

**Public Employees Benefits Board**  
**Meeting Minutes**

July 17, 2018  
Health Care Authority  
Sue Crystal Rooms A & B  
Olympia, Washington  
1:30 p.m. – 4:45 p.m.

**Members Present:**

Sue Birch  
Tom MacRobert  
Tim Barclay  
Harry Bossi  
Yvonne Tate

**Members via Phone:**

Greg Devereux  
Myra Johnson (joined late)

**Members Absent:**

Carol Dotlich

**PEB Board Counsel:**

Michelle Robert, Assistant Attorney General

**Call to Order**

**Sue Birch, Chair**, 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 Retirees Benefits (ERB) Division, provided an overview of the agenda.

Dave announced that Governor Inslee appointed Harry Bossi as a voting member since the last Board meeting. Harry moved from his non-voting position to the voting cost containment position vacated by Marilyn Guthrie.

**Long-Term Disability (LTD) Insurance**

Marcia Peterson, Benefit Strategy and Design Section Manager, ERB Division and Betsy Cottle, Procurement Manager, ERB Division. We want to talk about an opportunity regarding long-term disability insurance.

Slide 2 – Decisions for the PEB Board. The Standard, our current LTD vendor has agreed to do an open enrollment for current PEBB Program members even if they've

previously been denied coverage. The Board has two decisions in front of them. Do you want to take advantage of this opportunity for the members, and if so, what level of benefits should be offered at?

Slide 3 defines long-term disability insurance. It's used to replace your income when you become temporarily disabled or can't work. Long-term disability insurance acts as an incentive to get you back to work. That's why there's only a portion of your income that's replaced. Slide 4 defines disability. In the PEBB plan, disability is defined a bit differently than social security's definition. We want to point that out as it can create confusion. For the PEBB plan, a disability means being unable to perform with reasonable continuity the duties of your job due to sickness, injury, or otherwise during the benefit waiting period. Social security disability provides a benefit for different circumstances. The PEBB plan is specific to you being able to perform the duties of *your* job during a time when you're temporarily disabled. Social security refers to a disability that prevents you from performing *any* job during that period. It's a much longer term disability period and generally thought of as permanent.

Slide 5 – Current PEB Board Plan. As PEBB Program members, we have two options for long-term disability insurance. First, the basic LTD that's employer paid. It offers members 60% of the first \$400 of their monthly pay, a minimum of \$50 up to \$240 a month. It starts after 90 days or after the duration of your sick leave balance, whichever is longer. The benefit we're talking about today is the optional benefit. It's voluntary and employee paid. This covers 60% of the first \$10,000 of your monthly pay, a minimum of \$50 up to \$6,000 a month. It starts after the end of the benefit waiting period that you choose. The maximum benefit is based on your age when you become disabled.

The important part and what's relevant for today, is that members must enroll within 31 days of being eligible without providing evidence of insurability. After that, you're providing evidence of insurability. Only about 30% of PEBB Program members take advantage of this optional benefit at the time of enrollment. We did some research and discovered that is actually higher than you're seeing in the industry overall. The survey we're quoting from, the Life Insurance and Market Research Association (LIMRA), we thought was probably illustrative of the way people think about this benefit. In short, when people were asked if most people needed disability insurance, 65% of respondents said, "Yes, most people need disability insurance." We all need disability insurance. When asked, "Do you personally need disability insurance," only 48% said yes. When asked, "Do you actually have disability insurance," the number drops to 20%. It's a great benefit for other people is the conclusion.

According to social security, one in four people age 20 will experience a disability before they reach age 67. It's supposed to cover your salary should you become temporarily disabled. I say "temporarily," but the average duration of a claim is about three years, which is a long time to not be drawing a salary of any kind. Since half of all adults say they wouldn't be able to cover their salary for three months, and almost half don't have cash to cover a hypothetical \$400 emergency expense, this is of some concern.

In fact, within the ERB Division, staff had a very lively debate about this topic when putting this slide deck together. Some felt very strongly that they couldn't afford the benefit, particularly since they're still trying to pay off their student loans. Others just

hadn't thought about it since they joined state service many years ago, they were very young, and they weren't thinking about that but wishing they could apply now. And then there were those who knew someone who had suffered a disability and signed up as soon as they could. Some of us are just incredibly risk-averse and hate not being covered for unexpected expenses. We're all over the map. The fact is that we're all really pretty bad at estimating our individual risk. It's for this reason a lot of employers offer the optional employee paid benefit, but they're offering it as an opt-out benefit, which is to say you're automatically enrolled in it.

**Betsy Cottle:** I'm going to tell you more about our current long-term disability plan and the opportunity in front of us for our members. Slide 9 – Current Plan Enrollment, shows we have 133,000 eligible subscribers. Of those, 41,000 enrolled in optional long-term disability. Of those 133,000 eligible subscribers, we have a total of 5,500 people on a claim. Some have just basic, some have optional and basic. There are 610 people with a basic-only claim. This represents about 2.29% of our population, the number of people on a claim now. It's very low utilization, in general. It is an important benefit because if you don't have it, the financial implications are dire.

**Dave Iseminger:** One other piece, people ask, "What does 'subscriber' mean?" I want the record to show that the 133,000 number is active employees regardless of their Medicare status. It does not include retirees, because as a retiree, you're not at work. You don't have income to replace because you presumably have a pension.

**Sue Birch:** Betsy, do we have information on what percentages are related to sickness, injury, or pregnancy?

**Betsy Cottle:** I could certainly find out. I did not bring that with me, but I've definitely got that. Would you like to have a conversation about that before we vote next time?

**Sue Birch:** I was just curious. It might be good for the Board to hear that information if we have it.

**Betsy Cottle:** Slide 10 shows income state employees make. The table shows the number of people inside each income bracket. Our current plan covers up to \$120,000 of income per year. That's the majority of our state employees. There are approximately 2,000 people over \$120,000 at this time.

**Dave Iseminger:** Just for clarity, Betsy, you said 2,000. That was just the top band of over \$150,000.

**Betsy Cottle:** You're right. Thank you.

**Dave Iseminger:** I believe you meant to say about 4,800 who are over the \$120,000 amount. That's the magic line as we get to the recommendations and decisions for the Board later, of who might benefit if you increase the maximum optional benefit. Everybody up to \$120,000 could reach the current maximum benefit.

**Betsy Cottle:** Slides 11 and 12 show different kinds of claim examples and the associated premiums that relate to the coverage provided to each of these members. Slide 11 is an example for 38-year old Sally. She only has basic long-term disability.

She makes \$50,000 a year, receives \$240 a month, and pays no premium for this benefit.

The second example is Joe, also 38 years old, but he purchased optional, long-term disability coverage. He experiences a disabling condition and receives \$2,260.20 per month during his disabling period. The table shows possible premiums for the three most popular waiting periods available on our plan. If he were in the higher education group, his premium could be as low as \$17.50 a month, or as high as \$55 a month. If he were in the state employee group, it would be as low as \$15 or as high as \$45 a month.

**Dave Iseminger:** Betsy, I want to provide one more piece of clarity in example two. The box that says \$2,260.20 per month is the payout of just the optional benefit. The employee is still receiving a \$240 basic benefit. In real time, the employee is experiencing a \$2,500 benefit, with \$240 of it coming from the basic benefit and \$2,260 from the optional benefit. From the employee's experience, they're actually getting \$2,500 assuming they meet all the eligibility requirements, they don't have any other income disregards, lots of caveats.

**Harry Bossi:** On the upper end, the max is \$6,000 for the optional. So that person is earning - the high wage earner - would they be capped at \$6,000 for A and B or are they going to get \$6,240?

**Betsy Cottle:** They're capped at \$6,000.

**Harry Bossi:** So they really don't have the \$6,000 option. They really have a \$5,760 option, technically.

**Dave Iseminger:** And the state's picking up the premium for the first \$240, correct.

**Betsy Cottle:** Correct. The basic and optional work together to make the replacement percentage.

Slide 12. Example three is more complex. Henry, 48 years old, purchased optional long-term disability. He is a longer term disabled person and has qualified for social security disability, which is deducted from his optional payment. The note at the bottom of the slide that talks about deductible income and when it comes into play, depending on how long you are disabled and if you have income from other sources other than your disability product. Some income is deducted from your disability payment.

**Dave Iseminger:** The same thing as example two, what you're seeing here is \$460.20 is the value of the payment coming from the optional benefit because Henry elected optional, he would be getting \$1,800 and a check from the federal government under social security. He'd get a \$240 payment from the basic benefit from The Standard. He would actually be getting \$2,500 from these three sources. This is trying to show you the value of the optional benefit. If Henry had not elected an optional benefit, he would have received \$1,800 from the federal government and \$240 in the basic benefit.

**Sue Birch:** It's important to clarify that the social security disability process is up to two years. What payment could Henry expect during that two-year wait period?

**Betsy Cottle:** I can explore that in an illustration because you're right. There can be payments in the interim that end up going back and forth between the companies and social security. It's an iterative process and very complex. I can look for an example to show that.

**Sue Birch:** I think the point I'm trying to make, having been a nurse and seeing this play out time and time again, is that somebody like Henry would get the benefit of the payment during the two-year wait period and then they true-up and take back. I do think it's important because the idea here is to make certain people have income preservation so they're not destitute. This depicts that because of the timing issues on this sort of thing.

**Betsy Cottle:** Slide 13 shows our long relationship with The Standard Insurance Company and the premium history since 2002. Our premiums have varied, but not a lot. Regardless of what group you're in, this slide shows the continuity and good management by The Standard.

