

Public Employees Benefits Board

April 14, 2022

Public Employees Benefits Board

April 14, 2022

9:00 a.m. – 1:30 p.m.

Zoom Attendance Only

Health Care Authority
Sue Crystal A & B
626 8th Avenue SE
Olympia, Washington

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TAB 1

AGENDA

Public Employees Benefits Board
April 14, 2022
9:00 a.m. – 1:30 p.m.

**Aligning with [Governor's Proclamation 20-28](#),
all Board Members and public attendees
will only be able to attend virtually**

TO JOIN ZOOM MEETING – SEE INFORMATION BELOW

| | | | | |
|------------|--|-------|--|----------------------------|
| 9:00 a.m.* | Welcome and Introductions | | Sue Birch, Chair | |
| 9:05 a.m. | Meeting Overview | | Dave Iseminger, Director Employees & Retirees Benefits (ERB) Division | Information |
| 9:10 a.m. | Approval of Meeting Minutes • April 14, 2021 • May 12, 2021 | TAB 3 | Sue Birch, Chair | Action |
| 9:15 a.m. | Follow up from March 10, 2022 Meeting | TAB 4 | Dave Iseminger, Director ERB Division | Information/ Discussion |
| 9:20 a.m. | Remembering Yvonne Tate | | Dave Iseminger, Director ERB Division | Information/ Discussion |
| 9:35 a.m. | Policy and Rules Development | TAB 5 | Stella Ng, Policy & Rules Coordinator Emily Duchaine, Regulatory Analyst Policy, Rules, & Compliance Section ERB Division | Action |
| 10:00 a.m. | 2022 Annual Rule Making | TAB 6 | Stella Ng, Policy & Rules Coordinator Policy, Rules, & Compliance Section ERB Division | Information/ Discussion |
| 10:15 a.m. | 2022 Legislative Session Wrap Up | TAB 7 | Cade Walker, Executive Special Assistant, ERB Division | Information/ Discussion |
| 10:35 a.m. | Break | | | |
| 10:40 a.m. | 2024 Uniform Dental Plan (UDP) Dental Design | TAB 8 | Ellen Wolfhagen, Senior Account Manager, ERB Division | Information/ Discussion |
| 11:25 a.m. | PEBB Modernization Project Updates | TAB 9 | Chatrina Pitsch, PEBB IT Project Director, Enterprise Technology Svcs. | Information/ Discussion |
| 11:45 a.m. | Public Comment | | | |
| 12:00 p.m. | Transition to Executive Session | | | |
| 12:05 p.m. | Executive Session | | | |
| 1:25 p.m. | Closing | | Sue Birch, Chair | |
| 1:30 p.m. | Adjourn | | | |

*All Times Approximate

The Public Employees Benefits Board will meet Thursday, April 14, 2022. Due to COVID-19 and out of an abundance of caution, all Board Members and attendees will attend this meeting virtually.

The Board will consider all matters on the agenda plus any items that may normally come before them.

Pursuant to RCW 42.30.110(1)(I), the Board will meet in in Executive Session to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session will begin at 12:05 p.m. and conclude no later than 1:25 p.m.

No "action," as defined in RCW 42.30.020(3), will be taken at the Executive Session.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

To provide public comment by email, direct e-mail to: board@hca.wa.gov.

Materials posted at: <http://www.pebb.hca.wa.gov/board/> by close of business on April 11, 2022.

[Join Zoom Meeting](#)

Join Zoom Meeting

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Meeting ID: 865 2430 0204

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Find your local number: <https://us02web.zoom.us/u/kbyO7qjgvO>

PEB Board Members

| Name | Representing |
|--|--------------------------------------|
| Sue Birch, Director Health Care Authority 626 8 th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-2104 sue.birch@hca.wa.gov | Chair |
| Leanne Kunze, Executive Director Washington Federation of State Employees 1212 Jefferson Street, Suite 300 Olympia WA 98501 V 360-352-7603 PEBBoard@hca.wa.gov | State Employees |
| Elyette Weinstein 5000 Orvas CT SE Olympia WA 98501-4765 V 360-705-8388 PEBBoard@hca.wa.gov | State Retirees |
| Tom MacRobert 4527 Waldrick RD SE Olympia WA 98501 V 360-264-4450 PEBBoard@hca.wa.gov | K-12 Retirees |
| Scott Nicholson, Deputy Assistant Director State Human Resources Office of Financial Management PO Box 43113 Olympia WA 98504-3113 scott.nicholson@ofm.wa.gov | Benefits Management/Cost Containment |

PEB Board Members

| Name | Representing |
|--|--------------------------------------|
| Vacant PEBBoard@hca.wa.gov | Benefits Management/Cost Containment |
| John Comerford* 121 Vine ST Unit 1205 Seattle, WA V 206-625-3200 PEBBoard@hca.wa.gov | Benefits Management/Cost Containment |
| Harry Bossi 19619 23 rd DR SE Bothell WA 98012 V 360-689-9275 PEBBoard@hca.wa.gov | Benefits Management/Cost Containment |
| Legal Counsel | |
| Michael Tunick, Assistant Attorney General 7141 Cleanwater Dr SW PO Box 40124 Olympia WA 98504-0124 V 360-586-6495 MichaelT4@atg.wa.gov | |

*non-voting members

4/7/22



Washington State Health Care Authority
Public Employees Benefits Board
P.O. Box 42713 • Olympia, Washington 98504-2713
360-725-0856 • TTY 711 • FAX 360-586-9551 • www.pebb.hca.wa.gov

PEB BOARD MEETING SCHEDULE

2022 Public Employees Benefits (PEB) Board Meeting Schedule

The PEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501.

January 26, 2022 (Board Retreat) 9:00 a.m. – 4:00 p.m.

March 10, 2022 - 9:00 a.m. – 2:00 p.m.

April 14, 2022 - 9:00 a.m. – 2:00 p.m.

May 12, 2022 - 9:00 a.m. – 2:00 p.m.

June 9, 2022 - 9:00 a.m. – 2:00 p.m.

June 30, 2022 – 9:00 a.m. – 2:00 p.m.

July 14, 2022 - 9:00 a.m. – 2:00 p.m.

July 20, 2022 - 9:00 a.m. – 2:00 p.m.

July 27, 2022 - 9:00 a.m. – 2:00 p.m.

If you are a person with a disability and need a special accommodation, please contact Connie Bergener at 360-725-0856

7/16/21

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 16, 2021

TIME: 2:26 PM

WSR 21-15-079

TAB 2

PEB BOARD BY-LAWS

ARTICLE I

The Board and its Members

1. **Board Function**—The Public Employees Benefits Board (hereinafter “the PEBB” or “Board”) is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB’s function is to design and approve insurance benefit plans and establish eligibility criteria for participation in insurance benefit plans for Higher Education and State employees, State retirees, and school retirees.
2. **Staff**—Health Care Authority staff shall serve as staff to the Board.
3. **Appointment**—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board Members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.
4. **Non-Voting Member**—There shall be one non-voting Members appointed by the Governor because of their experience in health benefit management and cost containment.
5. **Privileges of Non-Voting Member**—The non-voting Member shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.
6. **Board Compensation**—Members of the Board shall be compensated in accordance with RCW [43.03.250](#) and shall be reimbursed for their travel expenses while on official business in accordance with RCW [43.03.050](#) and [43.03.060](#).

ARTICLE II

Board Officers and Duties

1. **Chair of the Board**—The Health Care Authority Administrator shall serve as Chair of the Board and shall preside at all meetings of the Board and shall have all powers and duties conferred by law and the Board’s By-laws. If the Chair cannot attend a regular or special meeting, he or she shall designate a Chair Pro-Tem to preside during such meeting.
2. **Other Officers**—(reserved)

ARTICLE III
Board Committees

(RESERVED)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.
2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.
3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.
4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.
5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 24 hours prior to the meeting date or as otherwise required by the Open Public Meetings Act.

Agendas may be sent by electronic mail and shall also be posted on the HCA website. An audio recording (or other generally accepted electronic recording) shall be made of the meeting. HCA staff will provide minutes summarizing each meeting from the audio recording. Summary minutes shall be provided to the Board for review and adoption at a subsequent Board meeting.

6. Attendance—Board Members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board Members at the meeting for the minutes.

