

Public Employees Benefits Board
Meeting Minutes

July 25, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 4:00 p.m.

Members Present:

Sue Birch
Tom MacRobert
Carol Dotlich
Tim Barclay
Harry Bossi
Yvonne Tate
Greg Devereux
Myra Johnson

PEB Board Counsel:

Katy Hatfield, Assistant Attorney General

Call to Order

Sue Birch, Chair, called the meeting to order at 1:37 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.

2019 Premium Resolutions

Beth Heston, Contract Manager, Employees and Retirees Benefits Division. Before Tanya presents the 2019 Premium Resolutions, I am going to answer some of your questions from last week regarding the benefit design changes. But first, I want to point out we are adding a virtual diabetes prevention program administered by Omada for all non-Medicare members to the Uniform Medical Plan.

Slide 3 – Medical Plan Changes. There are several changes under the Kaiser Permanente Plans. They will also be adding a virtual diabetes prevention program, also administered by Omada for all non-Medicare members. It's for non-Medicare members

because Medicare offers their own diabetes prevention program and Medicare won't cover ours.

Slide 4 – Dental Plan Changes. Under the Uniform Dental Plan, the limit on Class 3 restorations (crowns) will be lowered from seven years to five years.

Dave Iseminger: Slide 4, says the changes are to the Uniform Medical Plan. It's really the Uniform Dental Plan. We're not adding a crown benefit into our medical benefit.

Beth Heston: There was a question on the average inpatient days for SoundChoice. It is 3.17 and the annual out-of-pocket maximum does apply. \$2,000 per individual or \$4,000 per family.

Tom MacRobert: That means the maximum you would pay out-of-pocket? It was worded as no maximum.

Beth Heston: Correct, but it meant there was no maximum on the stay. When you reach the maximum out-of-pocket, that's it.

Tanya Deuel, PEBB Finance Unit Manager. Today, we are going to ask you to vote on the resolutions for both the Medicare and non-Medicare risk pools. I want to remind you these are organized by carrier for each of the risk pools. All plans within the Kaiser Foundation Health Plan of the Northwest will be in that resolution and so on for the non-Medicare risk pool. They are broken down by carrier for the Medicare risk pool.

Sue Birch: Slide 6 – Purpose of Board Action. Myra brought to our attention that we need to correct the date on this slide to July 17, 2018, "premiums presented on July 17, 2018."

Resolution PEBB 2018-06 – Non-Medicare Premium

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest employee and Non-Medicare retiree premiums.

Greg Devereux moved and Harry Bossi second a motion to approve.

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-06 passes.

Resolution PEBB 2018-07 – Non-Medicare Premium

Resolved that, the PEB Board endorses the Kaiser Permanente of Washington employee and Non-Medicare retiree premiums.

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-07 passes.

Resolution PEBB 2018-08 – Non-Medicare Premium

Resolved that, the PEB Board endorses the Uniform Medical Plan employee and Non-Medicare retiree premiums.

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-08 passes.

Resolution PEBB 2018-09 – Medicare Premium

Resolved that, the PEB Board endorses the monthly Medicare Explicit Subsidy of \$168 or 50% of premium, whichever is less.

As a point of clarification on the one-page list of resolutions in your Briefing Book, the fourth resolution listed, PEBB 2018-09, is listed as the Non-Medicare premium. It should read Medicare premium.

Dave Iseminger: Correct. The summary sheet in the back says Non-Medicare premium, but the resolution itself, Slide 10, says Medicare. It should be Medicare.

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-09 passes.

Resolution PEBB 2018-10 – Medicare Premium

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare premiums.

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-10 passes.

Resolution PEBB 2018-11 – Medicare Premium

Resolved that, the PEB Board endorses the Kaiser Permanente of Washington Medicare premiums.

Yvonne Tate moved and Tom MacRobert seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-11 passes.

Resolution PEBB 2018-12 – Medicare Premium

Resolved that, the PEB Board endorses the Uniform Medical Plan Medicare premiums.

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-12 passes.

Resolution PEBB 2018-13 – Medicare Premium

Resolved that, the PEB Board endorses the Premera Medicare premiums.

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

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-13 passes.

Dave Iseminger: I just want to say that there's a lot of staff work that went into what was a very quick vote from the Board. It contrasts with the experience of setting rates from last year. I did want to acknowledge the work staff put into bringing something to you that was able to go through such a quick vote from a procedural standpoint. It represents a lot of work the last couple of months by a lot of people in this agency.

Sue Birch: Thank you, Dave. And having seen this in action last year, I, too have to say the nearly \$20 million we're saving the state is a pretty great thing to be proud of. I do think it's part of the whole transformation the state has been undertaking. It's fabulous to see. And, Greg, I think you had a comment?

Greg Devereux: I, too, want to acknowledge that I think the staff did an incredible job. I know it takes a lot of time to get the rates that we ended up with and we really appreciate that effort.

Sue Birch: Great, thank you for those comments, Greg. And, Dave, I know you had an enormous leadership role. Thanks to the whole team. It really is remarkable.

Long-Term Disability Insurance

Betsy Cottle, Contract Manager for the current long-term disability product in the PEBB Program. I will also be managing the product for the SEBB Program population.

At our last meeting, we talked about the possibility of an open enrollment and Sue asked what the living wage is in Washington State. Slide 2 is a little complex, but it provides information for Washington. I pulled it directly from the Massachusetts Institute of Technology site. It is a calculation done by this particular scientist. It's a good comparison for what we're trying to cover with disability information.

Sue Birch: I actually wanted to see where, for this state, some of the breaks occurred. For example, one adult, three children, \$83,366, and I believe our average household right now is one adult, two children. I think that's the predominant configuration in this state. I recommend we look somewhere between \$65,000 to \$83,000, where many of our folks are living.

Betsy Cottle: You're right, because Slide 3 – PEBB Program Subscriber Income actually shows the breakdown of what our state employees make so that connection between the previous graph and what you've just described is correct.

Tom MacRobert: If you could go back to that previous slide, I'm assuming the minimum wage is the state minimum wage that's calculated. And then, can you give me the definition of poverty wage, how that's factored?

Betsy Cottle: Yes, the state minimum wage is what's calculated. Poverty wage is set by the federal government as a standard calculation being used by actuaries and all sorts of different programs.

To Sue's point, the largest number of people in our employment make between \$57,000 and \$60,000 a year, which is displayed on this slide. Slide 4 – Current Plan Enrollment is what we talked about last time. Who's enrolled and who's in a claim.

We also had questions about the kind of diagnosis the PEBB Program population has with the rest of the country, and that's on the Slide 5 – HCA LTD Diagnosis Comparison. This is a report The Standard provides us every year. It's presented in two different ways. The first is by comparison, how are we against the rest of The Standard's book of business, and by occupation, shown in Slide 6 – HCA TLD Diagnosis by Occupation.

Dave Iseminger: The Standard's book of business means nationally.

