would be one way of giving some little reward and it contributes for good health.

Lou McDermott: Our next meeting is scheduled for July 27, 1:30 to 3:30, same location.

Meeting adjourned at 2:25 p.m.