ARTICLE V
Meeting Procedures

1. Quorum—Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.
2. Order of Business—The order of business shall be determined by the agenda.
3. Teleconference Permitted—A Board Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, by telephone conference call, or video conference when in-person attendance is impracticable.
4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at Board meetings may also occur in conjunction with a public hearing or during the Board’s consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.
5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Board Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board.
6. Representing the Board’s Position on an Issue—No Board Member may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on an issue unless the majority of the Board approve of such position.
7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the Chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted, but the prohibition of proxy votes does not prevent a Chair Pro-Tem designated by the Health Care Authority Director from voting.
8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert’s Rules of Order. Board staff shall provide a copy of *Robert’s Rules* at all Board meetings.
9. Civility—While engaged in Board duties, Board Members’ conduct shall demonstrate civility, respect, and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.
10. State Ethics Law and Recusal—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW. A Board Member shall recuse himself or herself from casting a vote as necessary to comply with the Ethics in Public Service Act.

ARTICLE VI
Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.
2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

Last Revised July 15, 2020

TAB 3

Draft
Public Employees Benefits Board
Meeting Minutes

April 14, 2021
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
12:00 p.m. – 5:00 p.m.

The Briefing Book with the complete presentations can be found at:
<https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials>

Members Present via Phone

Sue Birch, Chair
Yvonne Tate
Scott Nicholson
Harry Bossi
Leanne Kunze
Tom MacRobert
Elyette Weinstein
John Comerford

PEB Board Counsel

Michael Tunick

Call to Order

Sue Birch, Chair, called the meeting to order at 12:06 p.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting is telephonic only and will address only those topics necessary and routine to complete the regular cycle of activity in our Board season.

Meeting Overview

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda.

This is our second meeting with our new tradition of highlighting a community that we serve. Today we highlight San Juan County.

Between the PEBB and SEBB Programs, we have about 7.5% of the population of the county served under one of the programs. That's a little over 1,400 residents of the county. When you add in the Medicaid Program, about 20% of the population in San Juan County is served by the Medicaid Program of the Health Care Authority. So,

between PEBB, SEBB, and Medicaid, we have about 28.5% of the entire population, which is around 17,000 individuals on the island.

The San Juan County unemployment rate is similar to the statewide average of about 4%. The per capita personal income is higher than the state and national average, but the median income is below that, which is indicative of a large retiree population. Retiree incomes included in the calculation of median income generally influence that calculation. There is a higher retiree population in the San Juan Islands.

Being an island community, primary care is generally delivered on the island as well as urgent care and emergent care. But when it comes to elective surgery or other elective and major procedures, a lot of individuals from San Juan County get those services in either Bellingham, Everett, or elsewhere in the upper Puget Sound region.

There has been increased availability of site services throughout the islands in recent years; but at the same time, the community has expressed need for additional in- and outpatient beds for acute mental health and substance abuse problems.

Other health care trends in the islands, they have noticeably lower cancer rates compared to state and national averages, lower birth rates and teens, again related to a larger retiree community. Because of those lower birth rates, lower teens, there's also limited availability of pediatricians.

The last highlight involves access issues because many of them go off the islands for those elective and planned procedures. The ferry system generally will run once per hour, and the one-way trip from the islands to the mainland, depending on how many islands it stops at, can take anywhere from 45 minutes to two hours. You're potentially looking at a round trip of four hours travel time. The ferry system can be cost prohibitive, especially for low-income families that live on the island.

I will finish my opening comments with a land acknowledgement statement. Our meeting is supported physically here in Olympia on the traditional territories of the Coast Salish people, specifically the Nisqually and Squaxin Island people. Olympia and South Puget Sound region are covered by the Treaty of Medicine Creek, which was signed under duress in 1854. We always want to continue acknowledging the role the tribal government has today in taking care of these lands.

Sue Birch: Dave, thank you for the land use acknowledgement and for our newfound tradition of showcasing parts of the state. I think it's a) so respectful and b) it helps us to understand the magnitude of the work we're doing and the state wideness of our efforts.

Approval of July 15, 2020 Meeting Minutes

Tom MacRobert moved, and Elyette Weinstein seconded a motion to approve. Minutes approved as written by unanimous vote.

Approval of July 22, 2020 Meeting Minutes

Yvonne Tate moved, and Elyette Weinstein seconded a motion to approve. Minutes approved as written by unanimous vote.

Approval of January 27, 2021 Meeting Minutes

Harry Bossi moved, and Scott Nicholson seconded a motion to approve. Minutes approved as written by unanimous vote.

Executive Session

Pursuant to RCW 42.30.110(1)(1), the Board met in Executive Session to consider proprietary or confidential non-published information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026.

Sue Birch: For members of the public, we are back in our public meeting from Executive Session.

During the next presentation on long-term disability insurance, the Board will act on resolutions presented at last month's Board meeting. Due to the lengthy nature of many of the resolutions being presented for action, and under Robert's Rules, Board Members agreed it wasn't necessary to read the full text of a resolution as it was distributed to members in advance of the meeting. The final version of the resolutions was also published for public review this past Monday evening.

Long-Term Disability (LTD) Insurance

Kimberly Gazard, Contract Manager, ERB Division, reviewed the policy resolutions and modifications to the policy resolutions based on SEBB stakeholder feedback received. Since the policy resolutions are almost identical between the PEBB and SEBB Programs, we thought SEBB comments would also apply for the PEBB policy resolutions, which is why I will be referring to SEBB feedback, too.

A follow-up request from the March SEBB Board Meeting was to provide examples of the benefit waiting period, so, we thought it would be helpful to share these examples with this Board, too. Slide 3 – Benefit Waiting Period PFML Example is an example of when an employee is receiving Paid Family and Medical Leave (PFML) benefits for 90 days and has 30 days in their sick leave bank. Because the PFML waiting period is greater than the sick leave waiting period, the LTD benefit would begin paying on day 91.

Slide 4 – Benefit Waiting Period Sick Leave Example, is an example of an employee receiving PFML benefits for 90 days with 120 days in their sick leave bank. Because the sick leave waiting period is greater than the PFML waiting period, the LTD benefit would begin paying on day 121.

Slide 5 – Benefit Waiting Period 90-days Example, is an example of an employee who is not receiving PFML benefits, and they have no sick leave. The LTD benefit would begin paying on day 91.

Dave Iseminger: We always have people asking if the benefit waiting periods are consecutive or concurrent. These examples are to drive home that all the benefit waiting period possibilities run concurrent to each other. First review the benefit waiting period analysis, identify which prong has the largest number, and that's the number. You don't add multiple numbers together.

John Comerford: Does short-term disability cover the first 90 days?

Kimberly Gazard: Usually it does. It depends on the circumstance and what is approved by the state, but generally, yes.

John Comerford: Does the employee have to use their sick leave before they can hit short-term disability?

Kimberly Gazard: I will follow up on that question with the division that handles PFML.

John Comerford: Great, thank you very much.

Kimberly Gazard: Slide 6 – Resolution PEBB 2021-10 Employee-Paid Long-Term Disability (LTD). I want to discuss the SEBB stakeholder feedback we received regarding distinguishing between paid time off (PTO) and vacation leave. The comment was regarding Resolution PEBB-2021-13, but since Resolution PEBB-2021-10 has the same benefit waiting period, I'll discuss it now. After receiving the request for clarification, we engaged Standard in the discussion with the goal of plain talking the benefit waiting period. To summarize the changes made for the final recommended resolution before you today, we changed the structure of the benefit waiting period to list as five separate sub bullets, which outline the waiting periods that could apply, depending on the member circumstances. There is also clarified language to resolve the confusion caused by the references between both PTO and vacation leave.

Sub bullet 4 uses the term non-vacation as an objective. An example of non-vacation would be how many employers, like the state, received additional emergency Covid-19 paid leave for use during the pandemic to ensure employees have paid leave if other leave balances were exhausted or too low.

Sub bullet 3. The term PTO has always historically been applied when employers do not have a dedicated sick leave bank. Instead, they will offer one single bucket of leave used for all purposes: personal, vacation, and sick leave. This concept is further complicated because some employers also use terms like vacation, paid time off, paid days, personal leave, annual leave, and use them all interchangeably. In commercial LTD products, generally the entire amount of leave in a single bucket is used when calculating the benefit waiting period. HCA was able to work with Standard and negotiate for our benefit waiting period purposes, we would only count 50% of the leave when you have the circumstance of a single PTO bucket, which resulted in the new term we will refer to as fractionated period of paid time off. The policy will have an explicit definition of the paid time off and then the fractionated period of paid time off.