**Dave Iseminger:** You might ask why premiums dropped for a while and why they went back up. Betsy will discuss claims, but I think it's called the Claim Fluctuation Account (CFA), which is basically the premium reserve account. We've had very favorable experiences some years where the reserve gets a surplus and it's used to temporarily buy down some of the rate. The surplus was spent down and around 2015, the Board made a decision to buy up into the plan, changing the date of social security retirement. It used to be 65 but as we all know, not everybody's social security retirement age is 65 anymore. It changes based on when you were born. That was a change in the plan and buying up to what's called the normal age of social security. The surplus has been completely utilized so we're now back to the "original" rates from a decade ago.

**Betsy Cottle:** Slides 14-16. The Board has two decisions to consider. Decision one is to determine whether or not this is a one-time opportunity to all eligible employees to purchase their optional long-term insurance, increase the value of their current coverage, or change their waiting period. The premium guarantee is through December 31, 2020. The proposed timeline is to offer an open enrollment in 2019 for a plan effective date in quarter two 2019. We would begin communications immediately after the Board vote if approved.

Decision two is whether or not to increase the plan's monthly maximum benefit. We now offer up to \$6,000, which covers the first \$10,000 a month of income. We could increase that maximum to cover up to the first \$15,667 per month or \$188,000 a year. Our current plan covers \$120,000. We could also increase the maximum to a \$10,000 payment per month.

**Dave Iseminger:** Betsy, it's a \$10,000 payment per month, which is 60% of that \$15,000 number you said. Which then annualized is \$188,000.

**Betsy Cottle:** Slide 17 – Claim Fluctuation Account (CFA). Part of your decision making is to consider the impact on the CFA. It is an account maintained by the vendor to stabilize the claims experience, as well as the premiums. Overall, long-term disability vendors generally keep between 25% and 50% of the annual premiums in a claims fluctuation account. The Standard Insurance Company maintains a CFA for our

optional long-term disability equal to 50% of annual premiums. We're talking about the value and percentage of the CFA because your decisions have an effect on the balances of those accounts.

Offering a one-time opportunity could possibly incur additional claims because more employees will enroll. Increasing the maximum monthly benefit could impact the CFA. The open enrollment could impact it. By doing both options, the risk of impact is at a higher percent. There's risk overall, but by doing both, we are likely to have a higher percentage impact to our CFA.

Slide 19 is our recommendation. We recommend authorizing a one-time open enrollment for optional LTD and retain the current benefit maximum of \$6,000 per month.

**Tim Barclay:** It seems to me that in the past if we've done underwriting and people have been turned down because they're higher risk, we do an open enrollment without requiring underwriting that these people should, I would expect, purchase coverage. I would if I were them. I would expect that means a deterioration in our risk pool. When we come around to the next renewal, we should see an increase in claims, I would expect, which is great from a perspective of those getting coverage. But from a financial management perspective, I would expect our rates would go up as a result of this action. Have we had any conversation with Standard to estimate what the result of this decision would mean on the premium increase for the pool as a whole when we renew in 2021?

**Betsy Cottle:** What you're saying is exactly the explanation of the risk. I can tell you the number of people still in our pool previously denied is just over 1,000 people. I'm hoping that will reassure you it's such a small number our experience should not be outrageously different next year or the year after we offer this opportunity.

**Yvonne Tate:** Coupled with the fact that your experience number is really small to begin with.

**Dave Iseminger:** We have talked with The Standard. There are a couple of challenges. Just because somebody signs up doesn't mean they're going to have a claim, let alone in the immediate future. It's one of the things Marcia and I were talking about. These people went through underwriting, presumably for whatever reason. That doesn't mean they necessarily predicted they were going to have a disability. They may have seen value in the product without necessarily experiencing the disability. If all 1,000 of these people flood in at the same time, it doesn't mean instantaneously there'll be 1,000 new claims.

In recent years, we had several years where we had what Standard has called exceptional claims or exceptional experience, where the experience for the pool for a couple of years was actually growing a surplus while we were trying to spend it down because we were having lower claims experience. We have a very well managed pool. What their expectation is, going forward with this type of recommendation of just having the open enrollment, the reserves, the CFA, could take somewhere between a 2% to 4% hit. Beyond that kind of rough range, there are too many variables for them to get

more specificity or more granularity at this point. They have guaranteed the rate through the end of 2020.

This plan would go live sometime in Quarter 2 2019. There would be some time to assess the risk over that 18 months. The Health Care Authority just went through a similar type of opportunity with life insurance. We saw a massive increase, but as staff discussed, people think about life insurance differently than disability. Marcia highlighted quite a bit of that. There are some people like me; my family utilizes insurance. The one day I didn't have medical insurance, I sat on my couch and didn't leave my home because I was afraid something was going to happen that day. I'm risk-averse. I'm always going to buy insurance. But, for some reason, ten years ago, I wasn't paying attention to this form. I was worried that maybe I'd fail underwriting and didn't want to get a bad mark on my history. I just stayed away from it all.

We have those type of people who are, for whatever reason, looking at their insurance in different lenses. We think people value LTD somewhat differently than life insurance. We don't expect the massive increase that we saw in life insurance but we do think there will be a lot of interest from some people. We can work with Standard to see if there's additional pieces we can bring to the Board for context next week.

**Tim Barclay:** How long has our basic LTD benefit been \$240 a month?

**Betsy Cottle:** Since its inception, as far I understand it.

**Tim Barclay:** Which was when?

**Dave Iseminger:** Roughly 1977.

**Tim Barclay:** Seems to me that benefit's a little inadequate. I'm worried about taking action now that could impact our experience. It seems to me we can make a case, based on our history and our current experience, which is very good, that at minimal cost, we could increase the basic LTD benefit, which, to me, has much more value than altering the optional benefit. Again, just brainstorming out loud. I don't want to take action today that impacts our ability to maybe enhance the basic benefit going forward. That's why I'm concerned about this issue with Standard and what a no-underwriting open enrollment does to our experience two years from now. My guess is if we started pushing today, it would take two years to be able to change that basic benefit. Just throwing that out as food-for-thought. Personally, I think that basic benefit is terrible. I don't know who can live on \$240 a month. If we could just think about that a little, but in terms of where do we really want the program to go in the long term, and what's in the best interest of our employees. I feel like if we can hit that basic benefit, we're going to be a lot better off than tweaking the optional benefit. That's my concern. I don't want to do something that impacts that ability.

**Harry Bossi:** I think Tim was very insightful in his comment and I think everybody would like the amount the state provided to be higher. How we do that within our financial constraints, I don't know. I think that deserves study. I don't necessarily have any heartburn with part of the proposal but I'm not sure it's a solution in search of a problem, in that I don't know relative to other comparable employers whether our enrollment rate is good, bad, or indifferent. Is 25% good? Are we trying to tell employees, "You need to

have more," so therefore, we created this on your behalf and it's worth the effort to go through all of this and have a rate hike? Again, I'm all for giving employees opportunities, but I'm not certain that it's an opportunity they've come forward and said they want.

**Greg Devereux:** I really like Tim's idea as well. I think it provides much more value for more people at the low end than we really need for people at the high end. I would love if the Health Care Authority could explore that further.

**Dave Iseminger:** We know we have to bring to this Board a discussion about the basic long-term disability benefit. One of the advantages we have to launching the sister program SEBB is that we've just completed a procurement on a disability benefit for a population similar in size. It has different demographic information, but our plan is to learn from that procurement experience and see what we can bring back to this Board after we've scoped a similarly sized population and see what the options are.

At the same time, this opportunity presented itself, in part because we were presenting information to the SEB Board the end of last calendar year, and doing comparisons of the current HCA administered benefit. The SEB Board wanted a procurement performed on a disability benefit. The Standard approached us with an opportunity to consider enhancements in the short term. As you've indicated, Tim, there is a multi-year road to changing the basic benefit. This could be an opportunity for some employees in the interim, to get coverage now that they otherwise couldn't get. Although it is an employee paid benefit, it's at least an opportunity to get additional coverage until that more systemic piece can be done on the basic benefit.

Taking action on this during this Board season doesn't preclude any changes to the basic benefit or a discussion on the basic benefit. It could have some of the financial implications you're concerned about, Tim. That is a multi-year road to work on the basic benefit. That is something the agency has in its plans to bring to the Board. It's an area when I joined the agency I was really concerned about, the value of the basic benefit. We're at a place where we're learning more about this benefit from the market and how it's changed since 1977. We're going to be working with Standard. They did the procurement on the SEBB side so we have a good partner who understands this relationship with PEBB and will be able to give us insight about how the benefit that's launched in SEBB, how much it would cost and what we might expect to experience in PEBB. It is in the near future plan to talk with the Board about the basic benefit. This is the short-term option that could give some relief on this benefit and give people an opportunity if they want to pay for additional coverage to have that opportunity. As Marcia pointed out at the beginning, the value of being able to get a benefit without going through medical underwriting has inherent value and is a unique opportunity. We learned that with life insurance and we think it is worth bringing to the Board for discussion, taking advantage of that type of opportunity.

**Sue Birch:** Thank you for that information. One of my questions, could we ask Standard and/or have staff dig into the livable wage for this state? I believe that just shifted and that would impact my decision between the \$6,000 and \$10,000 per month. I'm curious what baseline we're working with on a livable wage, even though it's an intermittent period, I think that's important information for the Board to have.



