Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Retired and Disabled School Employees Risk Pool Analysis

December 15, 2018

Engrossed House Bill 2242; Chapter 13, Laws of 2017;

RCW 41.05.022(4)

Retired and Disabled School Employees Risk Pool Analysis

Washington State Health Care Authority

Financial Services Division
P.O. Box 45510
Olympia, WA 98504
Phone: (360) 725-9817
Fax: (360) 586-9551
hca.wa.gov

Table of Contents

Executive Summary

The Washington State Health Care Authority (HCA) is submitting this report to the appropriate committees of the Legislature as required by Engrossed House Bill 2242 (2017), and codified by RCW 41.05.022(4) "State agent for purchasing health services – single community-rated risk pool." The statute requires that:

> "By December 15, 2018, the health care authority, in consultation with the board, shall submit to the appropriate committees of the legislature a complete analysis of the most appropriate risk pool for the retired and disabled school employees, to include at a minimum an analysis of the size of the non-Medicare and Medicare retiree enrollment pools, the impacts on cost for state and school district retirees of moving retirees from one pool to another, the need for and the amount of an ongoing retiree subsidy allocation from the active school employees, and the timing and suggested approach for a transition from one risk pool to another."

HCA initially took a broad approach and identified five possible risk pool scenarios for the retired and disabled school employees:

Option 1: Create a non-Medicare community-rated risk pool under the SEBB Program comprising school employees and school non-Medicare retirees. The other current PEBB Program non-Medicare retirees and *all* Medicare retirees would remain in their designated pools under the PEBB Program.

Option 2: Continue covering school retirees[1] in the PEBB Program risk pools, as stated in RCW 41.05.022(2) and RCW 41.05.080(3).

Option 3: Create two risk pools under the SEBB Program: a non-Medicare community-rated pool comprising school employees and school non-Medicare retirees, and a pool of school Medicare retirees. The other current PEBB Program non-Medicare and PEBB Program Medicare retirees would remain in their designated pools under the PEBB Program.

Option 4: Create three risk pools under the SEBB Program: one pool of school employees, one pool of school non-Medicare retirees, and one pool of school Medicare retirees. The other current PEBB Program non-Medicare and PEBB Program Medicare retirees would remain in their designated pools under the PEBB Program.

Option 5: Create one risk pool under the SEBB Program comprising all school employees and retirees, regardless of Medicare eligibility. The other current PEBB Program non-Medicare and PEBB Program Medicare retirees would remain in their designated pools under the PEBB Program.

[1] For purpose of this report and to improve clarity and understanding of the analysis, the statutory language of "retired and disabled school employees" is simplified to "school retirees".

Recommendation

After completing our analysis of the scenarios and consulting with the PEB Board and SEB Board during a joint meeting on September 17, 2018, HCA finds that Option 1 is the most appropriate future state risk pool structure for retired school employees. Due to the statutory, budget, and time constraints described in this report, HCA believes this risk pool structure could be in place by January 1, 2022 at the earliest. The current risk pool structure, outlined in Option 2, should continue to be in place until the constraints associated with Option 1 are addressed and resolved.

This report details the five options listed above and reports on the size of the non-Medicare and Medicare enrollment pools. It also analyzes the cost impacts associated with proposed risk pool changes, the need for and the amount of an ongoing subsidy allocation from active school employees, and the timing of and suggested approach to implementation.

Background

HCA is the designated single state agent for purchasing health services. On January 1, 1995, the Legislature required that certain state-purchased health programs merge into a single community-rated risk pool. The risk pool comprised:

- State employees
- Employees of school districts and educational service districts (ESDs) that voluntarily purchase benefits through the state
- Eligible retired and disabled school employees not eligible for Medicare parts A and B
- State retirees not eligible for parts A and B of Medicare.

Currently, when a school employee retires prior to becoming eligible for Medicare they can choose to become a PEBB Program subscriber and select PEBB Program medical plans within the PEBB Program non-Medicare risk pool. If a school employee retires and is eligible for Medicare, they can choose to join the PEBB Program Medicare risk pool and select PEBB Medicare medical plans. Retirees in the PEBB Program benefit from one of two subsidies depending on the risk pool in which they participate.

Non-Medicare retiree subscribers receive an implicit subsidy through community-rated plan premiums. The non-Medicare premium rates reflect the average cost of the entire risk pool, and the vast majority of the population in the PEBB non-Medicare risk pool are active employee subscribers and their dependents. The active employee subscribers and their dependents are typically younger and utilize fewer services compared to retiree subscribers, which drives costs down for the pool as a whole.

The rates for Medicare-eligible retired or disabled state or school employees are calculated separately. The PEBB Program Medicare risk pool includes only individuals eligible for Medicare parts A and B (RCW 41.05.080[3]). Medicare retiree subscribers receive an explicit subsidy, which is a dollar amount set by the Legislature or 50 percent of their plan premium, whichever is less. HCA collects the subsidized premium contribution from the retiree subscriber and pays the health plan the full premium rate.

With the passing of EHB 2242 (2017) and ESSB 6241 (2018), codified by RCW 41.05.022(3), health benefits for school active employees will be merged into a single community-rated risk pool—separate and distinct from the two risk pools in the PEBB Program.

K-12 Remittance

In 1993, the Washington State Legislature passed the K-12 Retiree Insurance Act establishing subsidized health insurance coverage for school district retirees. School districts and educational service districts (ESDs) are required by RCW 28A.400.410 to pay a specified amount, or allocation, to HCA to fund the retiree subsidies provided through the PEBB-managed programs. The subsidy allocation is often referred to as the "K-12 remittance."