Slide 7 – LTD Policy Definitions, defines the paid time off plan and fractionated period of paid time off. Standard's practice for employers with single PTO bucket is to exhaust the entire leave before payments begin. HCA's will be 50%.

Dave Iseminger: This does have implications for PEBB employers. The state agencies and higher education institutions in general have multiple buckets of leave. For example, at the Health Care Authority, we have a sick leave balance and an annual leave balance. We're a two-bucket world, but there are employers in the PEBB Program who have a single bucket of leave, which tends to be in our political

subdivisions the agency contracts with for access to PEBB benefits. Some prime examples are hospital districts, many of whom have a single bucket of leave. This is a small improvement in the benefit going forward if the Board adopts this resolution and includes this concept. Today if an employee from a single bucket of leave employment situation goes out on a claim, the *entire* bucket of leave is applied to their benefit waiting period. Come January 1, only half of that leave balance will. We've identified at least 18 to 20 employers with a total of roughly 2,500 to 3,000 employees this change impacts. It's a small language change for a real benefit enhancement with no impact to the rates or the risk pool.

Kimberly Gazard: I want to discuss the term "choice pension" on Slide 6 before moving on. A "choice pension" benefit design allows a subscriber to choose to receive payment from their employer for their pension. If a subscriber chooses to receive the benefit, it is deducted from their disability payment. A "No choice" pension benefit design deducts pension payments from the disability payment regardless of whether the subscriber receives that pension payment. The PEBB and SEBB Programs are setup for "choice pension" and subscribers can decide if they would like to receive payment from their pension. This policy design existed in the PEBB and SEBB Programs prior to the January 1, 2022 LTD redesign.

Elyette Weinstein: Would you explain the no choice sick leave, please?

Kimberly Gazard: No choice sick leave essentially means it's part of our benefit waiting period, so you must wait that period of time. For example, you wouldn't necessarily have to use your sick leave, but you must wait that time period. If you have 120 days of sick leave, you wouldn't have to use 120 days, but you would have to wait that period of time because it's part of the benefit waiting period. Members don't have a choice as far as applying that to a benefit waiting period.

Slide 8 – Resolution PEBB 2021-11 – Employee-Paid Long-Term Disability (LTD) Enrollment Procedures. HCA received SEBB feedback on this resolution requesting clarification that Evidence of Insurability is not required in the first two statements. Those changes for current and new employees would not have Evidence of Insurability required.

Dave Iseminger: Those were not substantive changes but asking for clarification language to say "pay both ways" instead of one way.

Kimberly Gazard: Right. We simply added the words "when Evidence of Insurability is not required" at the end of the first bullet and then the second to the last line in the second bullet.

Dave Iseminger: It was implied before but now it's expressly stated. Thank you.

Kimberly Gazard: Slide 9 - Resolution PEBB 2021-11 (*cont.*). Piggybacking on the SEBB feedback from the previous slide, we clarified in the first bullet that Evidence of Insurability (EOI) would not be required when an employee reduces coverage from the 60% plan to the 50% plan.

Slide 10 – Resolution PEBB 2021-12 Amending Resolution PEBB 2020-04 Relating to Default Enrollments. This resolution spells out the changes made.

Slide 11 - Resolution PEBB 2021-12 (*cont.*). In the fourth bullet, the word “basic” is replaced with “employer-paid.” The last bullet was added to reference the 60% coverage level of automatic enrollment.

Dave Iseminger: HCA had no feedback in either program since last meeting on this resolution.

Kimberly Gazard: Slide 12 – Resolution PEBB 2021-13 Employer-Paid Long-Term Disability Insurance. HCA did receive feedback on this resolution. The feedback I gave you on Resolution PEBB 2021-10 applies here. It's identical, but this is the employer-paid piece.

Sue Birch: Vote - Resolution PEBB 2021-10 - Employee-Paid Long-Term Disability

Resolved that, effective January 1, 2022, the benefit design of the supplemental (or optional) long-term disability benefit included in prior Board policy decisions and resolutions is rescinded and replaced with the following employee-paid LTD design:

Two separate employee-paid LTD insurance choices including: (a) coverage at 60% or (b) coverage at 50%. Both choices will have the following features:

The following benefit waiting period (the longer of):

- The following Benefit Waiting Period (the longer of):
 - 90 days;
 - The entire period of sick leave (excluding shared leave) for which the employee is eligible;
 - The Fractionated Period of Paid Time Off (PTO) for which the employee is eligible, if your employer has a PTO plan, as those terms are defined in the policy;
 - The entire period of other non-vacation salaried continuation leave for which the employee is eligible; or
 - The end of Washington Paid Family and Medical Leave Law for which the employee is receiving benefits
 - No Choice Sick Leave
 - Choice Pension
 - A Maximum Monthly Benefit of \$10,000 for the 60% coverage and \$8,333 for the 50% coverage

Leanne Kunze moved, and Scott Nicholson seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

Sue Birch: Resolution PEBB 2021-10 passes.

Sue Birch: Vote – Resolution PEBB 2021-11 – Employee-Paid Long-Term Disability (LTD) Enrollment Procedures

Resolved that,

- All employees who are eligible for the employer contribution towards PEBB benefits as of December 31, 2021 and not already enrolled in supplemental LTD insurance, or did not make an election (reducing or declining coverage) during an enrollment period established by the Health Care Authority in 2021, will be auto-enrolled in employee-paid LTD insurance at the 60% coverage level with an effective date of January 1, 2022 without Evidence of Insurability (EOI).
- An employee who becomes eligible for the employer contribution towards PEBB benefits on or after January 1, 2022 must make an election (reducing or declining coverage) during the benefit election period. If the employee fails to timely elect coverage, the employee will be defaulted into coverage according to Resolution PEBB 2021-12 without EOI. The effective date of coverage will be according to the policy established in May 1995.
- After January 1, 2022, an employee at any time may elect to reduce employee-paid LTD to the 50% coverage plan without EOI or fully decline employee-paid LTD. The effective date of the change in coverage will be the first day of the month following the date the employer receives the required election.
- An employee who seeks to increase coverage from the 50% coverage plan to the 60% coverage plan, or access previously declined employee-paid TD, will be subject to evidence of insurability. The effective date of the change in coverage will be the day of the month the contracted vendor approves the required form.
- Any employee who declines employee-paid LTD insurance will remain enrolled in employer-paid LTD insurance.

Tom MacRobert moved, and Elyette Weinstein seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

Sue Birch: Resolution PEBB 2021-11 passes.

Sue Birch: Vote – Resolution PEBB 2021-12 – Amending Resolution PEBB 2020-04 Relating to Default Enrollments

Resolved that, PEBB 2020-04’s third bullet is amended by striking the word “and” from the end of the sentence, the fourth bullet is amended by replacing the word “basic” with the word “employer-paid” and adding the word “;and” to the end of the sentence; and adding the following new fifth bullet “Enrollment in employee-paid long-term disability insurance at the 60% coverage level”.

This resolution now reads:

Resolved that, the default election for an eligible employee who fails to timely elect coverage will now be as follows:

- Enrollment in employee-only medical coverage;
- Enrollment in employee-only dental coverage;
- Enrollment in basic life insurance;
- Enrollment in employer-paid long-term disability insurance; and
- Enrollment in employee-paid long-term disability insurance at the 60% coverage level.

Scott Nicholson moved, and Elyette Weinstein seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

Sue Birch: Resolution PEBB 2021-12 passes.

Sue Birch: Vote – Resolution PEBB 2021-13 – Employer-Paid Long-Term Disability Insurance

Resolved that, effective January 1, 2022, the benefit design of the employer-paid (or basic) long-term disability benefit included in prior Board policy decisions and resolutions is rescinded and replaced with the following employer-paid LTD benefit design:

- The following Benefit Waiting Period (the longer of):
 - 90 days;
 - The entire period of sick leave (excluding shared leave) for which the employee is eligible;
 - The Fractionated Period of Time Off (PTO) for which the employee is eligible, if your employer has a PTO plan, as those terms are defined in the policy;
 - The entire period of other non-vacation salaried continuation leave for which the employee is eligible; or
 - The end of Washington Paid Family and Medical Leave for which the employee is receiving benefits
- No Choice Sick Leave
- Choice Pension
- Maximum Monthly Benefit \$240 (60 of \$400)

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

Voting to Approve: 7

Voting No: 0

Sue Birch: Resolution PEBB 2021-13 passes.