**Greg Devereux:** I thought one of the points Tim was making was that if we took action now it might influence the rates by 2021. I couldn't tell whether Dave was trying to make an alternative case to that. I would be concerned about rising up rates now and then not having as much leeway for changing the basic later on, even though it might be two years on.

**Dave Iseminger:** I was providing additional context for the Board's consideration on the topic. Remember this proposal comes with a rate guarantee through the end of 2020. Currently, the optional LTD benefit is under a rate lock through the end of 2019, and along with this, if the Board were to approve a one-time open enrollment, it would extend the current rates to a third year rate guarantee through the end of 2020. By the end of 2020 we will have launched a SEBB disability benefit and have gone through the exercise for procurements. We will have done the procurement, the contract negotiation, and launched a benefit with SEBB. That would be in the right timeframe during that rate block of an extra year to have the robust discussion about enhancing the basic benefit. Although this information might be a little bit dated from bienniums, I can say that one of the last times the agency evaluated changing the basic benefit, doubling the basic benefit to \$480 was somewhere between \$18 and \$20 million, as a rough proxy for the evaluation of that.

**Tim Barclay:** If you could ask Standard, it may be they also manage the rates separately for the optional coverage versus the basic coverage.

**Dave Iseminger:** They do.

**Tim Barclay:** So the answer may be, at the end of the day if we do this, and a worst-case scenario, our claim experience significantly deteriorates, it may be it has no impact on the basic coverage rates and only impacts the optional coverage. This, again, would be unfortunate for those people currently enrolled in the optional coverage. They would suffer and take a rate increase. I think that's what we're talking about, a risk there that is very different than impacting what they would do on our basic coverage. So if you could just confirm that.

**Dave Iseminger:** Tim, I was looking at Standard's last annual report 20 minutes before the Board meeting and they are separate rate tables so they are managed separately. I'm glad you actually raised that point. I should have thought to say that to answer your question, but the risk is managed separately for basic and optional. In fact, I don't like to put a vender on the spot but I turned around and Jennifer just nodded her head yes.

**Tim Barclay:** Thank you.

**Yvonne Tate:** I just want to say, I think it's a good idea to go ahead and offer that in lieu of not having any additional long-term disability coverage. I also think it's a good idea to try to improve the basic rate. I was on this Board for many, many years before the basic life insurance increased at all. I know it takes a while but I think they're both good ideas.

**Betsy Cottle:** Slide 20 – Draft Resolution PEBB 2018-05 – LTD One-Time New Enrollment Opportunity. During Q1 of 2019, the PEBB Program will offer all eligible employees an opportunity to purchase optional long-term disability insurance, increase

their optional long-term disability insurance, and/or change their benefit waiting period without providing evidence of insurability.

**Dave Iseminger:** To summarize, we will come back with information about the livable wage. I don't believe there's really any other questions that we have.

**Betsy Cottle:** Sue also wanted an illustration of the intersection of social security and disability insurance.

**Sue Birch:** And you're going to break out the claims we have by sickness, injury, and pregnancy.

### **Uniform Medical Plan (UMP) Plus Update on Grays Harbor County**

**Michael Arnis**, Account Manager, Uniform Medical Plan Plus. There are approximately 26,000 enrollees in the entire plan. Grays Harbor is one of nine counties under UMP Plus. Grays Harbor has been with us since 2017 and offered by both networks in UMP Plus, the Puget Sound High Value Network and the UW Medicine Accountable Care Network (ACN). In Grays Harbor County, both networks offer essentially the same provider, which is MultiCare Hospital, the community hospital in Grays Harbor County.

For 2019, we will no longer offer UMP Plus in Grays Harbor County. The Health Care Authority and both networks have been working with the Grays Harbor area to implement the accountable care network. With UMP Plus, we offer care through an accountable care network and the participating providers in an ACN takes on the financial as well as the clinical obligations of the contract with the network. It is an investment as a provider builds itself into ACN. It usually requires at least one, if not more than one, major health system. In the Grays Harbor situation, it is the community hospital. The financial picture with that hospital isn't in a place where they can take on the required investment. The other providers in the network and the other nine counties play a role. They work together in doing what they can to meet those financial and clinical obligations. But it really takes a medical center in the county to make an investment. Unfortunately, that hospital is just not in the position to do that now. Hopefully, it will get back on its feet someday. We would very much like to bring UMP Plus back into Grays Harbor County when that happens.

Slide 5 – Membership Support Grays Harbor County 2019. There will be plenty of support for our membership in Grays Harbor County in UMP Plus. We will have direct communications to the subscribers to let them know about other providers and plans in that county for 2019. The first letter goes out next week with a follow-up letter in September. We will provide assistance. There are about 150 UMP Plus subscribers in Grays Harbor County.

### **2019 Rates Overview**

**Tanya Deuel**, PEBB Finance Unit Manager, Financial Services Division. Today's presentation is about 2019 rates and premiums. Beth Heston will join me and go over proposed changes in the benefit designs for plan year 2019. Those changes are included in the rate package.

**Beth Heston**, PEBB Procurement Manager, ERB Division. Slide 3 shows 2019 plan changes for Employees and Non-Medicare Retirees for Kaiser Permanente of

Washington. As a reminder, for the Uniform Medical Plan, we will be adding the Virtual Diabetes Prevention Program for all non-Medicare members.

For Kaiser Permanente of Washington, there is the introduction of the Virtual Diabetes Prevention Program and some changes to the SoundChoice plan. SoundChoice will be offered in Kitsap and Spokane counties, in addition to the four counties where they are already offered. There will be changes to lower the deductible from \$250 to \$125 per person and from \$750 to \$375 per family. The coinsurance for primary care visits will be changed from a 15% coinsurance to a 0\$ copay. Most primary care visits will be at no cost. The massage therapy will be removed from the bundle that contains physical therapy, occupational therapy, and speech therapy, and set in a separate benefit. It will be 16 visits per year. Lastly, SoundChoice inpatient hospital services will increase from \$200 per day up to \$1,000 maximum cost-share to \$500 per admission with no maximum.

**Tom MacRobert:** Can you tell me when you say massage therapy visits are going to be separated out how many physical therapy, occupational therapy, and speech therapy visitations will you be able to have?

**Beth Heston:** Those visits stay at 60.

**Dave Iseminger:** For those of you who take your slide decks and compare across meetings, I want to be very transparent about the one thing that's different on the slide that Beth's presented from what was presented on June 20. As we went through the rate process, the original rates considered had a potential for unlimited massage in a separate bucket under SoundChoice. The final proposed rates include that maximum of 16. I want to highlight that difference from what was being considered at the beginning of the rate-setting process. There are things that change along the journey and that is one of those changes.

**Tom MacRobert:** Dave, I know we discussed this but I'm curious. Is what they are proposing for SoundChoice the same for all Kaiser Permanente plans, the separate massage and then the bundle?

**Beth Heston:** No, it will not be the same. It is only for this Sound Choice plan.

**Tom MacRobert:** So the massage therapy will be bundled in the other plans?

**Beth Heston:** Yes, in Kaiser WA, Classic, CDHP, Value, it will remain bundled with 60 visits.

**Dave Iseminger:** I would not be surprised if Kaiser WA considers whether to present in the next rate-setting year for 2020 aligning all plans. We were too far in the rate-setting process to change all of them for 2019. It would upset the apple cart too much, so they asked if they could change just the SoundChoice plan this year. They would consider potential changes to align their entire portfolio in future years.

**Sue Birch:** Can you remind me of the Virtual Diabetes Prevention Program name?

**Beth Heston:** It will be administered by Omada. It will be called Virtual Diabetes Prevention. They will be administering the UMP, as well. The plans should be fairly identical.

**Greg Devereux:** Dave, I know you probably don't have it, but I would be curious what the average inpatient hospital day usage is for SoundChoice.

**Dave Iseminger:** You're right, I do not know that off the top of my head, Greg, but we will make sure to follow up and get you the answer between now and the next Board meeting, but also share it at the next Board meeting.

**Tanya Deuel:** Slide 5 is employee information. It is the split between the employee and the employer premium contributions. There are a lot of numbers on this slide, as well as many slides coming up. I don't plan on reading through each of the rates on each of the lines and columns, but I will orient you to each slide. We can look at the things that stand out.

Slide 5 has plan names down the left and columns with proposed 2018 rates. Column 1 is the proposed 2019 employer contribution for a single subscriber. The middle column is the proposed 2019 employer contribution, and the far right column is proposed 2019 composite rate, composite rate meaning the total of the employer and the employee contribution.

The middle column, the proposed employer contribution known as the state index rate, is the same for all plans. At the January PEB Board Retreat, we said this is the state's contribution towards medical, which is an 85% weighted average. Visuals are included on Slides 28 through 30 of how we calculate the state index rate. I'll walk you through the examples.

Slide 28 is a sample illustration of how we calculate the state index rate. For this example, there are three plan bid rates, which do not match our current plan bid rates. The green box is one plan bid rate of \$550, the orange box is \$500, and the blue box is \$450. We take the number of adult units enrolled in each of these plans and multiply the plan bid rate times the adult units to get the total monthly cost. We take that monthly cost row of \$1,650, \$500, and \$2,700 to get the total cost of \$4,850 divided by the total people enrolled in our portfolio. That amount equals the weighted average of \$485. We multiply it by 85%. That is the state contribution, for a total of \$412.

Slide 29 determines how much the employee will pay, so we take those same plan bid rates across the top, the \$550, the \$500, and the \$450, and subtract the same \$412. You can see across the bottom that the employee contribution is the plan bid rate minus the index rate. That is the amount you are see on the employee/employer premium split on Slide 5.