The K-12 remittance provides revenue to fund both the implicit and explicit subsidies received by K-12 retirees enrolled in PEBB Program medical plans. Payment of the K-12 remittance is required from the

school districts or ESDs for each benefits-eligible K-12 employee, regardless of their funding source (state vs. local). However, school districts or ESDs that have elected to join the PEBB Program and enroll their active employees do not pay a separate monthly K-12 remittance.

Approximately 81 percent of the K-12 remittance that is collected from school districts and ESDs contributes to the explicit Medicare subsidy received by school retirees enrolled in PEBB Program Medicare plans. The additional 19 percent of the collected amount offsets the increased costs incurred by the school non-Medicare retirees that have higher utilization and cost relative to the PEBB non-Medicare risk pool as a whole. The amount collected to offset this amount is known as the "implicit subsidy" component of the remittance.

HCA calculates a suggested amount for the K-12 remittance. The calculation divides the estimated total value of the subsidies received by PEBB Program retirees by the total estimated active-employee count for both the PEBB Program and the K-12 school districts not participating in PEBB.

Although HCA calculates the suggested K-12 remittance value, the Legislature ultimately chooses the final amount specified in the state operating budget. The amount in the state operating budget is per full-time benefits-eligible (by district) school employee, with a prorated amount for eligible part-time employees. The prorated amount for part-time employees depends upon the prorated share of benefit contribution they receive from their districts.

Analysis

PEBB Program Enrollment

As of August 2018, the PEBB non-Medicare risk pool includes approximately 283,400 active and retired members. Of that number, approximately 133,000 are subscribers and the remaining are their dependents. The Medicare risk pool includes approximately 95,000 members; 68,000 of those members are subscribers and the remaining are their dependents.

Detailed breakdowns of the populations within each risk pool by member group are in Tables 1 and 2.

Table 1: Member Enrollment by Group — PEBB Program Non-Medicare Risk Pool, as of August 2018

Group	Approximate Enrollment Count	Percent Enrollment
State Employees (and their dependents)	234,000	83%
Other Employees* (and their dependents)	40,000	14%
State non-Medicare Retirees (and their dependents)	4,800	2%
School non-Medicare Retirees (and their dependents)	4,000	1%
Other non-Medicare Retirees** (and their dependents)	600	0%
Total Non-Medicare	**283,400**	**100%**

*Other Employees includes political subdivision, K-12, COBRA, LWOP, etc. employees and their dependents
**Other Retirees includes political subdivision retirees and their dependents

Table 2: Member Enrollment by Group — PEBB Program Medicare Risk Pool, as of August 2018

Group	Approximate Enrollment Count	Percent Enrollment
State Medicare Retirees (and their dependents)	43,550	46%
School Medicare Retirees (and their dependents)	48,000	51%
Other Medicare Retirees* (and their dependents)	3,000	3%
Total Medicare	**94,550**	**100%**

*Other Medicare Retirees includes political subdivision retirees and their dependents

Non-Medicare Retiree Risk Pool Claims Costs and Risk Scores

HCA reviewed claims costs and risk scores from calendar year 2017 across the different subgroups within the PEBB Program non-Medicare risk pool (Appendix B).

A risk score is a calculated number that is reflective of the amount of morbidity—i.e., the rate of disease or rate of "unhealthiness"— within a specific population. Risk scores are calculated based on demographic information, diagnosis codes, drug codes, and health care utilization. Populations with higher average risk scores typically have higher claims costs. Risk scores provide a method of estimating

expected claims costs for a population based on historically reported conditions, which adds additional context to the claims costs.

Numerical risk scores describe expected claims costs relative to the population average. For example, if we set the PEBB Program non-Medicare risk pool average risk score to 1.0, a member with a risk score of 1.5 is predicted to have claims utilization 50 percent higher than the average. The higher-than-average expected claims utilization is a result of the member's age, gender, and medical history.

In this analysis, we found that K-12 non-Medicare retirees had higher-than-average risk scores (Appendix B) and are expected to utilize approximately 70 percent more services than the current PEBB Program non-Medicare risk pool average. In addition, historically, K-12 non-Medicare retiree claims costs have been 30-40 percent more than the risk pool average. The state non-Medicare retirees also had higher-than-average risk scores, are expected to utilize 85 percent more services than the current non-Medicare risk pool average, and have generated claims costs 50-60 percent higher than the pool average.

Medicare Retiree Risk Pool Medical Benefits Cost

HCA analyzed the gross annual benefits costs of the PEBB Medicare retirees under the current Medicare subsidy structure. The medical benefits costs include self-insured medical claims, premiums paid for fully insured medical plans, and administrative costs associated with self-insured medical plans. School Medicare retirees make up 51 percent of the Medicare retiree risk pool. State Medicare retirees make up 46 percent of the Medicare retiree risk pool. Retirees from political subdivision employer groups make up the remaining 3 percent.