Sue Birch: Thank you for the work on making these important changes to our LTD benefit. It's a good example of balancing benefit design with every choice. Though collectively, we will all continue to work on improving the employer-paid portion. These

changes are significant to ensuring PEBB Program employees have a greater likelihood of robust income replacement when they unexpectedly need to transition from the workforce.

Policy Resolutions

Sue Birch: Stella Ng and Emily Duchaine have several resolutions for Board action today. For the eight dual enrollment resolutions Emily will be presenting, I recommend we follow the same process the Board just followed for the LTD resolutions. I will suggest we vote on all eight dual enrollment resolutions in one vote .

Stella Ng, Policy and Rules Coordinator, ERB Division Policy, Rules, and Compliance Section. Slide 7 - Resolution PEBB 2021-01 Removing the Retiree 2-Year Dental Plan Enrollment Requirement, received no stakeholder feedback.

Sue Birch: Vote – Resolution PEBB 2021-01 – Removing the Retiree 2-Year Dental Enrollment Requirement

Resolved that, the PEBB Program requirement that retiree dental must be maintained for at least two years if a PEBB Program retiree enrolls in a dental plan is rescinded as of January 1, 2022.

Elyette Weinstein moved, and Scott Nicholson seconded a motion to adopt.

Voting to Approve: 6

Voting No: 0

Leanne Kunze needed to step out temporarily and did not vote on this resolution.

Sue Birch: Resolution PEBB 2021-01 passes.

Stella Ng: Slide 8 - Resolution PEBB 2021-14 Authorizing a Gap of 31 Days or Less Between Periods of Enrollment in Qualified Coverages During the Deferral Period. HCA received no feedback on this resolution, but staff found a technical error on Example #2.

Slide 9 - Example #2 indicates George had two employer-based group medical coverages with a single gap of 30 days for the month of June in 2020. We made a technical correction on the answer in this revised Example #2. The evidence provided shows a single gap of 30 days throughout the deferral period between June 1 and June 30, 2020.

Sue Birch: Vote – Resolution PEBB 2021-14 – Authorizing A Gap of 31 Days or Less Between Periods of Enrollment in Qualified Coverages During the Deferral Period

Resolved that, effective January 1, 2022, an eligible retiree or survivor who deferred enrollment while enrolled in qualified coverage may later enroll themselves and their dependent in a PEBB health plan by submitting the required form and evidence of continuous enrollment in one or more qualifying coverages, except that a gap of 31

days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualified coverage, and between each period of enrollment in qualified coverages, during the deferral period.

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

Voting to Approve: 6

Voting No: 0

Leanne Kunze needed to step out temporarily and did not vote on this resolution.

Sue Birch: Resolution PEBB 2021-14 passes.

Stella Ng: Slide 10 - Resolution PEBB 2021-15 - Rescinding PEBB Policy Resolution #4 SmartHealth (as adopted on July 12, 2017). No feedback was received on this resolution.

Dave Iseminger: I know Leanne left but she had a question I wanted to answer on the record, which was the value of the annual gift card expenditures in recent years. It is going away under the Collective Bargaining Agreement, resulting in the policy resolution. The projected annual amount of money spent on the gift cards is \$1.125 million. I'll make sure to reach out to Leanne so she knows it was put on the record.

Sue Birch: Vote – Resolution PEBB 2021-15 – Rescinding PEBB Policy #4 SmartHealth (as adopted on July 12, 2017)

Resolved that, effective January 1, 2022, PEBB Policy Resolution #4, as adopted on July 12, 2017, is rescinded.

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

Voting to Approve: 6

Voting No: 0

Leanne Kunze needed to step out temporarily and did not vote on this resolution.

Sue Birch: Resolution PEBB 2021-15 passes.

Emily Duchaine, Regulatory Analyst, Policy, Rules, and Compliance Section, ERB Division. There are eight policy resolutions on dual enrollment for action today.

Slide 13 – Language Used Throughout This Presentation will provide definitions to the words used in the resolutions. These are intended to be distinct concepts for the purpose of these resolutions and are not to be equated with words like “waiver” and “default,” which are already defined. An employee or school employee is any employee eligible for the employer contribution toward PEBB or SEBB benefits, unless otherwise stated.

Slide 14 – Guidelines/Principles for Resolving Dual Enrollment were followed when developing the policy resolutions enabling HCA to resolve dual enrollment issues on behalf of the employee who doesn't act on their own. HCA will respect the default requirements already in place for each program, avoiding creating a gap in any coverage.

Slides 15-23 – Dual Enrollment Policy Resolutions. The resolutions were sent out for stakeholder review and HCA received no comments. The resolutions before you are identical to what was presented on March 17 with one exception. Resolution PEBB 2021-06 – Resolving Dual Enrollment Involving A PEBB Dependent With Multiple Medical Enrollments, Slide 20, contained an error. It stated, “the dependent will remain in SEBB benefits and will be auto disenrolled from the employee’s PEBB medical and/or dental, vision plans.” There is no separate vision plan in PEBB. Therefore, the resolution should state, “the dependent will remain in SEBB benefits and will be auto disenrolled from the employee’s PEBB medical and/or dental plans.” Slide 20 reflects that change.

Sue Birch: These eight lengthy dual enrollment resolutions work together as a set. A significant amount of time was spent reviewing these proposed examples at the last meeting. The Board already consented to not reading each resolution, so I'm now going to suggest we vote on all eight dual enrollment resolutions as a set in one motion. Any concerns with that process?

Since the Board has no objections, we'll proceed to voting on this set of resolutions.

Sue Birch: Vote – Resolutions PEBB 2021-02 through PEBB 2021-09

Resolution PEBB 2021-02 – Employees May Waive Enrollment in Medical

Resolved that, effective January 1, 2022, the “Waiver of Coverage” policy, as adopted in May 1995, is rescinded and is replaced with the following:

An employee who is eligible for the employer contribution toward PEBB benefits may waive their enrollment in a medical plan if they are enrolled in other employer-based group medical.

Exception: An employee may waive their enrollment in a PEBB medical plan to enroll in a SEBB medical plan only if they are enrolled in a SEBB dental plan and SEBB vision plan. In doing so, the employee also waives their enrollment in PEBB dental.

Resolution PEBB 2021-03 – PEBB Benefit Enrollment Requirements When SEBB Benefits Are Waived

Resolved that, a school employee who waives SEBB medical, SEBB dental, and SEBB vision for PEBB medical must be enrolled in a PEBB dental plan. If necessary, they will be automatically enrolled in the associated subscriber’s PEBB dental plan.

Resolution PEBB 2021-04 – Resolving Dual Enrollment When An Employee’s Only Medical Enrollment Is In SEBB

Resolved that, if the employee is enrolled only in PEBB dental, and is also enrolled in SEBB medical, and no action is taken to resolve their dual enrollment, the employee will remain in their SEBB benefits and they will be auto-disenrolled from the PEBB dental plan in which they are enrolled. The employee’s enrollments in PEBB life, AD& D, and LTD will remain.

Resolution PEBB 2021-05 – Resolving Dual Enrollment Involving Dual Subscriber Eligibility

Resolved that, if the employee is enrolled in PEBB medical as an employee and is also enrolled in SEBB medical as a school employee, and the employee has been enrolled in SEBB benefits longer than they’ve been enrolled in PEBB benefits, but no action is taken by the employee to resolve their dual enrollment, they will remain in their SEBB benefits and will be auto-disenrolled from their PEBB medical and PEBB dental plans. The employee’s enrollments in PEBB Life, AD&D, and LTD will remain.

If an employee is not enrolled in any medical but is enrolled only in PEBB dental and SEBB vision (with or without SEBB dental), the employee will be kept in SEBB benefits and auto-disenrolled from PEBB dental.

Resolution PEBB 2021-06 – Resolving Dual Enrollment Involving A PEBB Dependent With Multiple Medical Enrollments

Resolved that, if an employee’s dependent is enrolled in any PEBB benefits and the dependent is also a SEBB eligible school employee who is enrolled in SEBB medical as a school employee, and no action is taken by either the employee or the dependent to resolve the dependent’s dual enrollment, the dependent will remain in SEBB benefits and will be auto-disenrolled from the employee’s PEBB medical and/or dental plans in which they are enrolled.