Slide 30 goes into more detail of how we determine the tiers. We take that employee contribution and times it by the tiers. Tier 1 is a subscriber only. They pay that amount. Tier 2 is a subscriber and spouse. Tier 3 is a subscriber and child or children. It's the same rate no matter how many children you have enrolled in your plan. Tier 4, is the subscriber, spouse, and child or children.

That's how the weighted average is calculated.

Slide 6 is the employee contributions by tier. Again, on the left-hand side is the plan name and across the top are the Tiers. For each of those tiers, we have the 2018 premiums as well as the proposed 2019 premiums. The far right is a comparison of plan year 2018 to plan year 2019 change in a single subscriber rate broken down by both percentages and dollars. You may notice one of those doesn't look like the others. That is the Kaiser Washington SoundChoice plan. This is back to what Beth described for the Kaiser Washington SoundChoice plan and their proposed benefit design changes, having the Kaiser Washington plans being more aligned with the rest of the PEBB portfolio.

Slide 8 is the proposed non-Medicare retiree rates by tier. This will look similar to the last slide we just looked at with the plan names being down the left-hand side, the tiers across the top, comparing the 2018 rates to the proposed 2019 rates. On the far right, again, are the change from 2018 to 2019 and the change in the subscriber rate, both by percentage and dollar. You may notice that on the far right the percentages and dollars don't quite match up to the slide before. As a reminder, the non-Medicare retiree does pay the full rate. They don't get the 85% weighted average state index rate contribution from the state. Percentages may look smaller because it's on the full amount. When we looked at this percentage change in the far right, it is on the lower end of what we've seen over the last two procurement cycles. I looked over the last seven or eight years and we've seen between 3% to 5% average change.

**Dave Iseminger:** That's Tanya's way of saying "good news."

**Harry Bossi:** Tanya, does the subscriber rate for the non-Medicare retiree generally equate somewhere near the bid rate?

**Tanya Deuel:** Yes.

**Harry Bossi:** So there's not an additional administrative fee?

**Tanya Deuel:** There is an administrative fee. For plan year 2019, it's \$5.97. That's average, it's been around between \$6 and \$5 for the last few years.

Slide 10 is the Medicare retiree rates. On the left-hand side are the plan names for the Medicare plans. The next box over, single subscriber premium after Medicare explicit subsidy, is the amount the Medicare retiree will pay in premium. Middle column being the Medicare explicit subsidy, and the far right column titled "Composite" being the total of the Medicare retiree premium and the Medicare explicit subsidy. The Legislature did increase the subsidy for plan year 2019 from \$150 to \$168 to provide one-time relief in premiums. Not all of these are \$168 because the language still states that the Medicare explicit subsidy is set at \$168 or 50% of the premium. Only two plans were over that \$336 value so they got the full relief of the increase in the Medicare explicit subsidy.

Slide 11 - Medicare Retiree Premiums. This slide compares the single subscriber premium after the Medicare explicit subsidy from plan year 2018 to plan year 2019. Again, the far right columns have the change in single subscriber premium from plan year 2018 to plan year 2019. This is good news. We're seeing overall decreases. The

numbers in red are, in fact, negatives. They mean a decrease in premiums so the Medicare retirees will be paying less in plan year 2019 than they paid in 2018.

**Dave Iseminger:** It's counter-intuitive, Tanya, but red means good.

**Tanya Deuel:** Red means good in this sense. The legislature did increase the Medicare explicit subsidy by \$18 and we saw stable trends this year. Slide 12 is from my last presentation. I wanted to reinforce the impact of the Medicare explicit subsidy on the Medicare retiree premiums. The plan year 2019 column has been updated to include the rates you've seen today. As we walk across from left to right, we've included plan years 2016 through plan year 2019, the blue box being the Medicare explicit subsidy, and the orange being the Medicare retiree premium. As we have the total on the top, you can see it increased between 2016 and 2018, and the blue box in those same years remained the same, meaning the orange box has increased and the retiree premium has borne all of that increase. When we get to plan year 2018 versus plan year 2019, you can see the total across the top has remained relatively flat, as well as that blue box did increase from \$150 to \$168, meaning the orange box has decreased.

**Dave Iseminger:** Before we move on, I want to highlight something Tanya said, there's been a stable trend. We know pharmacy on the Medicare side is what's driving a lot of cost changes. We've been talking about pharmacy for well over two years. Trend tend to be pretty volatile. One year's trend is not completely predictive of another year's trend. The unfortunate reality is that by the time you see a trend it's like a freight train. It's going to hit you before you can really put on the brakes. When you think about the Medicare explicit subsidy, this past year the Legislature raised it for the first time in roughly six or seven years. We're not going to assume the trend will necessarily be stable again next year. We don't want to put all our eggs in one basket thinking there will be a retiree subsidy increase.

Last meeting we had a value-based formulary proposal that did not pass due to a split vote from the Board. Obviously, many more questions to come. We still plan to bring back and build upon that experience, ask questions, and have more conversations on the value-based formulary from last time. Some of it's good fortune, some of it's managing trend. We don't want to just rest on those laurels of what turned out to be a very good rate-setting year. We want to continue that conversation and reengage additional pharmacy conversations, building on the value formulary from the past year.

**Sue Birch:** Dave, thank you for that. I think it is impressive that we have as good of news as this. But I think you are absolutely right. When we look at some of the market analysis of what's coming around, especially specialty pharmacy, we would be remiss not to continue to try to drive towards greater value, not just with pharmacy but also as we see more movement in value-based purchasing, payments, and whatnot. We need to be very aggressive about trying to drive towards value. I think it's wise for you all to think about bringing back, again, any proposals that drive us towards greater value so we can protect our members.

**Greg Devereux:** Dave, your last comment about the formulary, that would be consideration in the future.

**Dave Iseminger:** Correct. We need to continue having that conversation. Not for 2019 but for as early as 2020.

**Greg Devereux:** Okay, thank you.

**Tanya Deuel:** Slide 14 – Dental Premiums. Plan name on the left. Comparing the subscriber rate from plan year 2018 to plan year 2019. Not too much news here. There was a slight increase in the Willamette dental plan rate. Willamette has not seen an increase in their rates since plan year 2014; in fact, they had a slight decrease in plan year 2015 and remained flat to 2018. We are proposing a rate increase for 2019 but it is at a two-year rate guarantee. As a reminder, this amount is paid 100% by the state for employees.

I do have a footnote on Slide 14 that was not included in Beth's presentation, but there is one benefit design change for the uniform dental plan. It's to reduce the limit on crowns from seven years to five years. This aligns with the industry and the other plans we offer.

Slide 15 – Life, AD&D, and LTD Premiums. Not much on this slide because there are no changes to plan year 2019. The basic benefit is employer funded and the optional employee funded.

**Dave Iseminger:** Essentially, we're in multi-year rate locks on all of those benefits, both basic and optional, state portion and employee portion.

**Tanya Deuel:** Slides 17 – 24 – Proposed Resolutions. We get into a handful of proposed resolutions you'll be asked to vote on next week. I'm not going to read through them today word for word because they are very similar. I'll let you know the differences.

Slide 17 – Proposed Resolution PEBB 2018-06 Non-Medicare Premium. The PEB Board endorses the Kaiser Foundation Health Plan of the Northwest employee and Non-Medicare retiree premiums.

Premiums meaning the full suite of rates.

Slide 18 – Proposed Resolution PEBB 2018-07 Non-Medicare Premium. This is the same but for the Kaiser Permanente of Washington.

Slide 19 – Proposed Resolution PEBB 2018-08 Non-Medicare Premium. Similar for the Uniform Medical plan.

Slide 20 – Proposed Resolution PEBB 2018-09 Medicare Resolution. The PEB Board endorses the monthly Medicare Explicit Subsidy of \$168 or 50% of premium, whichever is less.

The purpose of this resolution is because the Board does have the authority to set the Medicare Explicit Subsidy lower than what the Legislature set at \$168. We have written it as \$168 and would hope that you would approve as written.

**Dave Iseminger:** We assume you would not want to exercise the discretion to lower the subsidy. We have traditionally brought this resolution as a ratification of the Legislature's setting.

**Sue Birch:** There's a lot of non-verbal smiling of that \$168.

**Tanya Deuel:** Slide 21 – Proposed Resolution PEBB 2018-10 Medicare Premium. The PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare premiums.

Slide 22 – Proposed Resolution PEBB 2018-11 Medicare Premium. Kaiser Permanente of Washington Medicare premiums.

Slide 23 – Proposed Resolution PEBB 2018-12 Medicare Premium. Uniform Medical plan Medicare premiums.

Slide 24 – Proposed Resolution PEBB 2018-13 Medicare Premium. Premera Medicare premiums.

**Dave Iseminger:** The way the resolutions are written and for complete transparency, we have the Board take action on the premiums and then the presentations Beth has provided the context of the benefit changes that are wrapped up into those premiums. You do not have to take individual action on benefit design changes in these instances because if you were to pass and endorse the premiums, you have inherently accepted the benefit changes built into those rates. You can't de-couple those. We present to you the premium rates and make clear you're aware that you are implicitly including the benefit changes that Beth has overviewed.

**Sue Birch:** Thank you all for presenting this information. In the environment we're operating in, this is pretty remarkable. I think the pursuit in this state around driving towards value isn't something we would ordinarily see in Colorado. I do want to commend you all for your great negotiations, for our plans, and all the work that's been done. This is a lot to be proud of as we drive towards value. So thank you.