Betsy Cottle: As you can see, by occupation, the largest percentage of people who have a disability claim is in the professional class. It trends downward to service workers, office and clerical, technicians, etc. In general, the Health Care Authority is below the professional, but in almost every other class, we really vary from the national average. We're a different kind of population so our percentages are very different. I actually don't know why that's true.

Dave Iseminger: When it says Washington State Health Care Authority, that's the benefit that's administered by the agency on behalf of all employees. This is synonymous with the PEBB Program in this context. It's not agency specific, it's a reference to us as The Standard's client for the PEBB Program. Just for complete clarity.

Betsy Cottle: Slide 7 – LTD Claim Trends vs. Benchmarks. This slide is the Health Care Authority versus The Standard's book of business. The green and red triangles tell you whether or not we are above or below The Standard's book of business benchmark. Overall, we are very comparable by type of claim to The Standard's book of business.

Slide 8 – Benchmark Source Information, is about enrollment. This is the base information for data presented in the two previous slides.

Slide 9 – LTD and Social Security Disability. Sue had a question about how long disability and Social Security disability can interact with each other and this slide responds to that. Very briefly, long-term disability has an application process that is much shorter than Social Security disability. You can get to your long-term disability product more quickly than you can Social Security disability. What The Standard and most long-term disability vendors do is, in an effort to make sure the member is getting the best benefit from both products, coordinates the effort to assist the application process.

Most people don't need Social Security disability during their disability claim period. If they do in fact feel they are going to end up on a permanent disability claim with Social Security disability, there is going to be some overlap during that application process. So you're on long-term disability, you and your physician determine you are probably going to be disabled for quite awhile, you and The Standard, or your disability insurance carrier, will work together to get your completed application into Social Security disability. By the time that happens, you will have collected extra money from LTD that is going to be retroactively collected by the first Social Security disability payment. That period can be very disruptive and confusing for members because it can take a great amount of time to make that bridge. That's where a lot of confusion, fear, and complaints are happening because it's a very technical process.

Carol Dotlich: Can you describe for me how that works? So, you get some money you're not really entitled to when your Social Security kicks in, right. So, they take it back how?

Betsy Cottle: You will have received long-term disability payments and then you begin your social security disability income payments. Your long-term disability vendor will collect the Social Security disability coming in, balance your payments, and then pay you the remainder. Once that bridge has happened, you're on Social Security disability.

Carol Dotlich: So the money from Social Security is going directly to the vendor and the vendor pulls their money out and then gives you the money?

Betsy Cottle: That's right.

Sue Birch: For the record, I want to clarify we're talking about SSDI – Social Security Disability Insurance.

Betsy Cottle: Yes. Social Security Disability Insurance. Not your general Social Security.

Carol Dotlich: Understood.

Dave Iseminger: Typically with SSDI, there's a lump sum that comes because it's a retroactive determination. That's why there's this true up that occurs.

Carol Dotlich: Is there a point when the consumer is harmed? In other words, if the consumer is getting a set amount per month that they're counting on, when this change happens, is there a point at which the standard monthly amount is reduced?

Betsy Cottle: Depending on your plan. If you are finally on Social Security Disability, you may or may not be completing your long-term disability claim because disability insurance and Social Security disability insurance coordinate, but I would have to look at a specific claim and a specific set of circumstances to give you a very clear answer. But in general, there is a lump sum that comes from SSDI that goes to your disability vendor. They may see they've been paying you for three months too long so they're going to take that out before you get the rest of your income.

Sue Birch: For a little clarification. I do think there are certain medical conditions that impact the progression, the timeline, and the process. For example, certain types of cancer and things will either accelerate or slow down the process. I think that gets factored in some way shape or form. Probably muddying the waters, but it's very complex. But they true up over time and the time intervals can be very different based on the person's diagnosis.

Carol Dotlich: The reason for my question is I've dealt with overpayments and other circumstances, and sometimes, the taking back of the money paid is pretty painful for the person. That's why I'm asking. Is there an abrupt edge of the curb where people fall over or no?

Betsy Cottle: I really can't speak to it in a general way. It's extremely specific to each claim. If you are ever in the position that you find a PEBB Program member you feel has been harmed, I would love to hear about it.

Dave Iseminger: Carol, in general, the system's set up so that the member gets the payment from their long-term disability carrier and then that true up occurs. If you had a claim for \$2,000 a month, you'd be getting your \$2,000, on the separate track you would have your SSDI application that's going through. Once that's approved, the true up occurs. But, the whole while, you'd be getting your \$2,000 from your long-term disability carrier. The true up would occur, and going forward, you might get \$1,500 from Social Security Disability and a \$500 check from The Standard. But at all points, you would be continuing getting the claims. That's why I think Betsy would be surprised and would want to hear if there's a member that you are aware of, or any of you are aware of, to bring forward as an issue. That's how the system's supposed to work.

Betsy Cottle: Slide 10 – Decision #1 – Offer of a One-Time Opportunity. There are two decisions to be made. One is an opportunity for a one-time offer to our eligible employees to purchase optional long-term disability, increase their optional LTD, change the waiting period for their optional benefit. The offer is open to every eligible employee, even if they have previously been denied optional coverage. Premium rates will be guaranteed until January 1, 2021.

Dave Iseminger: Betsy, before you move on, I had some feedback this past week on second item in the first bullet, increase optional LTD. This could be confusing because, the reality is, this is a salary-based plan. You either have the optional benefit or you don't. Your choices are to purchase the LTD benefit or change your waiting period. Originally we were thinking about the macro payment an individual receives, and you're increasing your payment that you're getting if you're going from just basic coverage to both basic and optional. But that overly complicated things for folks. We actually have a revised resolution for you to take action on today that deletes the reference to increasing your optional LTD, because, again, as a salary-based plan, you either have it or you don't. You're not electing a different coverage amount like you would in another benefit such as life insurance.

Betsy Cottle: Slide 11 – Proposed Schedule. We would begin marketing almost immediately this year and offer an open enrollment event in quarter one of 2019 with a plan effective date in quarter 2 of 2019.

Slide 12 – Decision #2 – Increase Monthly Maximum Benefit. The second decision that that Board has available to them is to increase the plan maximum from \$6,000 per month to \$10,000 per month.

Slide 13 – Claim Fluctuation Account (CFA). Our long-term disability accounts, both basic and supplemental, are protected by a claim fluctuation account. This slide is a description of the account and how much The Standard keeps in ours. The Standard does maintain separate claim fluctuation accounts for employer-paid basic and employee-paid optional.

Dave Iseminger: We wanted to make that crystal clear on the record for the Board at the last meeting. We were 99.9% sure, and we double checked that last week. We wanted to be clear that if the Board were to take action and authorize an open enrollment on the optional benefit, it wouldn't impact the premium reserves on the basic side. It shouldn't influence the ability to take steps to work on the basic benefit and change that benefit in the future.