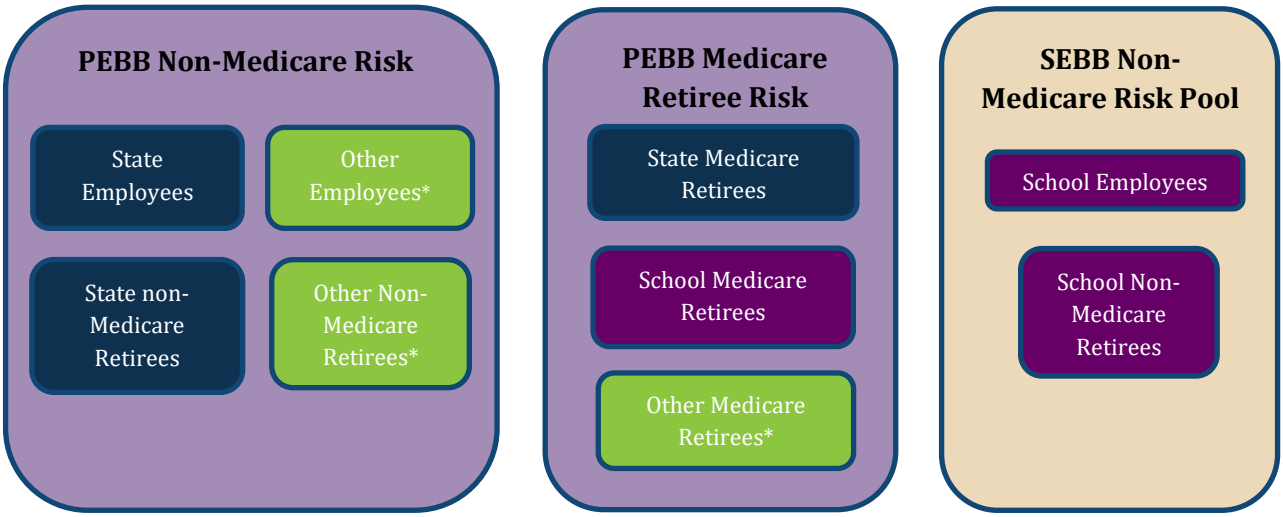
HCA found the total annual cost of school Medicare retirees was approximately 3 percent more than the total annual cost of state Medicare retirees. This cost difference is likely due to higher enrollment and variation in demographics, morbidity, and plan selection between the two populations.

Possible Risk Pool Scenarios

Option 1

- Create a non-Medicare community-rated risk pool under the SEBB Program comprising school employees and school non-Medicare retirees. The other current PEBB Program non-Medicare retirees and *all* Medicare retirees would remain in their designated pools under the PEBB Program.

Figure 1: Option 1 Risk Pools



*Other Employees includes political subdivision, K-12, COBRA, LWOP, etc. employees and their dependents
**Other Retirees includes political subdivision retirees and their dependents

Cost Impacts to State and School Retirees

As shown in Table 1 on page 5, there are approximately 283,400 members in the PEBB non-Medicare risk pool of which 4,000 are school non-Medicare retirees and their dependents. HCA estimates there will be approximately 140,000 eligible employees under the SEBB Program on January 1, 2020. If the SEBB Program population enrollment tier mix is similar to what is seen in the PEBB Program population when including dependents, it is likely that the SEBB active employee risk pool anticipated for plan year 2020 will have more than 200,000 members.

First, HCA considered cost impacts to the state non-Medicare retirees in the PEBB non-Medicare risk pool. Based on 2017 risk scores (Appendix B), we expect the K-12 early retiree population to utilize 65-70 percent more services than the PEBB non-Medicare risk pool average and their historical claims costs to be 30-40 percent higher. The presence of higher utilizers in the pool likely increases the blended premium rates. Our analysis of the per capita cost impact (Appendix B) indicates that removing the school non-Medicare retirees from the PEBB non-Medicare risk pool would reduce the overall cost of the PEBB non-Medicare risk pool by 0.5-1.0 percent.

Next, HCA considered cost impacts to the school employees and non-Medicare retirees in the new SEBB non-Medicare risk pool. Active school employees would experience an increase in premiums of similar

magnitude to the decrease noted above—assuming no sudden substantial growth in early school retirees. This increase in premiums is due to the increased average cost associated with retirees. Since they would no longer be in a non-Medicare risk pool with state non-Medicare retirees, school retirees could find that their premiums are lower than they would have been in the PEBB non-Medicare risk pool.

HCA recognizes there could be positive impact on member experience under this option. School retirees who are not yet eligible for Medicare would likely have the option to continue to choose from the plans offered to them under the SEBB Program while they were employed. During the joint PEB Board and SEB Board consultation on September 17, 2018 (Appendix A), we received feedback from several board members that the ability to continue enrollment in the same plans during early retirement years before an individual is Medicare eligible is of value.

HCA notes that, based on risk score analysis, we can make assumptions about the impact different populations may have on a SEBB non-Medicare risk pool, but the major cost drivers for this risk pool are the risk scores of the active school employees and the cost effectiveness of the HCA procurement process.

Lastly, at this time the HCA believes this option could be implemented without specific new additional funding.

Retiree Subsidy Allocation

If the school non-Medicare retirees were combined in a community-rated risk pool with the school active employees, the "implicit subsidy" portion of the K-12 remittance collected on their behalf and paid to the PEBB Program would no longer be needed. The method by which the K-12 remittance is calculated would need to be adjusted to account for funding the explicit subsidy only. As an example, for fiscal year 2019, the K-12 remittance is $68.67 per benefits eligible employee per month. The estimated portion of the remittance that accounts for the implicit subsidy is 19 percent. If the implicit subsidy portion of the K-12 remittance were no longer required, that would reduce the suggested remittance amount by approximately $13 per benefits eligible employee per month.

Timing and Approach

Option 1 requires careful consideration with regard to implementation, timing, and approach. In addition, legislative action would be needed to change existing statute (RCW 41.05.022[2]).

The terms of the SEBB Program collective bargaining tentative agreement preclude implementation of the option prior to January 1, 2022.