**Myra Johnson:** This is Myra, just logging in.

**Sue Birch:** Thanks for letting us know you are on.

### **Eligibility Policy Resolutions**

**Barb Scott,** Policy, Rules, and Compliance Section Manager, ERB Division. There are three policy resolutions for action before the Board today.

Policy Resolution PEBB 2018-02 is unchanged from what was presented at the June 20 meeting. It adds to the Board's existing policy for error correction.

**Sue Birch: Policy Resolution PEBB 2018-02 – Enrollment Error Correction: Resolved that,** if any employing agency errs and enrolls an employee or their dependents in PEBB insurance coverage when they are not eligible and it is clear there was no fraud or intentional misrepresentation by the employee involved, premiums and



any applicable premium surcharge paid by the employee will be refunded by the employing agency to the employee without rescinding the insurance coverage.

Tom MacRobert moved and Greg Devereux seconded a motion to adopt.

Voting to Approve: 6

Voting No: 0

Policy Resolution PEBB 2018-02 passes.

**Barb Scott:** Policy Resolution PEBB 2018-03 addresses eligibility for retiree term life insurance for state agency and higher education retirees who lose eligibility for PEBB due to not paying their health plan premium, or due to not maintaining enrollment in Medicare Part A and Part B. It would not extend to a retiree of an employer group who loses eligibility when the employer group stops participating or contracting for PEBB benefits. It's really just for state and higher education retirees who lose eligibility and the two instances where we see that were the two described.

**Dave Iseminger:** For those not familiar with the vernacular, employer group are those local governmental entities that contract with the Health Care Authority for access to PEBB benefits. Think library district, irrigation district, ports, anything that has the word "district" in it.

**Barb Scott:** The recommended policy is unchanged from the policy introduced at the June 20 meeting.

**Sue Birch: Policy Resolution PEBB 2018-03 – Retiree Term Life Insurance Eligibility**

**Resolved** that, a retiree who is no longer eligible to remain enrolled in a PEBB health plan may remain enrolled in retiree term life insurance coverage only.

Yvonne Tate moved and Greg Devereux seconded a motion to approve.

Voting to Approve: 6

Voting No: 0

Policy Resolution PEBB 2018-03 passes.

**Barb Scott:** Policy Resolution PEBB 2018-04 would allow a retiree to defer enrollment in PEBB coverage while enrolled in covered through the Civilian Health and Medical Program of the Department of Veteran Affairs, ChampVA. The only change to the policy in front of you from the June 20 meeting is the effective date. It has been changed to July 17, 2018 based on the Board's direction

**Sue Birch: Policy Resolution PEBB 2018-04 Retiree Insurance Coverage Deferral – ChampVA**

**Resolved that**, effective July 17, 2018, retirees and survivors may defer enrollment in a PEBB health plan if they are enrolled as a retiree or a dependent of a retiree in ChampVA.

A retiree or survivor who defers enrollment while enrolled as a retiree or dependent of a retiree in ChampVA will have a one-time opportunity to enroll in a PEBB health plan by submitting the required form and evidence of continuous enrollment within the HCA required enrollment timeframe.

Harry Bossi moved and Tom MacRobert seconded a motion to adopt.

### **Public Comment**

**Fred Yancey:** I represent Washington State school retirees. My only concern with this policy is that if I'm receiving a ChampVA program, how would I know that when I stop receiving it that I had a timeframe for Health Care Authority, that I qualified and that it had a timeframe in order to pick up PEBB? I don't know if you track retirees in terms of what they're doing for insurance. And then you would know and then you could let them know that policy. That's my only concern if I was somebody taking advantage of that. Thank you.

**Sue Birch:** Thank you, Fred, for your comments.

**Barb Scott:** When a retiree defers enrollment in PEBB coverage, they do that by completing a form that indicates rather than enrolling, they're choosing to defer coverage. When they do that, we communicate with them to let them know that we have deferred their coverage and during the time they're deferred, they have to be insured in some coverage in order to retain the right to come back. It points them to where they can get additional information about those rules. I would have to look at the letter to see if it doesn't actually state those rules as to your, "it's our understanding you're deferring for this reason and these would be the reasons you could come back." I would have to check that piece. I do know we communicate with our members to let them know that we've got their deferral request, we've taken action on it, and they have a responsibility to make sure they're covered during the time they're deferred in order to be able to retain their eligibility in the future.

**Tim Barclay:** To clarify to Fred's point, this resolution does not open the door for anyone to come back into the program who did not go through that deferral process at the time they dropped coverage. If somebody didn't do that and they've been enrolled in ChampVA for the last five years, it doesn't make them eligible to come back to PEBB. This is prospective only.

**Barb Scott:** That is correct.

Voting to Approve: 6  
Voting No: 0

Policy Resolution PEBB 2018-04 passes.

**Sue Birch:** We're going to take a ten-minute break.

[break]

## **2018 Annual Rule Making**

**Stella Ng**, Senior Policy Analyst, Policy, Rules, and Compliance Section, ERB Division. I'm going to give you high level information on this year's annual rule making, highlight the most significant changes and rule making actions we are considering. No action needed from the Board.

Slide 2 is the rule making timeline. August 2018 proposed amendments and new rules will be distributed for public comment. In September 2018 we will conduct a public hearing and adopt final rules. Amended rules will be effective January 1, 2019.

The focus of this year's rule making is divided into four areas. We are adding clarity to rules to better administer and manage PEBB benefits as identified by staff and stakeholders; making regulatory alignment to implement state legislation and to comply with federal requirements; amending rules on topics within the agency's authority; and implementing PEB Board policy resolutions adopted today.

Slide 4 – Administration and Benefits Management. We are clarifying some of our existing rules to better administer and manage PEBB benefits. This includes amending our COBRA rule to include a note that supports the authority under which dependents, like state-registered domestic partners, are eligible for coverage. We've done restructuring on our deferral rules to describe all populations and clearly define deferral timelines so all populations understand when they defer. We are adding additional language to rules to clarify a retiree who voluntarily terminates PEBB coverage cannot re-enroll in PEBB benefits unless the retiree becomes newly eligible again. We are amending premium payment rules to clearly describe the requirements for retirees and others who are electing to continue PEBB coverage on a self-pay basis and where to send the payment.

**Dave Iseminger:** Stella, most of the things you've described are just aligning with the current practices and things stakeholders have said.

**Stella Ng:** Yes, that's correct. We are clarifying requirements related to employees who received a retroactive disability retirement eligibility determination to enroll or defer PEBB retiree insurance coverage. We will include greater details specific to the different pension systems because we found it was confusing for our members. We're amending the election period for survivors to allow a full 60-day election period after the PEBB coverage ends. Currently, survivors get a 60-day election period at the death of the employees realigning with COBRA to allow either a 60-day election period at the death of the employee or when PEBB coverage ends.

**Dave Iseminger:** This may seem like a Board decision, but because this topic is aligning with specific federal law, we are informing you of that alignment, rather than bringing something where you don't have discretion.

**Stella Ng:** Slide 7 – Regulatory Alignment. We're making a number of changes to align with changes in regulations, implement legislation, and align with state statutes. This includes amending definitions to align with recent state legislation. For example, due to Engrossed Substitute Senate Bill 6241 and Engrossed House Bill 2242, we are making global changes in rules to be more gender neutral. We're amending language referencing dependent children aligning dependent children's definition and eligibility

rules for dependent child of age 26 with state statutes. We're amending language to incorporate the use of respectful language when referring to children with disabilities and we are amending and updating appeals to streamline the appeals process and improve resolution timelines.

Slide 8 – Amendments within HCA's Authority. This includes amending employee notice requirements related to medical FSA and DCAP to make a technical correction by amending the rule on employee notice requirements to stay 30 days or less. We're modifying it to be more technically accurate with the Cafeteria Plan rules. We're adding a 31-day requirement for transferring employees who are eligible for the state's salary reduction plan to notify the new agency. This will help with the transition of payroll deduction when the employee transfers to a new agency. And we're amending the employer group application process by adding alternative requirements for employers that are unable to provide historical claims data and cost information. We're specifying the \$25 wellness incentive gift card must be claimed within the same year it is earned. This clarification is to match with current practice.

**Tim Barclay:** I'm just curious, on the bullet point about amending the group application, can you describe what the alternative requirements are?

**Stella Ng:** There are three alternative requirements. One is a letter from the carrier indicating they will not or cannot provide claims data. This is specifically for the small group applications. They also have to complete an actuarial calculator. We're currently using the spousal calculator to provide information about the plan most employees are enrolled in. And also, we're asking them to provide current premiums of their plan.

**Tim Barclay:** Okay, thank you.

**Harry Bossi:** A follow-up question on that. On the employer groups, at one time there was a limitation. I think employer groups less than 100 or 100 or fewer didn't have to provide claims data. Is that still part of it or is there a cutoff point?

**Dave Iseminger:** The employer group process, and again, employer groups are those political subdivisions, for a lack of a better word, that are contracting with HCA for access to PEBB benefits, has had changes in recent years. Prior to 2016, there was a risk underwriting factor analysis performed by our actuaries to say whether a group that wanted to join and be part of the PEBB risk pool was riskier or had the same or better risk than the risk pool. Only those groups who had as good a risk or better than the PEBB risk pool were allowed to join. In 2016, the Legislature changed those rules and allowed anybody who wanted to join the PEBB risk pool from local governmental status to come in. We do assess, as a whole, the risk that the entire political subdivision population is increasing the overall risk in the pool. There's a surcharge applied to all of those employer groups.