Betsy Cottle: Slide 14 – Decision Considerations. Offering a one-time opportunity to PEBB Program employees could impact the optional plan's claim fluctuation account. There is the possibility for more claims if more people are enrolled. Increasing the maximum monthly benefit could also impact the employee-paid optional plan claim fluctuation account. By increasing the maximum monthly benefit, it becomes more attractive and could increase claims. If the Board chooses to offer a one-time open enrollment and increase the maximum monthly benefit, the impact to the employee paid optional CFA is assumed to be higher as is the possibility of a rate increase in the near future.

Dave Iseminger: It's only been one week and this was a very big topic to bring at the end of Board season, so we wanted to make sure we went through a fairly similar presentation with some added information from last meeting because it was something that we hadn't brought the Board on the journey this season. I wanted to be clear as to why we went over a lot of the same information again. Our actual recommendation is to go forward with the open enrollment piece and not have the Board take action on increasing the benefit maximum. We think that balances the variety of interests and is an appropriate use, without too much risk, of reserves. Our recommendation is what is before you in this resolution. This is a minor tweak from what was presented last week. There is no reference to increasing the optional benefit because, again as a salary-based plan, you either have the benefit or you don't.

Greg Devereux: I appreciate that distinction very much. And I appreciate Tim's comments from last time. I'm pleased with this.

Harry Bossi: I have a question regarding the open enrollment itself. That would be just a change – the enrollment? Somebody already had it and was satisfied with their waiting period they had already chosen and they can be passive and don't have to do anything?

Dave Iseminger: Yes, we'll work with the vendor to ensure nobody gets harmed, meaning that just because they don't raise their hand during the open enrollment that they don't lose anything. It's only added people. If people are happy with what they have now, they don't lose anything. It would only be changes they affirmatively ask for.

Tim Barclay: Dave, I just wanted to thank you for your work on this. I think it's important that we can give this opportunity to our members in light of that fact that our basic benefit is frankly inadequate. Maybe this will draw more attention to that and we can use this and leverage that and communicate to a broader audience the need to enhance that basic benefit.

Sue Birch: Resolution PEBB 2018-05 – LTD One-Time New Enrollment Opportunity

Resolved that, during Q1 of 2019, the PEBB Program will offer all eligible employees an opportunity, without providing evidence of insurability, to purchase optional LTD insurance or change their benefit waiting period.

Greg Devereux moved and Tim Barclay seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

Premium Resolution PEBB 2018-05 passes.

School Retiree Risk Pool Analysis Follow Up

Dave Iseminger: We don't anticipate this as the last time we talk about this topic with the Board, even this calendar year. We note this is a particularly sensitive and

important topic and a very important legislative report. The agency has been tasked with doing an evaluation and bringing forward information. I want to be clear that when Kayla described some scenarios at the last meeting, we described some of the considerations. I've heard in the last week that some people may have been trying to read into what Kayla was saying and looking for tea leaves as to what the agency was thinking, or what Kayla was thinking and saying. You described a more thorough analysis on one option, or one scenario than another scenario. We were just responding to questions. We're evaluating all the scenarios as thoroughly as we can for both fiscal and non-fiscal impacts. I don't want anyone on the Board to have the impression that there is a specific piece, a decision that has been made, or leaning towards a specific scenario. We really are evaluating as robustly as possible all the scenarios that Kayla described. I heard a lot of things in the last week about people's perceptions of the presentation from last week. I wanted to level set that we really are evaluating everything thoroughly and taking our role as an agency and reviewing this topic very seriously.

I want to remind you that as the agency is charged in fulfilling the responsibility to describe what it feels would be the appropriate risk pool arrangement, we are also tasked with consulting and getting your insight, as well as your sister Board - the School Employees Benefits Board. The agency is tasked with making the recommendation and the Board is tasked with providing insight.

We know there is more information that would help the Board give robust insight. So, reflecting on last week's discussion, we have some information that Kayla's going to describe today, but, we have worked on and are anticipating calling a special meeting of the Board under the Open Public Meetings Act the afternoon of September 17. We will have information that describes the relative impacts on the scenarios that Kayla presented at the last meeting and that we'll be able to give you more insight on relative impacts of those scenarios.

We will not have honed in and finalized a draft even at that point, so that to us is the best time to get the additional consultation from the Board as we round out and finalize the report. We will put it through the review process that all of our legislative reports go through and present it to the Legislature. Then we'll bring it back and discuss the final results of that report with the Board at the beginning of next Board season.

We feel it's important to provide both Boards with the same information at the same time and have a discussion because it's a topic that could impact both Programs. I want to be clear that the reason for calling a joint Board Meeting is not suggesting a collapsing of both programs. We are on a timeline for producing a very important report that could have profound impact on both Programs. And both are charged under legislation with giving us insight and consultation.

Kayla Hammer, Fiscal Information and Data Analyst. I'm providing a follow up to last week's presentation. Slide 2 – Enrollment Data. People were curious about what data we had. The bottom three rows in green, the political sub-division, last week I provided diagrams that had blue and purple bars that discussed the state employees and the school employees that were in the different PEBB risk pools, and also the different scenarios. I don't believe I stated explicitly that the state groups had the political

subdivision group lumped in. I specifically wanted to call them out in the data that we shared with you today. The blue rows are state employees and retirees, the purple is the school employees and retirees, and the green is the political sub-division employees.

Greg Devereux: Maybe I'm missing something, but the first purple school employee, 8,300, are these teachers and/or support . . .

Kayla Hammer: This is current enrollment in PEBB. So this is the non-Medicare PEBB risk pool and that's the approximate count from June 2018, of how many were enrolled in the PEBB Program.

Dave Iseminger: As a reminder, Greg, school districts currently have the opportunity to contract with the agency for access to PEBB benefits just like other political sub-divisions. We've tracked them as a school employee bucket for years because also, in part, at a certain threshold, Myra would become a voting member of the Board. It doesn't look like, unfortunately, Myra will hit that before the SEBB consolidation, but that was one of the reasons we needed to track that information. We have roughly, I believe at last count it was 71 or 72 school districts that have some or all of their bargaining units that access PEBB benefits for their employees. They tend to be smaller districts. It's 72 of them but it's only 8,300 individuals. We also have five of the nine educational service districts that contract for benefits.

Greg Devereux: So the legislative discussion, though, is not current PEBB enrollment, it's SEBB – the potential for SEBB and PEBB. Correct?

Kayla Hammer: No. What we're looking at is, when school employees retire, they have the option to come into PEBB.

Greg Devereux: I understand.

Kayla Hammer: So, what we're trying to do is figure out what's the best place for the K-12 retirees.

Greg Devereux: I haven't looked at it closely, I thought that the Legislature was interested, eventually, in potentially collapsing the risk pools for education and PEBB - SEBB.

Dave Iseminger: Greg, there are members of the Legislature that have a lot of ideas. I do want to point out a couple of clarifications. These three purple bars, that first one, that school employee bar, that exists in PEBB right now. All of those people move over to SEBB on 1/1/2020 and become part of the SEBB population. This report is about those bottom two rows, the school retiree non-Medicare and the school retiree Medicare, and discussing what the most appropriate risk pooling is going forward for those school retirees that currently are in the PEBB risk pools. Whether it's appropriate to maintain that current risk pooling arrangement or different arrangements.