A January 1, 2022 effective date for the creation of a SEBB non-Medicare risk pool will allow HCA's Employees and Retirees Benefits Division an appropriate amount of time to communicate changes to members. There is a small population of school non-Medicare retirees enrolled in PEBB Program medical plans. These members would likely be required to change medical plans under the new statute. Communicating the change is important to allow members ample time to make the right decisions for

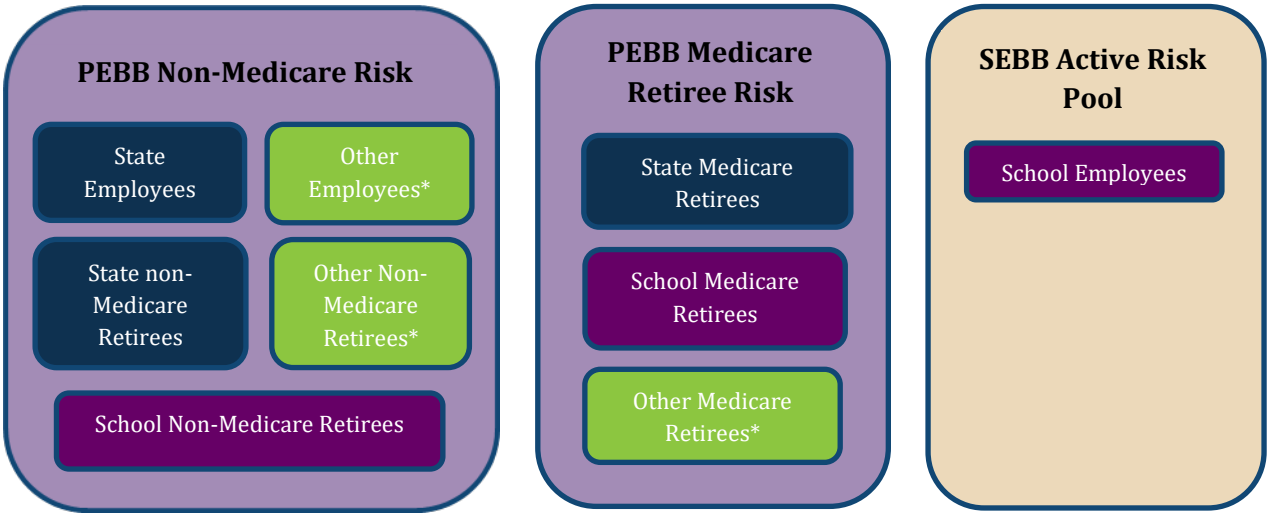
their families. Alternatively, a decision could be made to "grandfather" retirees who are already in the PEBB non-Medicare risk pool.

Last, HCA updates the contracted rates for medical plans annually. Changes to the risk pools will require communication with contracted carriers, contract updates, and updates and/or adjustments to rate development methodologies. Moreover, the SEBB system of record must be able to receive and process all rates.

Option 2

- Leave school retirees in the PEBB Program risk pools as stated in RCW 41.05.022(2) and RCW 41.05.080(3).

Figure 2: Option 2 Risk Pools



*Other Employees includes political subdivision, K-12, COBRA, LWOP, etc. employees and their dependents
**Other Retirees includes political subdivision retirees and their dependents

Cost Impacts to State and School Retirees

Option 2 currently exists for school retirees. In this scenario, the school non-Medicare retirees, other current PEBB Program non-Medicare retirees, and *all* Medicare retirees would remain in their designated pools under the PEBB Program (RCW 41.05.022[2]).

Given that this option maintains the status quo, state and school retirees would not incur new costs as a direct result of the risk pool structure.

Retiree Subsidy Allocation

In this scenario, both implicit and explicit subsidy amounts would still need to be paid to the PEBB Program. The methodology for calculating would remain the same as it is today.

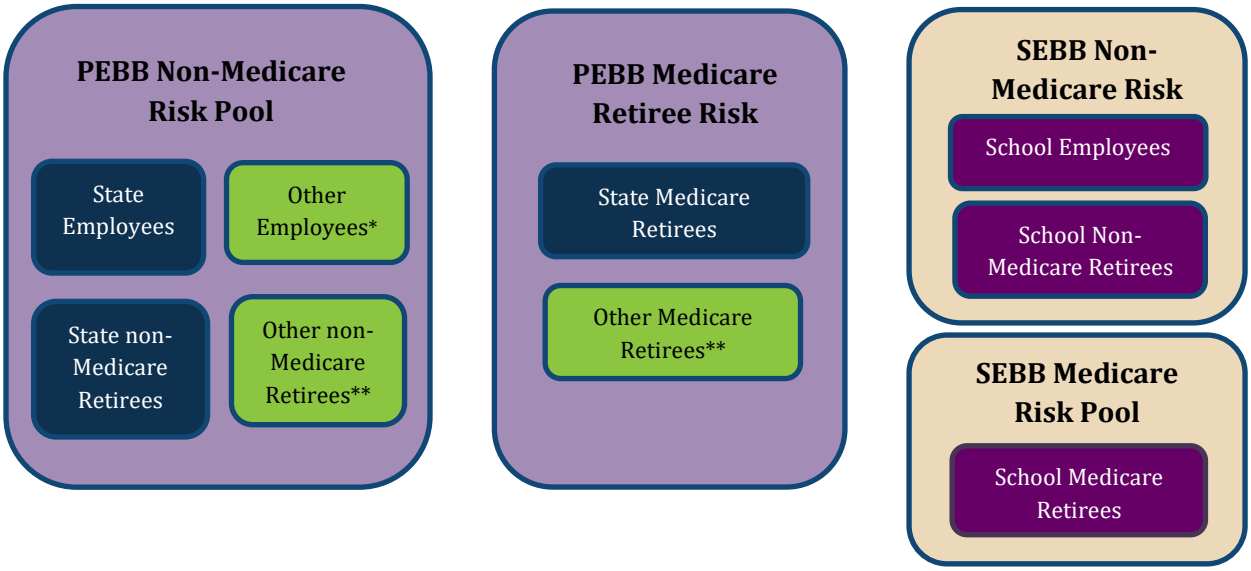
Timing and Approach

Unless affirmatively changed by the Legislature during the 2019 legislative session, the risk pools described above will be active on January 1, 2020.