Those changes have morphed over time. There is no specific limit on the size of an employer group at this point. We have some employer groups that are as small as three and our largest just under 1,000. In 2016 when anybody could join, the original rules the agency set up mandated that they provide claims information. There were some very small groups and to protect PHI, and because of a variety of other reasons, the entity wasn't able to get claims information, we came up with a proxy with our

actuarial services for the type of information. But any group can come regardless of their size.

**Harry Bossi:** Thanks. I'll try to ask the question again differently. Is there a threshold where you don't have to provide claims data? I know at one time, it was if the size of the group was less than 100, you didn't have to provide claims data. You had to provide past history of who you might be insured with and those kinds of things, but there was not a requirement for claims data. Is that no longer the case?

**Barb Scott:** Staff are confirming now. When it came to looking at real data in making a decision as to whether or not a group could come in, the Legislature set it at a fairly high level because it had to do with a surcharge that is applied for those groups in order to offset, as Dave described, what's going on in the pool. I believe the number where we really start to look at in an actuarial assessment of the group, is 5,000. I think anything below that, we wouldn't look. The reason we go ahead and collect the data is so our actuaries have that available as they try to set what the surcharge should look like.

**Dave Iseminger:** I think the other part of your question, Harry, is what we're seeing is it's roughly groups that are 25 and under are saying they're having challenges with giving us the original claims data piece. We are generally not seeing a problem, so I believe the way we've set it up is there is a requirement for this and if you can't provide it, there's the exception to that. But the expectation is anybody who can supply regardless of your size of one person or a thousand, if you have it, provide it. If you can't provide it, we go through the process for an exception. There's not a line that everybody under 25 doesn't have to do it. Everybody's expected to do it unless you have a hardship and you show us why.

**Barb Scott:** Rob, what was the answer?

**Rob Parkman:** There's no line.

**Dave Iseminger:** Rob confirmed what I just said.

**Barb Scott:** Okay, no line. Not even 5,000.

**Myra Johnson:** I have a question on the \$25 wellness incentive. I see that changing and we're adding it to the new fiscal year, or is it enrollment year, that they have to use the card by? I'm wondering if some people, as soon as they enroll, get excited about it and if they enroll in October or November, it expires in December.

**Dave Iseminger:** Myra, there is yet a third date that you've entered into the equation via your question, and that's when the gift card expires. Nothing about the policy and the amendment within HCA's authority that's described here has to do with the expiration of the gift card. There's the earning of the gift card, which under the SmartHealth wellness plan eligibility requirements set by the Board, is completing the well-being assessment. That's "earning" it. Then you have to claim it. Claim it is when SmartHealth sends you a link, you have to click on the link to get your gift card. This has nothing to do with whether that gift card expires. We've been very clear in the communications to members that you have to "earn and claim" the gift card within the plan year.

If there wasn't a requirement to claim it within the same plan year, these \$25 gift cards would have to be managed as lost property, contact to the recipient every couple of years for seven years. The administration of tracking this property would be too cumbersome if this requirement wasn't in place. We'd also have to track and help manage which W2 it goes on based on when it was claimed. Then you're trying to track over tax years as to which \$25 came when for each person. It becomes administratively challenging to manage over multiple years. When this was first set up, it was very clear that it was supposed to be earn it and claim, but the rule didn't actually say the word "claim" even though that's how it's all been described to members. It's not a functional change.

**Myra Johnson:** Thank you.

### **Emerging Medications**

**Ryan Pistori**, Assistant Chief Pharmacy Officer. Today is the second presentation on emerging medication as part of this new process. The first medication was Trogarzo, which was intended for a very small, select population of patients with HIV.

Today we'll be talking about the Erenumab or Aimovig, which is approved for the prevention of migraines. This medication will affect a larger population. Our cost analysis is slightly different than Trogarzo. Slide 2 is background information about Aimovig. It was approved by the FDA on May 17. This is the first drug in a new class of drugs used to prevent migraines, known as the calcitonin gene-related peptide inhibitors or CGRP inhibitors, as I'll refer to them going forward.

This is a new class of medication and there are other drugs in the pipeline that have not yet been approved but are expected to be approved either later this year or early next year. Those are Fremanezumab and Galcanezumab. With these two new drugs, there'll be three drugs in this class probably about this time next year, potentially even four, if another one comes out. There will be some competition in this class. The common theme about these new drugs is they're all being studied to treat migraine prevention or to prevent migraines from occurring. This medication was studied for both episodic migraines and chronic migraines. Those are for patients who have between 4 to 14 days of migraines per month, or those who have 15 or more migraine days per month. It doesn't matter how many migraines they have per month. It was studied for both and approved for both.

You may be asking yourself, "Are there other medications used to prevent migraines?" In fact, there are. Clinical guidelines from both the American Academy of Neurology and the American Headache Society recommend that certain beta-blockers, anticonvulsants, and antidepressants are used as first-line treatment for migraine prevention. There are other drugs studied to prevent migraines that may not be as efficacious or may be reserved for a very select refractory population. Those patients can use anti-hypertensives or potentially Botox.

Slide 3 is the beginning of the cost analysis where we tried to anticipate how many members could use these medications. Our initial assessment was to look at the entire UMP population, which at the time of this analysis was 256,000 members. We estimate approximately 3,844 may be using medications for migraine prevention. It's difficult to assess how many patients are using these medications for that indication just because

beta-blockers, anticonvulsants, antidepressants can be used for a number of different therapies. You can't tease that out. They could be using that medication for migraine prevention, to prevent depression, or to treat both. Based off of the initial population of 3,844, we are anticipating potentially 1% to 10% of this population may switch their medications, which is between 38 to 384 members who use this drug or a drug in this class in 2018.

Aimovig has been announced to cost approximately \$6,900 per patient per year, or about \$575 per month. This number does not include discounts we may receive as part of the Northwest Drug Consortium. We don't pay the full list price as part of our pharmacy benefit.

Slide 4 is the summary of our cost analysis. Putting that cost together with the population uptake and then adjusting it for the remainder of 2018. The experience that UMP may have with this new Aimovig or the other drugs in this CGRP class may cost the plan between \$113,000 to \$1.13 million in 2018. This really depends on the member uptake. As the members are switching off other medications to this medication, that will impact how much it costs the plan. These two numbers translate to approximately a 7-cent to a 73-cent per member per month cost, so the increase in the amount of monthly cost per member.

It's worth noting that this is what we anticipate seeing in 2018, but as drugs are approved by the FDA, as more enter the market, and as the pharmaceutical manufacturers continue to market them, we may see double the amount of members using it in 2019. We do expect growth for use in this drug class in the future. It's worth noting that Aimovig may not have significant medical cost offsets. The alternative therapies mentioned previously cost between \$7 to \$480 per 30-day supply. To put that in comparison, Aimovig was \$575. There are less costly, equally effective alternatives. There have been no studies on whether these drugs would decrease emergency room use or other medical cost offsets. There are no economic analyses at this time to determine non-medical cost offsets, like caregivers or other ways of compensating or providing patient care not typically calculated in the traditional health care system. The last bit of information I have about this drug is that members would pay \$150 for a 30-day supply of Aimovig. That is our Tier 3 specialty drug cost share, which is capped at \$150 per 30-day supply.

**Sue Birch:** Ryan, thank you for this information. I know our future is going to be linked with all your pharmacy work because this is the area that's really taking off, all this specialty pharmacy work. Next time you present, can you add two features to the presentation? First, I'm curious if this company has a consumer assistance program and if that's relevant. If there's anything out of the Northwest Drug Consortium that would impact our decision making. And secondly, since you have been doing such a wonderful job bringing us along on value-based pharmacy, if you can think about if this becomes a tier or the implications for that as we continue to look at that as an option in the future. I think we've all become more educated about the tiering and the impacts. I think it's great if you start helping us understand where this would fit into that schema.

**Ryan Pistorisi:** I'll try to answer both of those questions. For the consumer assistance program, I do believe there is one. When I was reviewing this drug earlier, I believe they did offer some type of patient assistance. I don't know the details of that patient

assistance program, but I do know they are offering some type of assistance for patients who are commercially insured, so not the members who are on Medicaid or Medicare.

For the future tiers, this drug and the other drugs in this class, we are planning on reviewing later this year at the Washington Pharmacy and Therapeutics (P&T) Committee. We will be presenting this to our P&T Committee for their review of the evidence of the safety of their comparative effectiveness. From there we'll be doing a cost analysis on this class and trying to leverage any rebates available. We are planning on managing this class in the near term.

### **Retired and Disabled School Employees Risk Pool Analysis Legislative Report**

**Kayla Hammer**, Fiscal Information and Data Analyst, Financial Services Division. Slide 3 – What is the Legislative Report? RCW 41.05.022(4) requires that the Health Care Authority, in consultation with the PEB and SEB Boards, complete and submit an analysis of the most appropriate risk pool for the retired and disabled school employees. This analysis is due to the legislature on December 15, 2018.

**Tom MacRobert:** Is this part of the initial legislation when they created the SEBB that they expected this report to be issued at the end of December?

**Kayla Hammer:** Yes.

**Dave Iseminger:** The other thing I want to add for the record is many people ask me why it has the phrase “retired and disabled school employees” instead of just “school employees” or “retired school employees?” It’s the statutory definition made decades ago. It’s the exact statutory language of the reference many people think of as retired school employees.