Two years ago, when HB 2242 passed and established the SEBB Program, that was probably the most recent time there had been discussion about having a single benefits

program for state and school employees, but the Legislature opted to establish the separate SEBB Program rather than combine programs. And now, whether that is what the Legislature determines is the best risk pooling arrangement for school employees going forward. They still have that option before them. That was the long standing debate within the Legislature and within the options described by the Health Care Authority and its K-12 school employee reports over the past couple of decades. They opted for the separate school benefit program and now this report is about those two bottom lines and what is the best risk pooling arrangement for school retirees.

Greg Devereux: I appreciate that clarification very much.

Tom MacRobert: Kayla, can you give me an example of a political subdivision employee group?

Kayla Hammer: Political subdivision groups are like fire districts and city government groups and groups that opt in to and have the opportunity to purchase PEBB benefits.

Dave Iseminger: We have approximately 300 employer groups. Basically, if it has the word district in it, irrigation district, water district, hospital district, fire district, library district, and counties and cities.

Tom MacRobert: And it's their choice to opt in or not.

Kayla Hammer: Yes.

Sue Birch: And you are referring to it as like a political sub unit

Kayla Hammer: Yes. That's where the term political subdivision that we use in our counts comes from.

Tim Barclay: I think it would be helpful, Dave, if you could articulate what you think the significance is of defining a risk pool. What does that mean? And from your perspective, what are the consequences of pooling employees together and to a risk pool? What does that mean? I think that would be helpful so that everyone is on the same page as we think about this heading into that September meeting as to what it really is we're looking at and what that means.

Dave Iseminger: Actually, Tim, I was anticipating this question and Megan and I discussed it before hand. I'm going to invite Megan to come up and provide insight to the Board. Know that she's not being put on the spot.

Megan Atkinson, Chief Financial Officer. Tim, I think there are a couple different things to think about when we think about the risk pools we have and operate. First, we have certain statutory requirements and certain statutory direction around our current risk pools. We have the two risk pools for PEBB that Kayla's walked you through of the active employees and the non-Medicare retirees, or early retirees as we often refer to them. And then the Medicare risk pool for Medicare retirees. In addition, we will have, as Dave was just mentioning, a SEBB active employee risk pool when we start offering the SEBB benefits January 1, 2020.

One of the things we think about with risk pools, is it mathematically possible to bifurcate or divvy up the population within a risk pool. I often associate the risk pools with how we're offering the plan portfolios, as well as how we're doing the rating of the population. There's an overall legislative requirement around our risk pools then we also have an organizational way we look at the risk pools and we think about the populations in the different risk pools and then we deal with that, the mathematics part through various rate adjustments, subsidies, and such. For example, with the non-Medicare retirees being part of the active employee risk pool, as you all are familiar, we calculate the value of different rate subsidies that pieces of the population in that risk pool are receiving, as a result of being in the risk pool.

It is possible, and there are no Affordable Care Act provisions or OIC provisions around how we structure the risk pools. We have flexibility, but I think there are things for us to consider. There are operational costs to managing different risk pools and then you hit a point of diminishing marginal returns if you have too many risk pools. In addition, we think about plan continuity for members as they are getting rated in different risk pools for access to certain plans versus, for example, like the Medicare retirees accessing the different Medicare plans. Other than current legislative direction around our risk pools, there isn't any other policy, law, or codification of even our agency practice. Those are the things we're talking about as we undertake this study. Pushing on each other's assumptions around why we have certain populations grouped together.

A conversation we had earlier this week was why we have our self-insured active members in the same risk pool with our managed care active members. We could divide those out and people could move between the risk pools based on their enrollment decisions. There's no reason why we couldn't do that, but my response was I don't think of bifurcating risk pools because of the ownership of the plan as really being that important, or that critical, or that foundational of a principle. It isn't something I would advocate or recommend, but again, it's an illustration of something we could do if we wanted to. There are operational costs to manage the different risk pools. I think you need to think about, as you're grouping the segments of our population in risk pools, we generally think about, and the public generally thinks about if you're in a risk pool, you're getting rated together, you're accessing the same rates. There's a reason why we're putting people together or separating people out into risk pools.

I don't know, Tim, if that gets to any of the things you were thinking about.

Tim Barclay: I think it does. I would add one more thing to that, and I think the risk pools in many ways define how the Legislature funds the program. When we start thinking about moving the populations around, it impacts how the Legislature is going to view the world and how they fund it. Which is one of the reasons that I would say it would make no sense, for example, to push the Medicare and the non-Medicare populations together because their funding sources and costs are so different. I think that's one of the things to consider, too, when we talk about how we split this up and where we move people, is from the Legislature's perspective. How they fund the program is tied to those risk pools.

Megan Atkinson: That's a very valid point. I appreciate you making that. When we think about the different risk pools, and think about the different ways to either put

population together or separate the population out, we want to think about, does it make sense to have populations rated together, funded together, or populations distinct from one another.

Kayla Birch: Slide 3 – Other State Examples. Another question that came up last week was what are other states doing? I did a little research over the last few days. As of 2017, I found 19 states that allow pooling of public employees and school employees. Of course, practices within those programs vary, but most of them appear to offer continued coverage to early retirees with no employer premium contribution much like what we do in PEBB currently. The Medicare risk pools are managed separately.

I provided a couple examples. In Oregon, there is the Oregon Educators Benefits Board (OEBB) and the Oregon Public Employee Benefits Board (OPEBB), much like the separation in Washington State. The state purchases the health benefits for those programs and then the non-Medicare retirees, both in OEBB and OPEBB have the option to continue their current coverage with no employer contribution, or they can purchase benefits through the PERS Health Insurance Program (PHIP). When they become Medicare eligible, they are removed from the OEBB Program or the OPEBB Program and the Medicare risk pool is managed by the PHIP.

New Jersey is similar to Oregon and Washington in the sense that they have a health benefits program for state employees and a school employee health benefits program, SHBP and SEHBP. The state offers all self-insured benefits and they have two separate pools of the State Health Benefits Program and the School Employee Benefits Program. The early retirees are able to continue the same benefits without the employer premium contribution. When they retire, they're able to purchase the Medicaid Advantage Plans offered through their state benefits program.

Also in my research, I found a couple financial analyses on alternative risk pool options. They did not find significant financial impacts by either separating or further combining risk pools. It seemed like most states are starting to embrace value-based purchasing strategies, or moving from fully insured to self-insured programs as a way to save money and help with the growing health care costs versus shifting risk pools around.

Harry Bossi: My understanding at this point is that SEBB could align the benefits differently with regard to what type of plan might be available or what the individual benefits within the plan might be. They may have more therapy visits or less therapy visits. They could have different copays, coinsurances, all deductibles. All those kinds of things. It seems to me that affects claims history and risk at some point. I don't know unless the SEBB and the PEBB were clearly pretty similar, very similar, they would want to combine the two employees, the actives. I don't know if that's even part of this discussion, but until you really had claims history determined, is there a significant difference? If there is no difference, then by all means, it makes sense to combine. But if the risk factors, the risk history, if you will, claims history, whatever goes into the risk pool analysis, is similar or nearly identical, then it seems to me fewer pools would make sense. I hope that comment made some sense.