Option 3

- Create two risk pools under the SEBB Program: a non-Medicare community-rated pool comprising school employees and school non-Medicare retirees, and a pool of school Medicare retirees. The other current PEBB Program non-Medicare and PEBB Program Medicare retirees would remain in their designated pools under the PEBB Program.

Figure 3: Option 3 Risk Pools



*Other Employees includes political subdivision, K-12, COBRA, LWOP, etc. employees and their dependents
**Other Retirees includes political subdivision retirees and their dependents

HCA considered the cost impacts of this change. Currently the state Medicare retirees and school Medicare retirees have similar enrollment (Table 2) and similar gross annual cost per retiree. HCA values the purchasing power associated with a single larger pool and sees no positive financial outcome for retirees by separating groups of similar risk and cost.

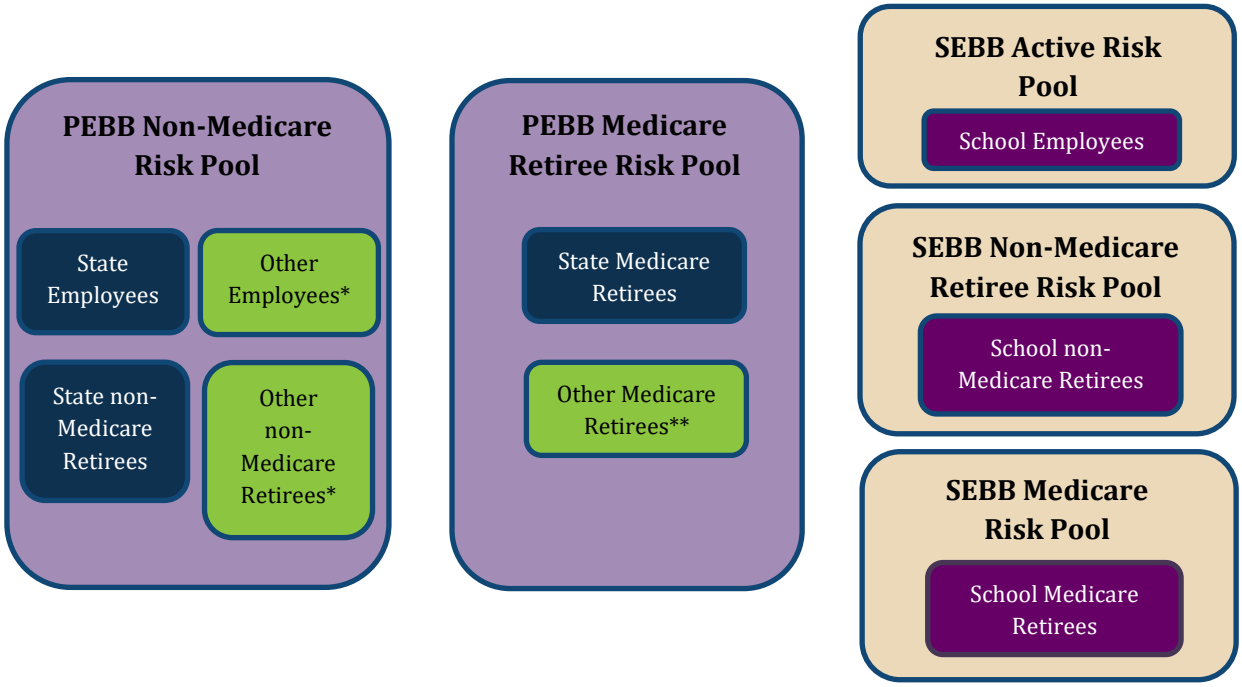
In addition, there would be new implementation and ongoing administrative costs associated with this scenario, as the SEBB Program would need to procure Medicare plans, manage additional contracts, and establish rates for the separate risk pool populations.

Also important to note, HCA is currently analyzing options for updating the PEBB Program Medicare portfolio.

Option 4

- Create three risk pools under the SEBB Program: one pool of school employees, one pool of school non-Medicare retirees, and one pool of school Medicare retirees. The other current PEBB Program non-Medicare and PEBB Program Medicare retirees would remain in their designated pools under the PEBB Program.

Figure 4: Option 4 Risk Pools



*Other Employees includes political subdivision, K-12, COBRA, LWOP, etc. employees and their dependents
**Other Retirees includes political subdivision retirees and their dependents

HCA considered the cost impact to school retirees in this scenario. As described above, the school non-Medicare retirees currently in the PEBB non-Medicare risk pool receive medical benefits at a favorable blended premium rate. Per 2017 claims data, the average risk score and the average cost for this population is higher than the average of the entire PEBB non-Medicare risk pool (Appendix B). If carriers rated the school non-Medicare retirees in a separate and distinct risk pool, as would occur under this scenario, there would be a significant increase in their premiums. HCA estimates a 58-60 percent increase to school non-Medicare retiree premiums in this scenario. The increased cost of benefits would make the plans unaffordable for many retirees.