**Tim Barclay:** Are you given direction as to the definition of most appropriate, or is that up to the agency to define as they produce their report?

**Dave Iseminger:** There's no guidance to that. It’s the phrase that exists in the legislation.

**Kayla Hammer:** Slide 4. Currently, when an eligible school employee retires, they have the option to join the PEBB Program and utilize the retiree benefit offerings. It would become part of one of the two risk pools currently managed by the Health Care Authority, the non-Medicare risk pool or the PEBB Medicare pool.

Slide 5 is a diagram of the current risk pools to help illustrate what the current scenarios are. On the non-Medicare risk pool, there are state employees, non-Medicare state retirees, and the non-Medicare school retirees in the purple box. The Medicare risk pool has Medicare state retirees and Medicare school retirees.

Slide 6 - Current PEB Board Benefits and Subsidies. School and state retirees that utilize PEBB are offered the same benefits at the same rates. The non-Medicare retirees can purchase PEBB non-Medicare plans and the Medicare retirees can purchase PEBB Medicare plans. The school and state retirees both receive subsidies of the same amount to help offset the cost of those benefits.



Slide 7 – Legislative Report Requirements. Per the RCW, the report will include the size of the non-Medicare and Medicare retiree enrollment pools, the impacts on cost for both state and school retirees for any proposed risk pool changes, the need for and the amount of an ongoing retiree subsidy allocation, and timing and approach of any risk pool changes.

In the next few slides, we're going to go over the things that will be considered in order to meet these legislative requirements. Slide 8 – Retiree Enrollment Pools, the following things will be reported on: the total retirees enrolled in the PEBB Program, this would include how many are school versus state retirees and how many are Medicare versus non-Medicare retirees and risk scores for each group listed.

Slide 9 – State and School Retiree Impacts. We must address the possible impacts on cost for both state and school retirees should any risk pool changes occur. There are several options to consider for school retirees. The possible changes are listed on this slide, but I'll go into more detail on the following slides with visual diagrams

Slide 10 – Create SEBB Program Non-Medicare Risk Pool. In this scenario, the school retirees not yet enrolled in Medicare would be removed from the PEBB Program and combined with the SEBB Program employees into one risk pool. They would be rebranded the SEBB Program Non-Medicare Risk Pool. In this particular scenario, the Medicare school retirees would stay in PEBB in the Medicare risk pool.

Slide 11 - Create SEBB Program Non-Medicare and Medicare Retirees Risk Pool. In this scenario, we would do the same thing I just mentioned, which would be to rebrand and create a Non-Medicare Risk Pool under the SEBB Program, removing the non-Medicare school retirees from PEBB into SEBB. We would also create a Medicare risk pool under the SEBB Program, removing those Medicare school retirees from the PEBB Program Medicare risk pool.

Slide 12 - Create Two Additional SEBB Program Risk Pools. In this scenario, there would be the following pools: the SEBB Program Employee Risk Pool, which already exists in the legislation currently; the SEBB Program Non-Medicare Retiree Risk Pool, removing non-Medicare school retirees from PEBB into the SEBB Program into their own risk pool; and then the SEBB Program Medicare Retiree Risk Pool, removing them from PEBB into the SEBB Program.

Slide 13 – One SEBB Program Risk Pool. In this scenario, there would be one risk pool under the SEBB Program. It would contain the school employees, the non-Medicare school retirees and the Medicare school retirees.

**Dave Iseminger:** On slide 13, in anticipation of questions either during public comment or from the Board, I want to highlight that the purview of this legislative report is focused on school retirees and what risk pool is appropriate for them. There have been discussions and comments from some Board Members, and questions in public comment, about combining the PEBB Program risk pools into a single risk pool like on this slide, having just one green box and one orange box. I want to say that although this report is focused on what to do with school retirees, those individuals interested in what the implications might be for a single risk pool might find this particular scenario

informative for their thoughts or ideas related to PEBB. The report is focused solely on school retiree options.

**Kayla Hammer:** I also have a note to add. Each scenario I just described, not only does it require an analysis of the impacts on cost, but also of the legality. The current risk pools that exist are legislatively mandated. Any changes would require legislative action. Furthermore, outside of Washington State law, there are federal regulations with Medicare and IRS when it comes to employee and retiree benefits. All of that will be considered as we're working on the analysis.

Slide 14 – Retiree Subsidy. Any risk pool scenario will include consideration of the possible impact to the retiree subsidy allocation, the need for an ongoing subsidy allocation, and the amount of that ongoing subsidy allocation.

Slide 15 – Timing and Approach. Each possible change to the current risk pools have different challenges that will affect the amount of time needed and the approach taken. We will consider required changes to legislation as the current risk pools are legislatively mandated. Any change requires legislative action. There are implementation and administrative considerations. Many work streams go into managing the risk pools, and each work stream has its own set of regulations and timelines needing to be kept and met during any sort of change. Some items listed on this slide are examples. If we were to develop any new risk pools, we would need to procure benefits for those risk pools. There's a lot that goes into procuring benefits and they would also need to be approved by the SEB Board for any new benefit offerings and what's going to offered to their members.

Hand-in-hand with the benefit design is the contract management as far as getting contracts into place. There's also very specific regulatory timelines with that. The rate development, if there were new benefits procured for new groups, we would need to set rates for each of those plans. That has its own timing concerns and things to think about. There are also member communications. Any changes would need to be communicated to members.

Slide 16 is the current report timeline.

Slide 17 – Discussion. HCA is interested in your opinion regarding this analysis. Some things we are interested in are your opinions on the scenarios discussed, the subsidies, implementation, and administrative concerns, or anything else you want to share. I realize it's a little on the spot to be asking for feedback so if you don't have anything today, you can give feedback to Connie and copy Dave up until COB August 10, 2018.

**Tim Barclay:** I think it's hard to add too many comments without some data and information. August 10 is fairly quick. Would you like a data request from us as to what we'd like to see or are you planning on putting information to give us? Or would you rather we just comment blindly? Where are we headed with this?

**Dave Iseminger:** For today, comment blindly and if there's specific pieces a Board Member wants to follow up with, asking more questions about data, we can see what we can provide to give more insight in order for you to give more insight by August 10. But for purposes of now, today, unfortunately, it would be blindly.

**Kim Wallace:** I'm here to support this presentation and share. As a SEBB Finance Manager, I want to share that Kayla's well underway in working with our actuarial consultants to compile relevant data, the members and their experience in the risk pools as we see them currently. We're starting to separate out the SEBB groupings of the various SEBB populations in the risk pools as well. It may be that we can absolutely provide some relevant and meaningful data to the Board in the next week or two. I wanted to note also that we are providing this presentation to the SEB Board on July 30. We will also be offering them the opportunity to ask questions, make any requests that they would like, etc. We're going to be as actively as possible engaging both the SEB Board and the PEB Board over the next two to three weeks. Please do share with us what would be especially helpful and meaningful to you.

**Sue Birch:** One thing I am hoping you all will bring back is any other relevant learnings from other states that have coverage for SEBB. If there are any leading states that have the construct in what they've done with the different risk pools, I'd like to see that comparison or see if there's anything to learn from them.

**Tom MacRobert:** Dave, because I do hate shooting blindly, on our agenda for our next meeting, if possible I'd like if we had an opportunity to put this on the agenda in order to give us time to reflect on this information and develop more thoughtful questions.

**Dave Iseminger:** Absolutely we can. We usually have a very short last meeting but we already have multiple things on the agenda to talk about. We can certainly engage in further discussion on this at the next public meeting if the Board wants additional time for comment. I'm assuming there are seven voting members of this Board and nine voting members of the other Board. That means there's probably at least 16 different opinions. We're trying to figure out the best way to memorialize the feedback and insight. The Board doesn't need to take a position on one pool over another. That's not the role of the Boards in the report, but provide your insight and how we wrap that up into the final report we're working on. Right now we're in the 'gathering your insight' stage of the process. I want to make sure it's clear we're not expecting the Board to take a vote on one pool over another. There's no specific value in that. Like I said, I'm sure there's 16 different opinions between the 16 voting minds on this particular issue. We can certainly put something on the next agenda for further discussion and allow you the week to reflect between now and the next meeting, and still have that follow up time through August 10 of additional things you want to submit for the agency to review.

**Tom MacRobert:** Thank you.

**Harry Bossi:** I don't know if it's a question or a comment, but the school retiree and the school component is relatively small. Is that correct? It's going to grow significantly in the future. I think when assumptions are made for the future it's critical because it may look entirely different when there's a ramp up to the enrollment. I don't know what the makeup is, of the groups -- the schools that are currently enrolled. But it'll be significantly different in a couple of years, I would guess. The age factors, the prior history, the claims history, and trying to project what that is going to look like in a couple of years with a considerably larger group, I'd be really interested in focusing on what kind of -- I don't think we can just say, "Well, claims data analysis this," so we'll just multiply that times a certain factor and that's what it will look like down the road. I don't have a solution to that, but I think it's something that needs to be carefully analyzed.

**Kim Wallace:** A couple thoughts as I hear you share, Harry. Of course the K12 employees who retire now, their state retiree option is in PEBB. Kayla has an overall statistic to share about the percentage of state retirees, what we would consider state employee retirees, in the Medicare retiree pool, the big pool compared to K12 retirees. We affectionately refer to one big pool of all the state and school retirees. We do have a lot of experience, and the data that Tim was referring to with the K12 retirees along with the state, it's actually not a small number. It's a sizeable group.