Resolution PEBB 2021-07 – Resolving Dual Enrollment Involving a Member With Multiple Medical Enrollments As A Dependent

Resolved that, if an employee’s dependent is enrolled in both PEBB medical and SEBB medical as a dependent and has been enrolled in SEBB benefits longer than they have been enrolled in PEBB benefits, but no action is taken to resolve the dual enrollment, the dependent will remain in SEBB benefits and will be auto-disenrolled from the employee’s PEBB medical and/or dental plans if they are enrolled.

If an employee’s dependent is not enrolled in any medical but is enrolled only in PEBB dental and SEBB vision (with or without SEBB dental) as a dependent, the dependent will be kept in SEBB benefits and auto-disenrolled from PEBB dental.

Exception: If there is a National Medical Support Order or a court order in place, enrollment will be in accordance with the order.

Resolution PEBB 2021-08 – PEBB Benefit Automatic Enrollments When SEBB Benefits Are Auto-Disenrolled

Resolved that, if an employee's dependent, who is also a school employee who was auto-disenrolled from their SEBB dental and SEBB vision as a result of SEBB Board Resolution 2021-04, the employee's dependent will be automatically enrolled in the employee's dental plan if they are not already enrolled.

Resolution PEBB 2021-09 – Enrollment Requirements When An Employee Loses Dependent Coverage In SEBB Benefits

Resolved that, if an employee who is eligible for the employer contribution towards PEBB benefits was enrolled as a dependent in SEBB benefits and is dropped by the SEBB subscriber, HCA will notify the employee of their removal from the SEBB subscriber's account and that they have experienced a special enrollment event. The employee will be required to return from waive status and elect PEBB medical and PEBB dental. If the employee's employing agency does not receive the school employee's required forms indicating their medical and dental elections within sixty days of the employee losing SEBB benefits, they will be defaulted into employee only PEBB medical and PEBB dental.

Yvonne Tate moved, and Tom MacRobert seconded a motion to adopt Resolutions PEBB 2021-02 through PEBB 2021-09.

Voting to Approve: 6
Voting No: 0

Leanne Kunze needed to step out temporarily and did not vote on this resolution.

Sue Birch: Resolutions PEBB 2021-02 through PEBB 2021-09 pass.

2021-23 Biennial Budget Update

Tanya Deuel, ERB Finance Manager, Financial Services Division. The Governor's budget proposal for the next biennium was discussed at the Retreat in January. Today I'll walk through what we know today about the House and the Senate proposals.

Slide 2 – Proposed Funding Rate. All three versions of the budget are still per employee per month and adequate to maintain the current level of benefits. HCA has no concerns with any underlying assumptions.

Slide 3 – PEBB Funding Rate. The Governor's proposed budget for the next biennium has the funding rate at \$988 for FY22 and \$1,018 for FY23. The Senate and House budgets propose the same funding rates, \$936 for FY22 and \$1,091 for FY23. Between the Governor's budget and when the House and the Senate made their proposals, HCA looked at more recent numbers. We update our projections each quarter to include updates on enrollment, utilization, trends, risk scores, etc. and there has been a couple updated versions of our modeling. You might notice a difference in some of those numbers.

Slide 4 – Medicare Explicit Subsidy, which is the amount the state contributes towards our Medicare retiree’s health care premiums. The amount listed is the maximum, which is \$183 or 50% of the premium, whichever is less. This amount was \$150 until 2019 when it was increased to \$168. In 2020, it was \$183, where it has remained since.

Slide 5 – Proposed Budget Similarities between the three proposed budgets. First is our third-party administrator (TPA) spending authority. This is the administrative amount paid to MODA, Regence, and Delta Dental to administer our self-insured products. This is a technicality to get increased spending authority to spend the money in these funds.

Scheduling tool replacement, which is used by our Customer Service Unit for scheduling. This \$285,000 that was funded in all three budgets is a portion of a larger decision package with the majority being attributable to PEBB. The nature of the Call Center is largely supporting our retirees, however, this decision package did include about 5% attributable to SEBB to support their COBRA members. The total package was \$300,000 funded between the PEBB and SEBB Programs.

HCA received half an FTE in our Outreach and Training staffing to increase support for our agencies. This was funded at \$102,000 for the PEBB Program. Similarly, to the decision package above, the funding here is part of a larger decision package. This decision package had a total request for three FTEs with the larger portion attributable to the SEBB Program.

The Board Authority item is neither decision package nor technically funding, but language that exists in all three versions of the budgets. The first part of the language relates to the Board's authority. Increases in benefits are not allowed to be considered unless costs are being offset by other benefit reductions.

Dave Iseminger: Board Members are familiar with this last piece. The Legislature is taking the opportunity to clarify, because of the relationship of the cost of the subsidy, that the concept of reopening the retiree window really does need to go through the Legislature. The Legislature knowing that bill has floated around a couple of years wanted to be very clear that question needs to travel through the legislative path and can't independently be decided under the statutory authority of the Board. The Legislature and the budget is making that authority expressly clear.

Tanya Deuel: Slide 6 – Collective Bargaining Agreement. Each even-year summer we go through bargaining for health care. That agreement needs to be ratified by the Legislature. Everything relating to health care with a financial impact was included in all three versions of the budgets. The employer/employees split, that amount referred to as the state index rate has remained at 85%. Dave mentioned on a previous presentation the \$25 collective bargaining agreement wellness gift card was eliminated, which was approximately \$1.1 million.

Slide 7 – Proposed Budget Differences. The first difference is HCA’s request for PEBB My Account. This is funding to support enhancements, maintaining, and operating the PEBB My Account system. The Governor's budget and the House budget both funded this at \$1.2 million, where the Senate funded it at \$853,000.

The next difference is the retiree enrollment window, which ties back to language discussed two slides ago. The Senate budget included language that required HCA to submit a report to the Legislature by January 2022 to estimate the fiscal impacts with providing a one-time enrollment window for retirees, to include the fiscal impacts of that Medicare explicit subsidy Dave referenced.

2021 Legislative Session

Cade Walker, Executive Special Assistant, ERB Division. Slide 2 – 2021 Bills Analyzed by ERB Division shows that, to date, a total of 143 bill analyses have been done by the Division. High priority bills are those with a financial impact of more than \$50,000 or impact to our rules or policies. Staff have reviewed and provided feedback on 74 hearings as of last week.

Slide 3 – 2021 Legislative Session – ERB High Level Lead Bills. This slide is the funnel of progression of the bills we are tracking for the ERB Division high lead bills. These have the most potential impact on our programs. I want to call attention to the three bills that have made it to the Governor's desk. Senate Bill 5322 has been signed. The two other bills, Senate Bill 5169, regarding personal protective equipment reimbursement and Senate Bill 5313, regarding nondiscrimination for transgender services, made it through the cut offs and is in the final process of having concurrence being done for the amendments in the opposite chamber. We'll continue to monitor those as they make their way to the Governor's desk for signature.

Slide 4 – Upcoming Session – Agency Request Legislation. Senate Bill 5322, pertaining to the prohibition of dual enrollment between the PEBB and SEBB Programs has passed and been signed by the Governor. HCA appreciates the Legislature for supporting this legislation to clarifying the dual enrollment prohibition to ensure HCA can administratively manage these situations.

Slide 5 – House Bill 1052 – Group Insurance Contract is another significant piece of legislation we were tracking that could impact our program. It did not make it past the Senate on Sunday. HCA is currently evaluating options with the Office of the Insurance Commissioner and our authorizing environment on how to resolve the issue of ensuring we can have performance-based contracting to include performance guarantees and performance standards in our contracts that are permissible and align with the current insurance code.

Slide 6 – Topical Areas of Introduced Legislation, lists pieces related to the Paid Family and Medical Leave Program that made it past the April 11 cutoff, and is awaiting concurrence from the Senate for amendments that were made to it. Although these don't have direct impacts on our long-term disability product, we keep a close eye on legislation that may have implications on our benefits. The Paid Family Medical Leave Program bookends with our long-term disability product. There are no apparent direct implications to our long-term disability program or other aspects of our programs.

Only Senate Bill 5195, regarding opioid overdose medication, was voted out of the House ahead of that cut off. We expect to see additional amendments on that legislation before it goes to the Governor's Office.