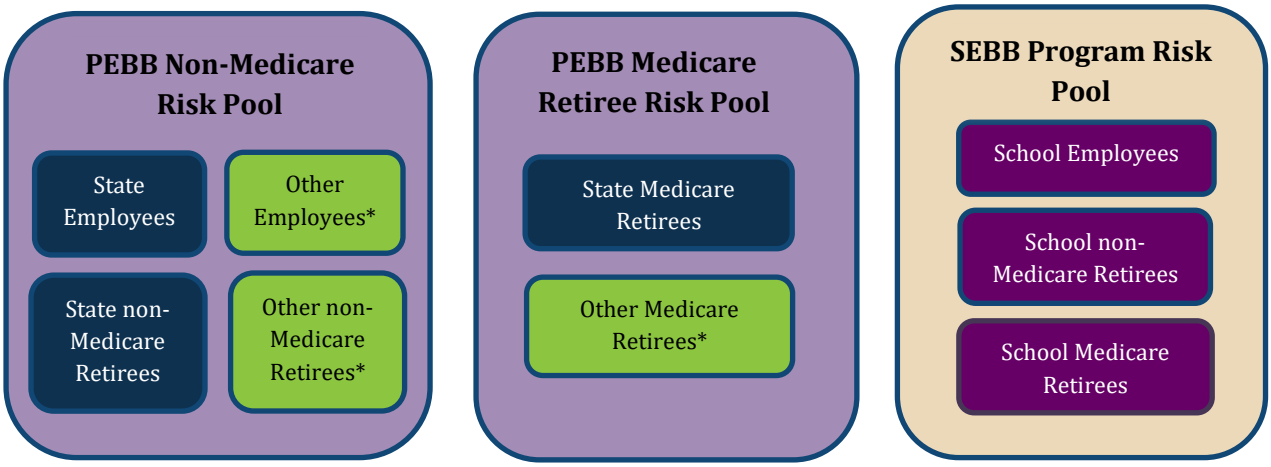
In addition, there would likely be new implementation and ongoing administrative costs associated with this scenario, as the SEBB Program would need to procure Medicare plans, manage additional contracts, and establish rates for the separate risk pool populations.

Cost impacts to school non-Medicare retirees of the magnitude discussed above, and additional unplanned funding needed to implement this scenario, leads HCA to the determination that option 4 is not viable.

Option 5

- Create one risk pool under the SEBB Program comprising all school employees and retirees, regardless of Medicare eligibility. The other current PEBB Program non-Medicare and PEBB Program Medicare retirees would remain in their designated pools under the PEBB Program.

Figure 5: Option 5 Risk Pools



*Other Employees includes political subdivision, K-12, COBRA, LWOP, etc. employees and their dependents
**Other Retirees includes political subdivision retirees and their dependents

Medicare retirees, pursuant to Centers for Medicare & Medicaid Services (CMS) regulations (section 1882 of the Social Security Act), cannot purchase the same medical plans as non-Medicare eligible employees. Because the plan offerings are separate between the populations that would exist in option 5, carriers could not utilize community-rated risk pool pricing. The Medicare carriers would only serve the Medicare population and rate their plans appropriately.

Based on the regulations associated with the Medicare population, the way in which the Medicare vs. non-Medicare populations are funded by the Legislature, and after the consultation with the PEB Board and SEB Board, HCA has determined option 5 is not viable.

Conclusion

After analyzing the retiree risk pools and populations that currently exist under the PEBB Program and consulting with the PEB Board and SEB Board, HCA believes there are two appropriate risk pool structures for school retirees: Options 1 and 2 described above.

Option 1 is the desired future state of the SEBB Program. This risk pool arrangement would have little to no cost impact on retirees or employees and minimizes disruption for members. Due to the statutory, budget, and time constraints listed above in the Option 1 analysis, HCA believes that this risk pool scenario could be in place by January 1, 2022 at the earliest. Until the constraints are addressed and resolved, HCA feels the current risk pool scenario outlined in Option 2 is the most appropriate and should remain in place.

Appendix A: PEB and SEB Boards Consultation

Note: This appendix is a summary of the feedback received from both the PEB Board and SEB Board during the joint consultation on September 17, 2018. Between the two Boards there are a total of 16 current voting board members, 1 non-voting board member, and 1 non-voting board member vacancy. The various positions on the two Boards fulfill certain statutory representation requirements as described in RCW 41.05.055(2) and RCW 41.05.740(2). During the consultation, HCA SEBB Finance discussed the implications of each scenario and answered clarifying questions as needed. After concluding the presentation, we requested the board members provide feedback and informed them that it would be summarized in this report. The following is a summary of the comments received.

Board member 1: Believed the single risk pool option made no sense due to the way in which we manage the risk pools. However, the option of a non-Medicare SEBB risk pool makes sense because moving the K-12 retirees would have little impact on either risk pool. Furthermore, there would no longer be a need for that portion of the K-12 remittance and the added expense to the school active employees would be a wash. There is also an administrative simplification in this scenario. Creating both a non-Medicare and Medicare pool under SEBB makes little sense. The PEBB Program is currently restructuring the Medicare benefit offerings and this scenario adds no value concerning keeping the programs consistent. Rating the non-Medicare retirees on their own, three risk pools under the SEBB Program, is not worth it. The only scenario outside of the current PEBB Program risk pools is the non-Medicare risk pool under SEBB (Option 1).

Board member 2: Concurred with the previous statement and added that any scenario that added administrative burden to the programs is not worth it.

Board member 3: Saw no value in switching from the current PEBB Program risk pool scenarios (Option 2). Currently it is such a small population that he felt that few people would feel the impact.

Board member 4: In response to the previous comments about little impact to retirees, mentioned that the number of K-12 early retirees would likely increase over time. This board member supported the idea of a smooth transition for K-12 members and the potential for them to keep their active employee insurance in early retirement years prior to Medicare eligibility (Option 1).