One of the dynamics we also are aware of, and I think other people can speak to if needed more deeply and expertly than I can, but we're also aware of the dynamic of just communicating and people -- do K12 employees currently understand their PEBB benefit options in the PEBB Program? You may be thinking or suggesting something that we are aware of and with the advent of the SEBB Program, it's going to be clearer to K12 employees across the state that they belong to this consolidated benefits program, one big statewide program. I think it will be clearer to them that their move over to PEBB as a retiree or their option to stay in SEBB as a retiree should that come to pass. That's going to be more understandable to them. We could see some changes in terms of people moving into coming into the PEBB or SEBB retiree pool from their K12 employment. But rest assured, right now we have many, many K12 retirees currently under the managed PEBB pool.

**Harry Bossi:** And that's a misunderstanding on my part. I came from a different place in a different part of the country that wasn't the same. I misunderstood. And so I just retract the question.

**Kim Wallace:** Well, isn't it about 50/50 actually, right now?

**Kayla Hammer:** Yes. In the Medicare pool, specifically, it is about a 50/50 split of retired state Medicare retired school. However, in the non-Medicare pool, there's a smaller population.

**Tom MacRobert:** Kim, is it fair to say the non-Medicare school retirees is the smallest group of the ones you're talking about? The active school employees, the Medicare school retirees, and the non-Medicare would be the smallest of those groups, correct? Is one of the things you have to complete in this analysis as people that are currently active school retirees retire, it's what pool they would then go into whether it would be SEBB or PEBB? That's a major concern going forward. I would assume that were those groups separated, you would get quite a small group moving forward. I don't know if I'm making myself very clear on that.

**Kim Wallace:** You are, Tom. One of the things we're aware of and we want to track carefully in this analysis, is what the experience is. There's financial analysis, of course. But it's very important to us that we understand what the experience is for all of the employees and retirees that we're responsible for their benefits. If you start thinking of an employee and then you imagine they retire and they are not 65, as they are retiring and does it make sense for them, from a member experience, what benefits do they have to choose from, etc., currently K12 employees who are, say 55, retire and have the option to join PEBB benefits. Those PEBB benefits are different than the benefits they have as a K12 employee, of course. You might imagine a future where a K12 employee is receiving benefits under the SEBB Program. They retire and they're 55.

They stay in the SEBB Program as a non-Medicare retiree. They don't change perhaps over to PEBB until they're 65. I guess I'm just saying I think that's what you're raising is that we're not only running numbers, we're also looking at this from what makes the most sense to all of those folks out there and to administer efficiently and effectively. There are a number of different angles that will go into this, the study and the analysis, numbers being one piece.

**Tom MacRobert:** Thank you.

**Greg Devereux:** I think this is a lot to chew on. I hope to do it before August 10 and get back to you. I must say, I have to comment that Kayla's use of simple boxes and visuals was really good.

**Sue Birch:** Absolutely. When Tom began to speak, we all flipped to page 13, going, "Wait, which box? Yellow? Green?" So thank you. That's going to be really important as we go forward.

**Tom MacRobert:** I'd like to know what the numbers are at our next meeting for the after school employees, the non-Medicare school retirees, and the Medicare school retirees. If you could provide those numbers, that would be great.

**Kayla Hammer:** I don't have the active school employee numbers but I do have the most recent, June 2018. I have the non-Medicare retired K12 and it's about 4,000.

**Tom MacRobert:** Medicare school retirees.

**Kayla Hammer:** Medicare, June 2018, 48,000.

**Tom MacRobert:** 48,000.

**Dave Iseminger:** Tom, we'll follow up with the actives, but I know it's roughly between 3,000 and 5,000.

**Tom MacRobert:** I'm talking about the entire pool of active, like you would be the SEBB pool of active school employees.

**Dave Iseminger:** The future pool? The future third pool?

**Tom MacRobert:** Yes.

**Dave Iseminger:** We can answer that now, too. The best we can estimate at this point, the number we've been using is from the S275, the report that I believe is OSPI's report, and the estimate is roughly 134,000 subscribers that would be part of that pool.

**Kim Wallace:** Eligible employees.

**Dave Iseminger:** Eligible employees. And then once you add in dependents, that is part of the grand question with the consolidation is because the premium variability and the tiered ratios that exist in K12, there is not uniform accessibility to adding dependents.

We're trying to use dental data as a proxy. Our best estimates we've used is the entire pool would be somewhere from 200,000 to 300,000.

**Tom MacRobert:** Did you say you knew or you had a guesstimate on what the PEBB enrollees are that are active school employees now?

**Dave Iseminger:** Yes, currently, it's roughly 3% to 5% of the K-12 employee population. I said 3,000 to 5,000 earlier, I meant 3% to 5% and it's actually 4,000 to 6,000 employees. It's roughly 72 school districts and five of the educational service districts. It's not all of the bargaining units in all of them either. Roughly half of the school districts that have opted to join PEBB at this point include all bargaining units. The other half is just a few of their bargaining units. As a reminder, there's somewhere between 900 and 1,000 bargaining units amongst the 295 school districts.

**Tom MacRobert:** Okay, thank you.

**Kayla Hammer:** Just to add to this sort of 134,000-ish estimate from the S275 data Dave was talking about, that does not include substitute teachers. There is definitely a bit of unknown there, but we're doing our best to get to the bottom of it.

**Tom MacRobert:** Thank you.

**Sue Birch:** We'll have lots more information coming back at us. Then we can keep adding questions and directing you to go find out more information. That's why we have plenty of time to get this report done by December. Kayla, you're going to have a busy next few months.

**Kayla Hammer:** That's the truth.

### **Public Comment**

**Fred Yancey:** I represent the Washington State School Retirees Association. I just want the record to reflect that I'm disappointed with the process here. You're asked to deal with this very significant issue as to what to do with retirees and where to place them and what to do with K12 school employees together. And you have absolutely no information. A decision you have less than three weeks, or August 7, you know, or August 10, whatever the timeline is to give feedback on this important concept, but you have no data in which to make a judgment based on it. So I have real concerns, you know? When you're asked your opinions regarding the analysis and initial thoughts on this, all I could give you is shooting in the blind, which is what you had referenced. And so I'm disappointed that the process doesn't start with information before you arrive at a conclusion. You're getting information after you've been asked to come to terms with some sort of conclusion.

**Sue Birch:** Fred, thank you for your comments. I do want to clarify on behalf of what I heard from staff, which was we are beginning a process. They're going to gather their own kind of information and bring it forward and share it with both Boards. The report is not written. We're going through a process. I think they're asking Board Members to please start thinking about what other information is going to come forward. So please submit your questions or comments in writing so we can be aware of that or contribute those to Board Members as we get further into the process.

**Fred Yancey:** And that's exactly my point. Questions and comments when you have no data under which to generate questions or comments. I mean, I can tell you what I think about risk pools and which of the seven scenarios I would prefer. But I have no data, you know, to justify that choice. And you're going to analyze, I assume, seven different scenarios. And according to this and maybe I've misread this, presentation July 30, an internal review, which I take as an internal agency review through September through November, which is probably the development of the very same information that I am saying you need upfront. OFM review and then December 15, report due. So with all due respect, I don't see where this is an evolving process that will come repeatedly before the Board. I understand this meeting a week from now, the next meeting will call for your conclusions, if you will. I'm just concerned.

**Sue Birch:** Thank you for your comments, Fred. We so note those and as we go through the process and have information, we will be sharing that information as transparently as possible and involving the public and calling for comment as we go through the process. So thank you.

**Tom MacRobert:** I do have one more question. This OFM review, so after you have developed your data I'm assuming you are going to have to submit that data to the Office of Financial Management and they're going to include some data as well, what their analysis is of the cost?

**Dave Iseminger:** Formal legislative reports like this one, and this agency has at least 48 due this calendar year alone, have a formal process that they go through in order to make it on the legislature's desk. Part of this agency's commitment to getting our homework in on time per the legislature's request is to produce draft reports that OFM reviews and provides us insight and feedback. That's a standard part of any legislative reports process. It's not necessarily them doing an independent review. It's them looking at the report that we have crafted and giving us feedback. We finalize the report and turn it into the Legislature. It's just a standard part of all legislative reports that this agency does.

**Tom MacRobert:** Good. Keeps you busy. [laughter]

**Sue Birch:** Our next meeting is July 25 from 1:30 p.m. to 4:00 p.m.

### **Preview of July 25, 2018 PEB Board Meeting**

**Dave Iseminger:** Typically, the next Board meeting only has one agenda item, the conclusion of the rate setting process and asking you to take action on those rates. But as you see, our Briefing Books continue to grow every meeting. We have three other topics for July 25. We'll bring back long-term disability and answer additional questions related to that, and ask the Board to take action on that piece. We're also going to include additional discussion of the K12 retiree report after your ability to take this presentation back and think about some of the pieces we just discussed and see what other information we can bring to the Board.

The fourth agenda item, I'm fairly confident very few people remember January's retreat, but we began having a discussion about the broader Medicare retiree portfolio options. There have been discussions from the Board in prior years about different benefit option structures for Medicare retirees. The Legislature this last budget cycle

allocated funds for some analysis that doesn't rise to the level of the legislative report about some of the retiree plan options. We're going to have a presentation about that, picking up where we left off in January. This will also set the stage for a significant conversation with the Board during the 2019 Board season. So those are the four things: rates, long-term disability, more discussion on K12 retiree report, and Medicare retiree portfolio analysis.

**Sue Birch:** Meeting adjourned at 4:15 p.m.