Dave Iseminger: Harry, I want to reconfirm that this analysis and this discussion does not include any discussion about combining the active employee risk pools of PEBB and

SEBB. The Legislature clearly made a third separate risk pool and it would require a legislative act. The agency has not been tasked with another report about a consolidation of SEBB employees and state employees. That sort of consolidation isn't part of this analysis at this time.

I also want to highlight, what Harry's alluded to, that the SEB Board is currently and on Monday, receiving more information per their request about different treatment limitations for their self-insured plans. Although they have established self-insured plans that build off of the Uniform Medical Plans that this Board has authorized for this program, they have some interest in, and want to evaluate, some differences.

I want to assure this Board that as each Board makes its own decisions with regards to benefit information and changes, as an agency we will evaluate that change for the other program and bring that information to the other program. If they go forward with making a change on a treatment limitation, for example, we will then evaluate that for the PEBB Program and bring this Board information about what the cost or impacts would be in making a similar change. If you made an action and change in your benefit design, we would similarly present that to the SEB Board so we can try to maintain a similar alignment of benefits where it makes sense and the Boards both feel that it makes sense just to help with the administrative processes of educating both of these populations.

They're all coming to the same Health Care Authority website. We've been thinking very deliberately about branding for the self-insured plans for the SEBB Program. They need to use the Uniform Medical Plan name, but there are other words in those names. There is Classic, CDHP, Plus, but we are trying to make sure the populations are of enough size that at some point, whether you have 100,000 or 130,000 people, you know, at a certain point the population is large enough that they all start to look the same. We want to make sure we're analyzing benefit design for both Boards where one takes action that the other may be interested in taking action.

Carol Dotlich: Do you know if there is a significant difference in the claims history of the two groups? The retired public employees and the retired school employees? Is there a significant claims history difference?

Kayla Hammer: We are in the early phases of collecting data so I can't speak to that yet, but I do believe that will be part of the conversation when we meet again in September.

Tom MacRobert: I've already expressed to Dave that I had lots of things I was going to say and lots of questions I was going to ask, but my big concern with this is when we were asking for input, we didn't have enough information. We were going to be referring to your slides where you had the color charts. I like this one, I don't like that one, but the resolution of having another meeting in September really takes care of my major concerns because Dave said they would have the information necessary to share with us so we could make informed decisions about what we want to do moving forward. Thank you for that and I won't make any motions.

Dave Iseminger: We'll be able to describe order of magnitude and relative impacts for different scenarios. We're going to be very careful about getting too granular. We don't

want to talk about pennies, we want to talk about the macro order of magnitude of these types of shifts. We will be able to provide that relative impact analysis or insight so that you can draw your own conclusions and provide your own insight on the scenarios being evaluated.

Tom MacRobert: Keeping with the topic of motions, would it be necessary to make a motion to have that date set for September 17?

Dave Iseminger: No, the agency has the authority under the Open Public Meetings Act to call a special meeting. There is not action needed from the Board. I set a date so you can get it on your calendars. At the last meeting I asked the Board Members to provide Connie and me any comments you had at this point by August 10. I still want you to think about it. We'll get your next round of feedback at the next Board Meeting.

Carol Dotlich: I'm very interested in any analysis of the differences between the two retiree pools. In other words, is there a difference in the expense in the extent of the medications they're on, the number of hospital visits, the number of doctor visits. I want to know if there are significant patterns of difference between the two groups.

Kayla Hammer: I can't say for sure the analysis will get that granular as far as the number of hospital visits and things like that, but we will be looking at relative cost differences between groups.

Centers of Excellence Update – Spinal Bundle

Marcia Peterson, Manager, Benefit, Strategy, and Design Section, ERB Division. I have no handouts. I think it was the April 25 meeting where we gave you a report on the Centers of Excellence Program for total joint replacement. We mentioned at that time we were in the process of doing a procurement for another bundle. The new bundle is for spinal fusion, or lumbar fusion more technically. We have identified two Centers of Excellence that we will be working with going forward. They are Capital Medical Center in Olympia and Virginia Mason Medical Center.

Provided we complete and sign the contracts with them, starting on January 1, 2019, UMP Classic and CDHP members will be able to go to either of these Centers. If going to either of these Centers of Excellence, Capital Medical Center or Virginia Mason, and undergo an evaluation for appropriateness and fitness for surgery following the Bree Criteria, the member will have little to no out-of-pocket costs. In Classic, they don't have to meet their deductible or copays. For the CDHP, because of IRS regulations, you are required to meet your deductible. But in general, we try to ensure that finances are not a barrier to anyone using this program as long as it takes place at one of those Centers of Excellence.

Just like the total joint replacement benefit, the Centers of Excellence Program is administered by Premera. They work with the member to gather their medical records and create a welcome packet. They basically hold the member's hand through the process even to the degree of helping with their travel itinerary, the hotel they'll stay at, and so forth, if travel is involved.

This is a voluntary benefit for folks. We hope we've created enough of an incentive and eliminated the barriers so members will use these Centers of Excellence. We've done

the work and they do meet the quality criteria. A member can still go to any provider within the Regence network who can provide this service, but they won't have the financial incentive, no out-of-pocket costs.

As a reminder, our goal with the Centers of Excellence Program is to encourage our members to use appropriate care, to use the best possible quality of care, and to design and create a program that is seamless and provides the best possible quality for the member.

Sue Birch: Marcia, I want to make a comment. I'm new to this state, the Centers of Excellence, and the bundles. Again, I commend you because we've now moved from one Centers of Excellence to the second with other possible services in this process. There's a movement that's happening with transformation and I think the fact that you all are building entities and partnerships around low cost and high quality is really where we're able to save as we bring all of health care into this venue of low cost, high quality, and we even things out. It's going to keep paying dividends for us and we'll be able to have those great flat premiums we're liking, or reduced premiums. I want to thank you all. It's fabulous to hear that we've now got another bundle.

Marcia Peterson: And great member experience, as well. I could go on and on about this, Dave knows, because I think this is such a great program for our members. It's exciting to see, you know with the first bundle, we had Virginia Mason, which is a great place. They provide great care, great quality. This time around we were pleased to see a community hospital like Capital come forward. So many of our members live in this area and go there anyway. Capital really stepped up. They worked hard to meet our criteria and the Bree criteria. That's exciting because our members may not want to travel to Seattle if they live here or in Thurston County. Lots of kudos to Capital and Orthopaedic Associates for stepping up.

Sue Birch: I want to remind Board Members that these procedures come with warranties. They guarantee their work. It's a fabulous concept in health care.

Medicare Retiree Health Benefits

Molly Christie, Strategic Plan Project Manager, Benefit, Strategy, and Design Section, ERB. In this presentation, I will discuss current enrollment in the PEBB Medicare plans, why we're evaluating the Medicare portfolio, why UMP Medicare rates have been increasing, how PEBB has tried to mitigate these growing costs, the declining value of the Retiree Drug Subsidy, Medicare retiree benefit options that other states have pursued, and our project timeline.