Board member 5: Had concerns about the impact on premiums for active employees should the scenario exist under SEBB with a non-Medicare retiree pool (Option 1). Had concerns about an increased number of high utilizers being rated with the active employees.

Board member 6: In response to the comments about increased cost to active school employee premiums, reminded the group that the premiums could increase, but the K-12 remittance would likely decrease and end up balancing out the overall cost.

Board member 7: Agreed with others' comments that the non-Medicare risk pool under SEBB (Option 1) was the only viable option outside of the current scenario, but voiced concern for active employees. Any increase to premiums would not be welcome.

Board member 8: Agreed with other board members that the non-Medicare risk pool under SEBB makes sense (Option 1). Having a Medicare pool under SEBB made sense as well (Option 3), but only if there was a reason to separate the Medicare groups.

Board member 9: Agreed with the others that the only alternative option that makes sense would be to create a non-Medicare risk pool under SEBB (Option 1), but assumes there is very little impact to costs either way.

Board member 10: Agreed with the other board members that if any changes occur, that creating a non-Medicare risk pool under SEBB makes sense (Option 1).

Appendix B: Non-Medicare Risk Pool Claims, Cost and Risk Score Analysis

This analysis, completed by Milliman, Inc. and submitted to HCA on November 26, 2018, is being included in its entirety as Appendix B.

1301 Fifth Avenue, Suite 3800
Seattle, WA 98101-2605
Aaron Gates: +1 206 504 5570
Ben Diederich +1 206 504 5561
aaron.gates@milliman.com
ben.diederich@milliman.com

MEMORANDUM

November 26, 2018

To: Megan Atkinson
From: Aaron Gates, Ben Diederich
CC: Kayla Hammer
Re: Relative Costs and Risk Scores for PEBB and SEBB Sub-Groups

This memorandum provides supporting documentation for analysis of retiree risk pool arrangements under the School Employee Benefit Board (SEBB) Program. We understand that you will use the analysis to inform the Retiree Risk Pool Report pursuant with Engrossed House Bill 2242 (2017), and RCW 41.05.022 (4). It is not appropriate for any other purpose. This work was done under 2nd Tier Solicitation 18-006 and is subject to terms and conditions of the contract between Milliman and Washington State Health Care Authority (HCA) effective December 15, 2017.

Summary

Relative Costs and Risk Scores

We analyzed claims costs and risk scores in calendar year 2017 for applicable sub-groups of the non-Medicare risk pool in order to compare claims costs between employees and early retirees from State/Higher Education and K-12 populations (including active employees of K-12 groups participating in PEBB).

Table 1 shows per adult unit per month (PAUPM) claims cost relativities and risk score relativities for State and K-12 cohorts in 2017. Both active employees and early retirees are included in the comparisons.

Table 1
PEBB Subgroup Comparison
2017 Claims Cost and Risk Score Relativities

Cohort	Adult Units	Claims Cost (PAUPM)	Risk Score
State Agency & High Ed			
State Agency & High Ed - Active	2,252,093	0.97	0.97
State Agency & High Ed - Early Retiree	56,072	1.63	1.85
K-12/ESD			
K-12/ESD - Active	66,101	1.02	0.89
K-12/ESD - Early Retiree	53,008	1.27	1.68
Other	284,165	1.04	1.00
Total - PEBB Non-Medicare	**2,711,439**	**1.00**	**1.00**

Risk scores add additional context to the claims cost relativities by quantifying a cohort's expected resource use based on historically reported conditions. Population cohorts with higher average risk scores are expected to have higher costs and need more resources due to increased population morbidity. For example, a member with a risk score of 1.5 is expected to have utilization (and as a result, total costs) 50% higher than the average member in the PEBB risk pool based on age, gender, and

medical diagnosis code history. The risk score metric does not account for differences in practice patterns, unit cost across delivery systems or benefit plan impacts on claim costs. The risk score represents relative resource use based on the reference population within the risk score model.

For some of the population cohorts in the table above, the PAUPM cost relativity is significantly different from the risk score relativity. Most notably, the risk score relativity for K-12 Early Retirees is materially higher than the claims cost relativity. This relationship is consistent with prior analyses Milliman has conducted using 2015 and 2016 data. Given that relative risk scores have been consistently higher than relative costs over multiple years for K-12 Early Retirees, we would recommend that HCA place more reliance on cost relativities.

Risk Pool Per-Capita Cost Impact

Table 2 estimates the per-capita cost impact between two risk pool options, which as we understand are outlined in the HCA SEBB Retiree Risk Pool Report. Option 1 removes K-12 active employees and K-12 Early Retirees from the current PEBB risk pool while Option 2 removes only K-12 actives.

Table 2
PEBB Non-Medicare Risk Pool Impact (2017 Relativities)

	Option 1			Option 2		
	Adult Units	**Claims Cost**	**Risk Score**	**Adult Units**	**Claims Cost**	**Risk Score**
State Agency & High Ed						
State Agency & High Ed - Active	2,252,093	0.972	0.968	2,252,093	0.972	0.968
State Agency & High Ed - Early Retiree	56,072	1.632	1.853	56,072	1.632	1.853
K-12/ESD						
K-12/ESD - Active	N/A	N/A	N/A	N/A	N/A	N/A
K-12/ESD - Early Retiree	N/A	N/A	N/A	53,008	1.268	1.682
Other	284,165	1.041	0.999	284,165	1.041	0.999
Total - PEBB Non-Medicare	**2,592,331**	**0.994**	**0.989**	**2,645,338**	**0.999**	**0.999**

The estimated impact of switching to Option 1 from the current risk pool assumption (Option 2) would be a reduction of approximately 0.5 - 1.0% on PAUPM costs in the PEBB risk pool. Based on our current understanding of the SEBB Active population, the enrollment count and morbidity profile is expected to be similar to the PEBB Program. To the extent that the two risk pools are similar, we would expect the impact to the SEBB risk pool to be an *increase* in PAUPM costs of a similar magnitude. The impacts on the SEBB pool will not be known until after the open enrollment period for 1/1/2020 and there is an assessment of the morbidity profile for the new risk pool.