Slide 7 - Topical Areas of Introduced Legislation (*cont.*). Senate Bill 5018 concerning acupuncture and Eastern medicine passed and is on the Governor's desk for signing. It expands some services. Carrier feedback on this legislation indicated the expanded services are already covered under all our health plans.

House Bill 1196, Audio-only Telemedicine made it through the cut off. HCA will track this bill to see when it gets to the Governor's desk for signature. Once session ends, I will have a final presentation for the Board at a meeting to provide the final details of what transpired during session.

2021 Annual Rule Making

Stella Ng, Policy and Rules Coordinator, ERB Division, provided a high-level discussion on this year's rule making and highlighted significant changes and actions HCA is considering. No action is needed from the Board.

Slide 2 – Rule Making Timeline is the timeline for rules to be adopted for a January 1, 2022 effective date.

Slide 3 – Focus of Rule Making. The focus of this year's rule making is divided into three different areas: adding clarity to rules to better administer and manage PEBB benefits as identified by staff and stakeholders; regulatory alignment; and to implement PEB Board policy resolutions.

Slides 4 and 5 – Administration and Benefits Management. HCA will: 1) add Medicare Part D late enrollment penalty payment be made to the contracted vendor; 2) clarify when a faculty's PEBB medical and dental will begin upon regaining eligibility; 3) restructure deferral rule for readability; 4) describe acceptable delivery methods for filing an appeal; and 5) clarify that a survivor of a retiree who has deferred enrollment may enroll or continue to defer enrollment in PEBB retiree insurance coverage upon the death of a retiree.

Slide 6 – Regulatory Alignment. A few changes were made to implement legislation related to Senate Bill 5322.

Elyette Weinstein: I applaud your clarifications of the deferral provisions. Is there any planned training for these in-house human services departments? I understand that some of us retirees can contact the Health Care Authority, but before we retire, the dearth of knowledge in these human resources departments is appalling. It really would help if these departments were trained, and it was emphasized that they need to talk to retirees / proposed retirees with questions.

Dave Iseminger: Elyette, that's an operational question and something I will talk about with our Benefits Accounts section manager to see if we can describe what we do today that may lead into other ideas for additional work that can be done in that area.

Sue Birch: Thank you, Dave. I will also bring that up to the Cabinet level just to see if there's any cross-agency ideas, and maybe work with Tracy Guerin at Department of Retirement Services about how we could step up those services in the state. We'll need a little time, but that would be a good thing for us to work on during the summer.

American Rescue Plan Act of 2021 (ARPA) – Premium Assistance for COBRA Continuation Coverage

Emily Duchaine, Regulatory Analyst, ERB Division. President Biden signed ARPA into law on March 11, 2021. It provides almost \$2 trillion in Covid-19 relief funding and includes provisions of health care coverage including a 100% COBRA premium subsidy, Dependent Care Assistance Program increase to contributions of \$10,500 maximum for 2021, Medicaid financing and eligibility rule changes, and health insurance marketplace subsidies. Today, we're only discussing the impacts to COBRA and providing a high-level overview of how HCA is preparing for the subsidy.

Slides 3 and 4 – COBRA subsidy Eligibility. The subsidy is available to assist eligible individuals (AEIs). This is a federal term included in ARPA, defined as employees and their dependents who lose or have lost health coverage due to involuntary termination or reduction in hours, voluntary or involuntary, and who are federally eligible for COBRA. Federally eligible for COBRA means a qualified beneficiary or their qualified dependents. For example, a legal spouse or child. A domestic partner is not considered a qualified beneficiary because federal law does not recognize domestic partners as tax dependents.

AEIs are defined as employees and their dependents who either elected COBRA or will elect COBRA on or after April 1, 2021, and before the subsidy ends on September 30, 2021, or who became eligible for COBRA prior to April 1, 2021, and their period of COBRA coverage includes any month between April and September 2021, the subsidy period. It's important to note that even if the individual did not elect COBRA when it was initially offered to them, or they did elect COBRA, but they discontinued it before April 1, they're still eligible to elect COBRA. They can either retroactively elect and have COBRA coverage back to when they lost their employer-sponsored group health coverage and pay whatever back premiums are due, or they can take advantage of the subsidy during the subsidy period and start their COBRA coverage active April 1. Anyone who had or could have had COBRA as far back as November 2019 would potentially be eligible because their 18 months of coverage would extend through April 2021.

Slide 5 – Temporary 100% COBRA Subsidy Timeline. The premiums will be subsidized for six months starting April 1, 2021 through to September 30, 2021. This applies to both medical and dental premiums. This subsidy will end earlier than September 30 for an individual if they become eligible for Medicare or other group health coverage.

Slide 6 – Resolutions PEBB 2020-01 and PEBB 2020-02. These two resolutions are still in effect. The maximum period of continuation coverage was extended until two months after the date the Governor terminates the state of emergency. We are still in that state of emergency. The enrollment timelines were extended to 30 days past the date the Governor terminates the state of emergency.

Slides 7 - 9 – Implementation. HCA will be notifying assistance-eligible individuals of the subsidy availability and the extended election period by May 30, 2021, which is required by the Act. HCA will also be notifying the assistance-eligible individuals of the subsidy expiration, which must be done between 15 and 45 days before the expiration date of the subsidy, which is September 30, unless the subsidy is expiring because the assistance-eligible individual has become eligible for coverage under another group

health plan or Medicare. The notice obligation can be met by amending existing notices already in place or by providing required notices that the federal government has issued in a separate document.

HCA will work with employing agencies to identify assistance-eligible individuals. For existing members, employing agencies will need to verify whether the loss of coverage was due to an involuntary reduction in hours or termination. The federal model notices were released last week. There is a requirement for qualified beneficiaries to attest that they believe they are an assistance-eligible individual by checking certain boxes. That's one way of determining eligibility. HCA will still need to work with the employing agencies to verify certain pieces of information. That's a process we're still ironing out. HCA will provide guidance to those agencies we will work with.

Federal notices have already been released. We are comparing those to the communications we prepared in advance to get ready. Information on the subsidy will be made available on the PEBB continuation coverage COBRA website. HCA staff will be trained on how to determine eligibility of those AEs.

Dave Iseminger: Emily's presentation was supposed to be just the policy piece. The May meeting will be about the operational side, the interactions and training that will be done by the Outreach and Training Unit to gather the data, and support from our Customer Service Center.

Behavioral Health Overview

Dr. Emily Transue, HCA Medical Director, and **Lauren Johnston**, SEBB Procurement Manager, ERB Division. **Dr Transue:** This is a topic that was front and center for us at the Health Care Authority and in the PEBB Program, even prior to the arrival of the pandemic. It has increased in importance since. HCA is aware of the tremendous needs in the population, the importance to meet those needs, and meeting a wide variety of different levels for different people.

Lauren Johnston: Slides 3 and 4 – PEBB Plan Behavioral Health Coverage, are a high-level illustration showing all our carriers have comprehensive behavioral health coverage. The term behavioral health includes both mental health and substance use disorder. Although our carriers have different cost shares, all plans provide several different options to access mental health and substance use disorder treatment. Slide 3 shows the types of in-person care a member can access. Slide 4 shows the types of remote care a member can access whether it's through a contracted virtual care provider or speaking with their existing provider remotely. All our carriers have a nurse line they can call as well as additional programs.

Slides 5 and 6 – Network Adequacy. Carriers assess their network adequacy in different ways. For example, our fully insured carriers like KP Northwest and KP Washington submit their product filing to the Office of the Insurance Commissioner (OIC). This filing includes information like the number of providers within a specific category within a specific radius or a certain amount of time it would take to get to a provider, like the emergency room. These filings are reviewed by the OIC to ensure they meet the OIC's requirements. Most of our carriers are accredited by the National Committee on Quality Assurance (NCQA), which includes an accreditation for network

adequacy. Our carriers also measure access and capacity through member calls and outbound surveys. High-volume services can be identified through claims utilization.

When our carriers identify specific areas of need, they work to expand their networks to improve access, decrease wait times, and improve ease of access to care for the needs identified. Our carriers are constantly recruiting new providers, trying to retain existing providers, and working to create strategic partnerships to ensure they have national providers incorporated into their networks. Our carriers have ramped up their virtual care and telehealth offerings, which we saw in their claims' utilization. There has been a dramatic increase in the use of both telemedicine and virtual care. Kaiser Northwest uses patient partners in mental health to help identify opportunities, different pain points, programs offered, and processes for when a member is trying to access care. Each of our carriers measure access times for routine or urgent care to improve access and to work on improvement.