Slide 2 – PEBB Program Retiree Health Benefits. An evaluation of the PEBB Program retiree health benefits has been a work in progress since the beginning of this year. In January, staff presented to the Board, background information on retiree health benefits. In the 2018 legislative session, the Governor set aside funding for HCA to evaluate PEBB retiree coverage options. I'll share our goal for this evaluation, as well as our progress thus far.

Our goal is to better understand sustainable and supportive plan offerings, specifically for our Medicare retirees who make up approximately 90% of the PEBB Program retiree

population. This includes understanding reliable strategies for maximizing federal resources and stabilizing member premiums.

Slide 3 – PEBB Program Medicare Retiree Plan Offerings and Enrollment. As of June 2018, PEBB had approximately 93,000 members in its five retiree plans. There are four rows on the table, two of the plans are under Kaiser WA, the classic Medicare plan and the Medicare Advantage plan. The majority of members are in UMP Classic Medicare, more than half. All members in a PEBB Medicare plan must be enrolled in original Medicare to be eligible for our plans. This covers Medicare Part A, or inpatient and hospital services, and Medicare Part B, outpatient or physician services. The UMP Classic Medicare and the Kaiser Washington Plans are coordination of benefit plans, which means they're charged as a secondary insurer after Medicare.

In contrast, we have two Medicare Advantage plans, one under Kaiser WA and the other in Kaiser NW, which replaces original Medicare. They cover Medicare Part A and Part B and receive funding from the Centers for Medicare and Medicaid Services (CMA) to cover Medicare eligible costs for those plans.

We also have a Premera Supplement Plan F that helps offset out-of-pocket expenses for original Medicare, including deductibles and coinsurances. We have just over 14,000 members in Plan F. As a note, changes in federal law effective January 1, 2020 will prohibit new enrollees in Plan F for purchasing any national Medicare supplement plan off policy, so the OIC has recently released information that Washington can offer a new Plan G. Plan G is essentially identical to Plan F, but it doesn't cover Medicare Part B deductible. The average Medicare Part B deductible is about \$183. So that is a consideration.

I will discuss Medicare Part D Plans later in the presentation, but I will note that all four of our plans under Kaiser WA, UMP, and Kaiser NW offer creditable coverage, so they offer prescription benefits. They are not Part D benefits. They're not Medicare products. They have been deemed by CMS to be equivalent to, or as generous as, the standard Part D benefit, but they do not receive Part D subsidies.

Slide 4 – Why Evaluate PEBB Program? There are a number of compelling reasons. First, it's time. Medicare has changed a lot in the past decade or more, and so have this population of PEBB Medicare retirees. For instance, in 2006, CMS implemented Medicare Part D, the Medicare prescription drug benefit. It's available to all Medicare retirees. Prior to 2006, most Medicare retirees were receiving prescription drug coverage through an employer-sponsored retiree plan. Those that did not have access to an employer-sponsored plan did not have access to prescription drug coverage. So, Medicare Part D was introduced to fill that gap.

The Medicare retiree population, both within PEBB and nationally, has been changing since the introduction of Part D. The size of the population continues to grow. This is particularly as baby boomers reach 65. The retiree population is also aging, people today are living longer, they're living healthier, and that adds to the size of the population as well.

The second reason we're evaluating the PEBB Medicare Program has to do with the Retiree Drug Subsidy (RDS). The RDS Program was introduced alongside Medicare

Part D with the intent to incentivize employers that offered prescription drug coverage to their Medicare retirees to continue doing so. In order to incent these employers to continue offering prescription drug coverage, CMS would essentially refund 28% of allowable drug costs. Many employers took advantage of that at the time. There are fewer and fewer offering prescription benefits to retirees through an RDS plan.

Carol Dotlich: Could I stop you for a moment? You said 28%? What was that figure again?

Molly Christie: Up to 28% of allowable drug costs.

The point of all this is as prescription spending increased, the value of the Retiree Drug Subsidy has declined. What we get back from the subsidy and how we can pass it on to members in terms of the cost of their plan, the out-of-pocket they're spending, is declining. There may be other options such as Medicare Part D subsidies that would provide greater value. We will explore those.

As we've discussed throughout the Board season, volatility in the prescription drug market is resulting in instability in member premiums. We understand this is a particular challenge for PEBB Medicare retirees on fixed incomes.

To illustrate this last point, the chart on Slide 5 – UMP Classic Medicare Rates reflects UMP Classic Medicare rates since 2012. It's broken down by pharmacy and medical costs. The pharmacy costs are in dark blue, the medical costs are in light blue, and these are total rates excluding the \$5 HCA admin fee, and not including the explicit subsidy. In other words, these are not broken down by employer versus retiree paid. I'd like to note a large portion, which is more than half for most of these years, of the bid rate is attributed to prescription spending. This portion has been steadily growing. There has been an increase of almost \$100 since 2012, whereas at the same time when you look at the medical costs, the portion of the bid rate attributed to medical has been relatively stable. It was around \$180 in plan year 2013 and it's within \$10 of that (\$189) for 2019.

What this shows us is that with prescription drug volatility, where we're going to see the increase in premiums, is primarily due to prescription spending. There is the market factor. We're seeing the prices for prescription drugs go up, the utilization of specialty drugs increase, new specialty drugs entering the market, but also the PEBB UMP Classic Plan is the only source of prescription coverage for Medicare retirees enrolled in that plan. They don't get prescription coverage through Medicare. Essentially, we're seeing Medicare helping cushion the costs of our medical services of that part of the premium because we're secondary payer. That's not the case for prescriptions. That's where a lot of this growth is occurring.

And another point is that volatility, when I use this term, I don't necessarily mean a straight upward trend. You might see some dips, you might see some unexpected numbers, and I think that is a large part of it, it's unpredictable. This upward trend has been relatively sharp in the past few years. Luckily, in plan year 2019, we're going to see it level off. I will temper that by saying that downward trend may not continue because there is so much uncertainty with prescription drugs right now.

Tom MacRobert: I'm looking at this chart and I'm curious if you can explain. If you look at the prescription drug amounts, they are actually fairly stable – slight increases, but then, between 2017 and 2018, you had a \$51 increase. It's a big jump. Other years not so much. What caused a significant jump in that particular year?

Molly Christie: That's a great question. I don't have the answer.

Sue Birch: I believe it's specialty drugs. I wish Ryan or Donna were, but I believe it's the specialty drug advances. We can get back to you with more information in that because Ryan or Donna will have some information.

Dave Iseminger: I do think it's specialty drug, but we'll get clarity back to the Board.

Sue Birch: I do want to comment. There was information out this morning about Medicare releasing a new study on driving towards value-based formularies and trying to contain pharmacy pricing with moving toward generics and a few other things on the Medicare side. I will ask staff to come back to us with actions we can take to try to reign in our pharmacy spend so we get the best value for our members. I will ask you all to pull that together. I can't find it right now, but information released this morning. Medicare has definitely started to talk about moving towards generics and moving towards value-based formularies. I'm sure that issue will be coming back to the full Board.