Methodology and Assumptions

For the analysis of relative costs and risk scores, the population is limited to the subscribers and members associated with the non-Medicare risk pool for whom risk scores are assigned. Risk scores are assigned using the following criteria:

- Only non-Medicare eligible members are assigned a risk score. Medicare eligible dependents of non-Medicare eligible subscribers are excluded.
- Members with medical eligibility within the 12 month period of October 1, 2016 through September 30, 2017 were assigned diagnosis based prospective risk scores for use in the 2019 Procurement.

- Members without historical medical eligibility or diagnosis codes, but with age and gender information as of March, 2018 are assigned risk scores based on age and gender only. Less than 1% of non-Medicare eligible members were assigned risk scores based on age and gender only.
- Members without historical medical eligibility or age and gender information as of March, 2018 are not assigned a risk score and are excluded from this analysis. Less than 0.1% of non-Medicare eligible members were excluded for not having a risk score.

Relative costs were calculated for per adult unit per month (PAUPM) costs. The adult units for both active subscribers and retiree subscribers within the non-Medicare risk pool are calculated using the adult unit multiplier for each tier, shown below. These are the approved adult unit multipliers for the PEBB program.

Table 2
Adult Unit Multiplier by Tier

Tier Category	Adult Unit Multiplier
Subscriber	1
Subscriber and Spouse	2
Subscriber and Child(ren)	1.75
Full Family	2.75

Claims costs were calculated based on claims incurred in 2017, with an adjustment for incurred but not paid claims (IBNP). Self-Insured claims used runout through March 2018 while fully-insured claims used runout through December 2017.

The non-Medicare risk pool includes all actively at work enrollees, and retirees who are not yet eligible for Medicare.

Risk scores represent actual diagnoses in the 12 month period of October 1, 2016 through September 30, 2017. Risk scores were processed using Verscend Technologies DxCG® Intelligence risk adjustment model. Average risk scores for each cohort are weighted by member months. This is in contrast to the risk adjustment values calculated for 2019 procurement, in which the risk scores are revenue neutral across the entire non-Medicare population and are weighted by both members and bid rate premiums. This methodology difference resulted in small changes to composite risk scores, and was compensated for by applying a small true-up factor by plan.

The risk scores provided in this analysis are prospective, and relate to expected future costs or resource need for each member. This approach is in contrast to historical claims costs, which have some correlation to members' future claims costs but are historical in nature. The numerical risk scores are normalized to 1.0 across the PEBB non-Medicare population, and describe expected resource use relative to the population average based on the risk model used to develop the raw risk scores.

Milliman

Additional Considerations not Addressed in this Analysis

There are several additional issues that should be considered when evaluating the relative costs and risk scores of the K-12 and State/Higher Education populations. They include, but are not limited to:

- **Underlying causes of results.** The results presented represent expenditures calculated from 2017 claims data and risk scores calculated based upon data between October 2016 and September 2017. Based on this analysis, there is no evidence that the differences identified between any two similar populations represent systematic differences based on persistent properties of either population. A more thorough analysis of results over multiple calendar years may produce insight into systematic differences in results.

- **Benefit design.** The expenditure relativities given in this analysis are for claims paid by the plans. The distribution of members between plans may have a material impact on the relativities for paid claims. This component of the cost differences is not addressed in this analysis.

- **Unassigned Claims.** The claims data contains a significant amount of paid claims that are incurred with no associated membership information in the PMED database for the subscriber SSN, gender, and date of birth in a given month. Approximately 6% of medical claims and 1% of pharmacy claims fall in to this category. Because it is not possible to assign these claims to one of the cohorts in our analysis (State Active, K-12, etc.), we have excluded these unassigned claims from the analysis. These claims are a result of HCA's policy to allow for retroactive enrollment with the benefit plan prior to the subscriber being active in HCA's eligibility system.

Limitations

The information contained in this memorandum has been prepared for the Washington State Health Care Authority (HCA). It is our understanding that the information contained in this memorandum may be utilized in a public document. To the extent that the information supports other documents, this memorandum should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this memorandum to third parties. Likewise, third parties are instructed that they are to place no reliance upon this memorandum prepared for HCA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this memorandum must rely upon their own experts in drawing conclusions about the assumptions and factors used for projection of future budgets.

Actual experience will vary from our estimates for many reasons, including differences in population health status, in reimbursement levels, and in the delivery of healthcare services, as well as other non-random and random factors. Our projected estimates are not predictions of the future; they are projections or estimates based on assumptions. If the underlying data or other listings are inaccurate or incomplete, this analysis may also be inaccurate or incomplete. Emerging results should be carefully monitored with assumptions adjusted as appropriate.

In performing this analysis, Milliman has relied upon data ultimately provided by the Health Care Authority, as well as HCA's third party administrators and fully-insured carriers. We have also relied on Incurred but not Reported liability estimates supplied by our office. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our

assignment. To the extent that there are errors contained within this data, the results of our analysis could produce erroneous results.

We are members of the American Academy of Actuaries, and we meet the qualification standards for performing the analyses in this memorandum.

We look forward to discussing the results of this analysis with you.

Sincerely,

Ben Diederich, FSA, MAAA
Consulting Actuary

Aaron Gates, FSA, MAAA
Actuary