Emily Transue: Slides 7 and 8 – Similar Programs Offered Across Multiple Plans.

Some plans are common or have similar offerings across plans, and some are more distinct. Some that are similar are several online- and phone-based applications.

Those include My Strength, which is offered by KP Northwest and KP Washington. This is a cognitive behavioral therapy application, which is essentially the principle that often mood is driven by thought patterns and thoughts. If we teach people how to modify and be conscious of those thoughts, mood tends to get much better. Likewise, teaching healthy coping mechanisms. Both of those principles have been shown to have short term and radical improvement in people's emotional state. My Strength is a clinical application that addresses several different individual needs. There are tailored programs to each need a person has.

Calm is another application offered by the Kaisers. This app focuses on meditation techniques, as well as mental resilience, sleep, and sleep hygiene.

Find Your Words is an application to help provide tools and the words to talk about depression with others. It's highly rated self-help based on cognitive behavioral therapy principles. There is behavioral health case management with all our carriers with licensed case managers who provide members with assistance such as coordination of care, care plan management, understanding, and navigating benefits and care options.

Some plans provide concierge services to help connect members to the care they need. The Uniform Medical Plan (UMP) offers Quartet. It takes members and matches them to mental health providers who have openings based on a criteria like geography, insurance, clinical needs, and their personal preferences. Members can self-refer or their primary or specialist provider can help them connect to a provider.

Magellan Healthcare has a product offered by Kaiser Washington that does much the same thing, helping members connect to in-network providers, and specifically to get that first appointment scheduled.

Slide 9 – Plan Specific Programs. Kaiser Northwest offers peer support specialists who have lived experience of either behavioral health, mental health, or substance abuse issues, who share that lived experience and what helped guide them to recovery with our members. Kaiser Northwest also has programs aimed at teens. They have an

intensive outpatient program for teens and another they're planning aimed at older teens and young adults who are particularly at-risk groups for these issues and can be very hard to reach. It's currently on hold because of issues around Covid. Hoping to start this summer.

AbleTo is offered by UnitedHealthcare. This has specific eight-week modules around certain issues, generally involving medical and behavioral comorbidities. The modules are directed towards providing an intersection specifically between medical and behavioral issues.

Slides 10 and 11 – Future Areas of Focus include the Recovery Pathways Program, currently in the pilot stage, with KPNW, focusing on patients with co-occurring disorders. The program includes a psychiatrist, your support specialists, and focus therapists with training in co-occurring disorders. They plan to expand if all goes well.

Also with KPNW is the Spravato (Ketamine) Treatment Program, which is a novel antidepressant previously used as a general anesthetic, recently approved for treatment-resistant depression. The program is currently in the planning phases with the intent to implement in 2021.

KPWA will focus on mental health and wellness recruitment and retention to address gaps in representation. Partnering with the University of Washington Master's in Health Administration (MHA) students on their Capstone Project.

UMP is considering Omada Mind, which is a pilot project currently available to 1,200 members who signed up in Fall of 2020. This is whole person care with dedicated support for anxiety, depression, and stress via Omada for a Behavioral Health Program.

UMP is also considering myStrength, a cognitive behavioral therapy application; a diverse clinical application to meet individual needs of each person.

UnitedHealthcare currently has several programs in proprietary and confidential stages.

Lauren Johnston: Slide 12 – Legislation Passed in 2019. House Bill 1099, referred to as Brennen's Law, requires carriers to provide network adequacy to consumers. The Employees and Retirees Benefits Division has included information on Brennen's Law in the SEBB and PEBB enrollment guides and on the HCA website. The OIC is currently in the process of going through rule development around this bill.

Slide 13 – Legislation Passed in 2020. Engrossed Substitute House Bill 2642 removes barriers to substance use disorder treatment and requires our PEBB carriers, as well as the UMP, to provide coverage for no less than two days, excluding weekends and holidays in a behavioral health agency that provides inpatient and residential substance use disorder treatment prior to conducting utilization review, and provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting utilization review. It also requires our carriers to coordinate care between facilities to ensure seamless transfer as soon as possible to an appropriate and available facility or level of care. The health plan must pay the agent for the cost of care at the current facility until the seamless transfer to the new facility or level of care is complete. It does not require a behavioral health agency to

keep a person until the next level of care is available, but that in the event they do keep the patient, the carrier is required to continue to pay for those days until that transfer to the next level of care is available based on mutually approved treatment.

Emily Transue: Slide 14 – Mental Health Parity. This slide speaks to local laws and federal requirements around mental health parity. In general, federal law prohibits group health plans from imposing any less favorable benefit limitations on mental health or substance use treatment than on medical or surgical benefits. This idea has been around since the Mental Health Parity and Addiction Equity Act of 2008. It has gone through multiple modifications over time, with the last major changes in 2016. Essentially, if you cover something under medical or surgical, you require of a comparable thing under mental health benefit. Our PEBB plans meet this requirement. This is an active ongoing discussion. The interpretation and understanding of parity continue to evolve. It's not difficult to say if you cover in-patient care for medical care, you cover it for behavioral health care. It gets more complicated as you think about applied behavioral analysis for autism, which really doesn't have a comparable service on the physical health side. It has continued to become more sophisticated in how we think about what's equitable and appropriate for parity. Those conversations are ongoing between HCA and our plans.

Lauren Johnston: Slides 15 and 16 - Information on How to Access Services. Members can find more information on our HCA website on how to access services.

Slides 18 – 24 – Appendix, are individual slides for each carrier that is the same information on the website. It also includes questions a member could ask that may help guide the conversation when talking to their customer service representative about their plan, or maybe to identify a care manager. The information also includes phone numbers that a member can use when calling their plan. We always encourage members to call their health plan first if they have any questions on how to access care.

Emily Transue: Slide 16 – SmartHealth. One of the themes you're hearing us say is that different people have very different needs. HCA wants to have different resources available to meet those needs. The challenge being not everyone is aware of how to put a label on what they're experiencing.

SmartHealth is an important tool in our wellness program, available to all PEBB and SEBB Program employees. There are several behavioral health related topics on SmartHealth. Every carrier has a tile around mental health and mental health care. There is currently a mental health tips tile that will run through November. There will also be a tile around mental health during May, Mental Health Month. Eligible members can log in or register for an account if they don't have one and can explore what's available through SmartHealth and earn points for their wellness incentives for performing these activities.

Sue Birch: Thank you, Dr. Transue and Lauren. I want to encourage Board Members, you serve as dignitaries and our syndromic surveillance watching for things like emergency reviews, or alcohol sales, and some of the indicators we watch for in psychological distress are really concerning. We need an educated society about spreading the word and echoing these messages of available services. We know there are challenges for people to get in for counseling, which is why we've committed to

keeping our nearly 2,000 Zoom licenses available for our behavioral health workforce. If you have any interest in taking Mental Health First Aid through our agency or learning more about the subject, this is an area we're going to continue to evolve and get more services. We do get quite a few complaints that parents can't get their kids in for counseling services. We simply do not have the workforce and the system set up in America yet to really advance on more stable access to behavioral health care. I appreciate all the staff is doing and sharing with us, but please, Board Members, serve as spokespersons because life's really been hard on all of us watching, and referring, and doing our part in advocating for more resources in this really critical area.

Public Comment

No public comment.

Next Meeting

May 12, 2021

12:00 p.m. – 3:00 p.m.

Preview of April 7, 2021 PEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the May 12, 2021 Board Meeting.

Meeting Adjourned: 3:23 p.m.

Draft
Public Employees Benefits Board
Meeting Minutes

May 12, 2021
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
12:00 p.m. – 3:00 p.m.

The Briefing Book with the complete presentations can be found at:
<https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials>

Members Present via Phone

Sue Birch, Chair
Elyette Weinstein
Tom MacRobert
Leanne Kunze
Yvonne Tate
John Comerford
Scott Nicholson
Harry Bossi

PEB Board Counsel

Michael Tunick

Call to Order

Sue Birch, Chair, called the meeting to order at 12:05 p.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting is via Zoom only.

Meeting Overview

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda.