Molly Christie: Slide 6 – Cost Mitigation Strategies. There are two major strategies PEBB has been using to mitigate increasing Medicare costs. On the state side, there is the Retiree Drug Subsidy, which we discussed earlier. PEBB Medicare health plans with creditable drug coverage participate in the RDS and the state receives approximately \$21M each year deposited into the state general fund. The explicit subsidy is another strategy that helps reduce member out-of-pocket spending on Medicare plan premiums. In 2018, the Legislature increased the explicit subsidy from \$150 to \$168 effective 2019. However, the cost of this increase alone was nearly equal to the money the state received in RDS revenue in a single calendar year. There is some canceling out of the revenue that the state received through RDS and the expenditure on the increase in the explicit subsidy.

Tom MacRobert: You keep referring to this as a one-time increase, but I'm assuming it's going to remain \$168 going forward. It's not going to drop back to \$150. A one-time increase would be just for this coming year and it would change again.

Dave Iseminger: We talked about that exact wording of the slide. The Legislature hasn't taken an action to change it for several years and then this was the change, and just because they made this change doesn't mean that they wouldn't necessarily make another change up or down. The outlook shows they moved it from \$150 to \$168, but as we know, in any specific budget cycle, anything can change. It was trying to convey that there's not an assumption that there would be another increase just because there was an increase this last legislative cycle.

Molly Christie: Slide 7 – Explicit Subsidy Impact on UMP Medicare Premium. This slide illustrates why the state is at risk of not qualifying for the Retiree Drug Subsidy in

future years. The retiree-paid portion of the Medicare premium is represented in dark blue and the state-paid portion, also known as the explicit subsidy, is represented in light blue. UMP Medicare premiums have been increasing sharply in recent years. They leveled off in 2019, primarily driven by increasing prescription spending. As the retiree-paid portion, the dark blue bar, increases and the light blue bar does not increase at the same pace, UMP Medicare is at risk of no longer qualifying for the RDS. I will provide a caveat to this and this is specifically for the UMP Medicare plan. It's more dire for UMP Medicare, less so for the Kaiser plans that also participate in the RDS program. The \$18 increase in the explicit subsidy helped offset premium costs and it will help offset the premium costs in plan year 2019. Additional increases to the explicit subsidy will likely be required to maintain eligibility for RDS past 2019.

Carol Dotlich: Can you tell me why the difference between the Kaiser plans and the UMP? Why one will qualify and the other will not?

Molly Christie: They are better able to contain costs for prescription spending. Their premiums haven't risen at the same pace as the UMP premiums.

Carol Dotlich: But I thought they had a jump in their premium price a year ago.

Molly Christie: Yes. It has to do with measuring against the standard Part D benefit as the benchmark. Our plans have become very expensive compared to the Standard Part D benefit and the Kaiser plans. Their prescription coverage is not quite as expensive compared to that Part D benefit.

Dave Iseminger: Carol, the other piece is that Kaiser plans replace A and B. Rather than being a coordination of benefit secondary, they actually qualify for multiple federal streams of funding. It's not just the RDS subsidy. They have multiple ways and multiple funding sources to help offset premium increases that members may experience that are not funding streams available under the current structure of the UMP Classic Medicare plan. That helps absorb the shock that members may experience from a premium increase. There are more financial funding streams that the A / B replacement plans have that a creditable coverage plan does not.

Carol Dotlich: Does that make Kaiser a Medicare Advantage Plan?

Molly Christie: We have two Kaiser Medicare Advantage Plans. They have prescription drug coverage, but it's not Part D drug coverage. You can have a Medicare Advantage Plan with or without drug coverage. The prescription drug coverage can either be Part D coverage or it can be creditable drug coverage. The subsidies for each of those are different. If it's a Part D plan, there's specific Part D subsidies. If it's creditable drug coverage, there's the RDS.

What Dave is saying is, for Advantage plans, they get subsidies for Medicare A and B because they cover those as well. The way the bidding process works for those, if there's additional money left over, they split that with CMS and then they need to use that money to either make their plan more generous or reduce the cost of their plan. Medicare Advantage plans tend to have more generous Part D coverage when they offer Part D, than, for instance, a standalone Part D plan because they have a little bit more wiggle room.

Slide 8 – State Spending on Explicit Subsidy vs. RDS Revenue. This graph shows the state expenditure on the explicit subsidy, represented by the green trend line. It has been increasing. RDS revenue, in blue, has remained flat. The assumed upward trend in the state expenditure, is based on potentially necessary increases to the explicit subsidy to maintain RDS revenue eligibility, as well as 4% retiree population growth. As the former slide showed, increases in the explicit subsidy would likely be required to maintain eligibility for the RDS after 2019. However, the revenue from the RDS is unlikely to increase and that causes a gap between state expenditure and state revenue for Medicare plans. Recent years have seen a steep decline in the number of states and large employers that participate in RDS. Between 2010 and 2017, the number of Medicare beneficiaries whose employers received RDS fell from 6.8 million to 1.6 million. And in 2017, approximately 2.7% of all Medicare beneficiaries were enrolled in plans receiving the RDS, whereas 72.5% were receiving their prescription benefits through Part D plans.

Twelve states offer prescription drug coverage to Medicare retirees through an RDS plan. Eight of those states have an RDS plan only. That's the only way they offer prescription benefits. The remaining states have a combination of an employer group waiver plan and an RDS plan.

Carol Dotlich: With the prescription drug costs going up, there have been a lot of advances in prescription treatments for people, drugs that have actually cured diseases that people suffered with long term. Do you see an opportunity for the prescription drug cost trend to go down as a result of some curative ability of the newer drugs?

Molly Christie: I don't know if the prescription drug costs would go down. I think medical costs will go down if you're having drugs that are curing, for instance Hepatitis C. Associated costs for treating Hepatitis C throughout a patient's life are extremely high. The cost of medication to cure it is also extremely high, but it may be offset by no longer having to treat the disease. I see it as a possibility. I don't know if it means that the price of the prescriptions themselves would go down.

Dave Iseminger: I think that's a good attempt at that one. I think this is another example of there is no real general answer to that question. It's going to be very case specific because it's going to be what is the price of that drug versus the overall plan cost. If you're trying to parse out overall plan costs going down because it goes up in one area or down in another area, and just because it does that on one drug doesn't mean it will do it on the next drug or the next disease state. That's an interesting piece for us to consider, Carol. That's a really tough one to predict on even a general basis because it will vary from drug to drug and disease state to disease state.

Carol Dotlich: I'm not seeing huge increases in the medical costs on your chart. I see the increase in the pharmacy. Am I wrong about that?

Molly Christie: No, you're not. That's absolutely what it's showing and I think a big part of that is because we're secondary. We're paying secondary to Medicare. They're insulating us from a lot of the medical costs. Medical costs may still be going up and are likely still going up, but Medicare A & B, original Medicare is covering most of that before the UMP Medicare plan has to pay out.

Sue Birch: I would ask staff to confer with our pharmacy specialists because of the nationally acclaimed DUR Program, which is a Drug Utilization Review group that we participate in. There'll be some information that can come back to the Board. Carol, especially on this kind of harbinger of what's to come around prescription costs. I believe we can get better information from Ryan and/or Donna or our physician team because I've seen information out there and I bet we could make an article or two available because I think the future looks very bleak around pharmaceutical pricing without explicit federal activity. I don't see that coming either.

Molly Christie: Slide 9 – What Other States Are Doing. How are other states providing retiree benefits to their Medicare retirees. One option is the Employer Group Waiver Plan, commonly referred to as the egg whip (EGWP). EGWPs are self-insured or fully insured Part D products and authorized by CMS. They're available only to an employer's retirees. There is a provision for Part D plans that on the individual market, the Part D plan has to be available to all Medicare beneficiaries within the service area. For UMP, that would be an issue because we have UMP members across the country and internationally. With an EGWP, the plan only has to offer that coverage to the retirees. It doesn't have to offer to everybody nationally who is a Medicare beneficiary. EGWPs also have an optional wraparound provision, the EGWP Plus Wrap, which allows for benefits similar to an employer's current prescription coverage, so there is a bit of customization that is possible with an EGWP.

Between 2010 and 2017, Medicare retiree enrollment in EGWPs grew from 2.4 million to 6.8 million. They are becoming more popular. There's also the Medicare Advantage Plus Part D (MA-PD) plan which I mentioned earlier. An MA-PD is a one-stop shop for all of your Medicare benefits. You have your original Medicare Part A and B, as well as prescription drugs. The prescription drug benefit is the standard defined Part D benefit. Many Medicare Advantage plans offer enhanced benefits for the standard Part D benefit and beyond those that are offered by standalone Part D plans. 35 states have implemented either an EGWP or an MA-PD for retired Medicare eligible public employees.

Part D plans have become more attractive to employers partly because CMS offers a direct subsidy. It's a prospective risk adjusted direct subsidy and a reinsurance subsidy to Part D plans that aims to cover 74.5% of the cost of basic benefits. There's also manufacturer discounts available to Part D plans under the Affordable Care Act. This is the coverage gap discount program, the 50% manufactured discounts for brand name drugs that's in the donut hole. And these help reduce or offset plan and member costs in that donut hole period of the standard Part D benefit. To reiterate, PEBB doesn't offer any Part D prescription drug coverage. We have creditable drug coverage so we do not currently have access to these Part D subsidies or the coverage gap discount program. Finally, there's the private exchange option.

These are common options although the private exchange has only been implemented in one state. This is a portfolio of group coverage Medicare plans, so including supplemental plans, Part D plans, Advantage plans managed by insurance carriers or consultants and these do allow for greater plan choice compared to a typical employer offering for retirees. For instance, at the beginning of this meeting I went on one of the exchanges and said I was a 65-year old man looking for benefits, I live in Olympia, I

have no disability, and the results were nine Medigap plans, the supplement plans; 16 standalone Part D plans; and 20 Medicare Advantage plans.

Sue Birch: Can you share what particular state you were referring to?

Molly Christie: Nevada.

Sue Birch: Nevada has this. Thank you.

Molly Christie: Slide 10 – Timeline. We're in the evaluation stage, the bright blue on the left-hand side. Through the end of the year, we'll be evaluating options. We will present options, one or more to the Board in January. 2019 activities listed on this timeline are subject to legislative action and Board approval. 2020 is implementation and hopefully launch of a new portfolio, or change the portfolio in 2021.

Dave Iseminger: Chair Birch, can I ask that we take a five-minute recess? We have one more item we need to bring to the Board. We're finalizing it now.

Break

Sue Birch: Dave, we have something to add in. Take it away.

Dave Iseminger: We don't have the Board vote on benefit changes typically because they are wrapped into the inherent endorsement of the rates. However, the change to the dental benefit doesn't have a corresponding rate resolution. In order for the Class 3 benefit to change in the Uniform Dental Plan, the Board has to take action to change the benefit. I apologize for bringing this without giving you a week to review. I think it's a very straight forward concept, but we can answer any questions you have. This resolution is to ask the Board to adopt the change in Class 3 restoration limits. Change it to five years from seven years. The change would be effective the first of the coming plan year.

This is a Uniform Dental Plan only change because the five-year limitation on Class 3 already exists within the two managed care plans. This is aligning this change to the other parts of the portfolio. We've described it but not in resolution format at the prior meetings and past presentations.

Sue Birch: Dave, could you remind the Board what dental plan Class 3 includes?

Dave Iseminger: Crowns are an example.

Sue Birch: Resolution PEBB 2018-14 – Uniform Dental Plan. **Resolved that,** beginning January 1, 2019, the Uniform Dental Plan Class 3 Restoration Limit will be five years.

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

Voting to Approve: 7

Voting No: 0

Resolution PEBB 2018-14 passes.

Public Comment

Maria Britton, Executive Director, Retired Public Employees Council of Washington. I had a question regarding the Medicare Retiree Health Care Benefit. On Slide 8 of that presentation, am I correct in thinking that most likely we will not get the RDS because the state subsidy will be \$168, but the amount required is \$192?

Sue Birch: No, I don't think that is correct. This information is informational only and staff is preparing the Board for further information. I think they were just trying to show the spend on the subsidy versus the RDS revenue. I think it's dangerous to infer any conclusions at this point. Is that correct, Molly?

Molly Christie: Yes.

Maria Britton: Okay. I'm also wondering is there a reason that the Kaiser and Medicare Advantage plans don't use Part D? Is it a rule or is there a reason why they don't?

Beth Heston: As the Kaiser contract manager, I can tell you that their benefit is actually richer than Part D's requirement.

Maria Britton Sipe: Okay, so they wouldn't get more of a benefit if they went through that? It wouldn't be cheaper for the plan? The insurance? Okay. And then I wanted to clarify on the EGWP, Slide 9. Did you say that retirees who, if they were under that, would have to stay local to get the coverage?

Molly Christie: No, they don't have to stay local which is one of the nice things about it. They can still live wherever they want in the country. Internationally could potentially be a problem. It is complicated now. But what's nice about the EGWP is the plan itself wouldn't have to be offered to all Medicare retirees where one of our Medicare retirees lives. It would only be for PEBB Medicare retirees.

Maria Britton Sipe: Okay. And finally, I just wanted to share that in terms of the Exchange, that would not be something that many of our members would find attractive. That's one of the reasons so many of them go to UMP because their cognitive level is declining. Having that much choice and being that overwhelmed is extremely scary for a lot of them. I just wanted to share that. Thank you very much for your time.

Sue Birch: Thank you for those comments. I want to remind the Board Members that the next meeting is September 17 in the afternoon. Thank you, Dave for all your leadership and to your team for doing such a great job. We are thrilled to be saving the state about \$20M and to be doing good work for all of our members. Thank you very much.

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