For today's Board Meeting, we're highlighting Southwest Washington, both Cowlitz and Clark Counties. Demographically, about seven percent of the population of Cowlitz County and Clark County each are in the PEBB and SEBB Programs. In the Medicaid program is an additional 33% of the Cowlitz County population enrolled in Medicaid and an additional 24% in Clark County in Medicaid. Between Medicaid, PEBB Program, and SEBB Program, we serve 40% of the Cowlitz County population and 30% of Clark County's population.

Unemployment rates are higher in Cowlitz County and lower in Clark County relative to the state. Same for the uninsured rates. Cowlitz County is hovering around 8%, Clark County is a little under 5%, and the statewide uninsured rate is about 6.8%. Median household incomes in that region are higher than national averages but lower than statewide averages. Housing costs are higher than the national averages but generally tracking within the state. It's important to highlight that Clark County essentially is a commuter population or suburb of Portland. There's more accessibility in that region because of access to the Metropolitan health care infrastructure. Between availability within the Vancouver Clinic, Peace Health Southwest, Legacy Salmon Creek, as well as Oregon Health System University, and other parts of the Portland infrastructure, there's a lot of accessibility within the region of where to access services.

The last thing I want to highlight that's unique to the PEBB Program is political subdivisions of the state can contract with the Health Care Authority for access to PEBB benefits. Currently over 300 political subdivisions participate in the PEBB Program. Other entities can also contract with HCA for benefits, like tribal governments, several of which are in the Cowlitz County Region. That includes the Cowlitz Tribe and the Cowlitz Tribal Housing Authority. They're around our 10th largest political subdivision, out of roughly 300 to 325 subdivisions.

This leads me to the land acknowledgement statement I share at the beginning of each meeting. I want to acknowledge that our meeting is supported physically in Olympia at the Health Care Authority on the traditional territories of the Coast Salish people. This area was a primary portage to and from the Puget Sound. The lands were shared by several tribes, including some we know today as the Squaxin Island Tribe and the Nisqually Tribe. HCA wants to honor and thank their ancestors and leaders who have been stewards of these lands and waters since time immemorial.

Sue Birch: The Board will now go into Executive Session. Pursuant to RCW 42.30.110(1)(l), the Board will now meet in Executive Session to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services, as provided in RCW 41.05.026.

Executive Session Concluded at 1:13 p.m.

2021-23 Biennial Budget Update

Tanya Deuel, ERB Finance Manager, Financial Services Division. Slide 2 – Final Funding Rates shows the funding rates for FY 2022 and FY 2023. In the next legislative session, HCA will possibly update the FY 2023 funding rate. Both amounts match the House and the Senate that I presented to you last month. We believe the underlying assumptions are adequate to maintain our current level of benefits and have no concerns with these funding rates.

Slide 3 – Medicare Explicit Subsidy. This is the state's contribution towards our Medicare retirees' health care premiums. The amount remains the same at \$183 or 50% of the premium, whichever is less. This amount has not changed since calendar year 2020.

Slide 4 – Collective Bargaining Agreement. The amounts on this slide remain the same since our last discussion. The employer and employee split will remain at 85% for the employer and 15% for the employee. A \$25 collective bargaining agreement wellness incentive gift card has been eliminated in bargaining, which was valued at approximately \$1.1 million per calendar year.

Dave Iseminger: There are dozens of collective bargaining agreements negotiated by the Governor's Office. A few of those agreements did not result in a successor agreement or a new contract. When that happens, the existing contract evergreens for a year and negotiations continue. There are a few instances where a successor agreement was not reached and the old or existing agreement evergreens over. Under those narrow situations, HCA will continue to honor that collective bargaining provision related to the gift cards. Although the gift cards are being eliminated and retired for most of the program, there are a few vestige agreements and a couple of isolated scenarios where gift cards will remain for a brief period into 2022.

John Comerford: I mentioned this to Dave earlier or a couple months ago. The concern I have is some folks probably receive Medicare. I only pay \$169 a month for my supplement. I'm just wondering, that seems high, \$183 or 50%, whichever is lower. Do we negotiate Medicare rates on a regular basis, every year?

Tanya Deuel: Yes, annually. In January, we start the Request for Renewal (RFR) process, where we ask carriers to start the negotiation process to identify proposed benefit design changes or anything they need to change for legislation that passed. HCA is in the first round now working through rate negotiations. We receive proposals from each Medicare carrier - Kaiser and Premera for the supplement plans. We get bid rate proposals and then develop those rates ourselves for the Uniform Medical Plan. Over the next couple months, there will be multiple rounds of reviewing underlying assumptions, looking at trends and impacts to those rates for each of our carriers. HCA goes back and forth negotiating to get the lowest possible premium for the member. The bid rates received from the carriers are then reduced by the Medicare explicit subsidy. The amount the member pays is less, that \$183 or 50% of the premium.

John Comerford: Do we ever have a more open and competitive process where we invite other carriers to submit bids?

Tanya Deuel: We just did. This last calendar year was the first year when we did an open procurement for a Medicare Advantage product. We solicited a national PPO network for a Medicare Advantage product plus Part D. That's where we were able to identify UnitedHealthcare as the winning bidder of that procurement, providing two new plans.

Sue Birch: John, it's important to clarify that, without looking at the specifics of a supplemental product, it's not a fair comparison to think about price solely. Those are very different products is my very broad statement. I think we'd have to understand a lot more about your concern there.

Tanya Deuel: We definitely have supplemental products. We have coordination of benefit products that have coordination of benefits with original Medicare, as well as Medicare Advantage products, one with Part D and one without Part D.

John Comerford: I'll follow it up over the next year. Thank you very much.

Tanya Deuel: No problem. John, we will be getting into our Medicare rate presentations over the next month or two where we will walk through specifics of plan design and rate recommendations to the Board, both in Executive Session and publicly.

John Comerford: Great. Thank you very much.

Elyette Weinstein: Tanya, I'm assuming when you talk about employee plans, you're referring to active employees. You would say retiree if you meant retiree benefits or retiree plans, am I correct?

Tanya Deuel: Typically, unless I just had a slip up that you're pointing out.

Elyette Weinstein: Okay. Secondly, on Slide 5, what does TPA stand for?

Tanya Deuel: That's my next slide. Slide 5 – Final Conference Budget Funding, refers to the decision packages funded through the conference budget. I've walked through these both at the retreat and our last Board meeting. This is the final funding we received. Elyette, to answer your question on my first bullet, TPA spending authority is our Third Party Administrators. These are who HCA contracts with to administer our self-insured medical and dental plans, primarily Regence and Delta Dental. Each year we get increased enrollment in those self-insured products, so HCA needs to request spending authority from the Legislature to be able to spend those funds from those accounts. \$5.9 million is a typical decision package you will see mentioned year after year as our enrollment increases in those self-insured products. Typically, this amount is already included in our funding rate projections and this is to catch up with that spending authority.

The scheduling tool replacement decision package is the tool used by our Customer Service Unit for staff scheduling. The decision package was a total of \$300,000 split between the PEBB and the SEBB Programs, with the majority attributable to PEBB with 95%.

Benefits Administrator Customer Support received half an FTE in our Outreach and Training Unit to support agencies. This was also part of a larger decision package between the two Programs. The SEBB Program received 2.5 FTEs.

PEBB My Account received \$1.2 million, which includes two FTEs to support enhancements for a more robust maintenance and operations of our PEBB My Account system.

Dave Iseminger: We will bring a presentation later this Board season on PEBB My Account about launching that product and its use. The \$1.2 million is for maintenance and operations staff going forward once the platform launches.

Sue Birch: I want to punctuate what Dave's saying about PEBB My Account because we as Board Members will receive a lot of feedback. Dave will bring back more but we are modernizing for the first time in 20-some years. We will go from a paper enrollment

system to a fully automated account enrollment system. It's a big deal and Dave's done this successfully with SEBB My Account, so we're pulling those features over to the PEBB Program. This is a significant mile marker for the work of the ERB Division.

Dave Iseminger: Two pieces of context: 40 years, not 25 years. Paper isn't going away in its entirety. It will continue to be an option, but we're moving from a world where paper is the only option to electronic self service, which we know members will take advantage of.

Sue Birch: I knew it was a very long time!

Tanya Deuel: Slide 6 – Final Conference Budget Provision. This is new for the Board, so I wanted to include it in this presentation. In the final conference budget, we did receive a proviso where HCA will provide a legislative report by next January to estimate the financial impacts of providing a one-time open enrollment window for our retirees. Currently, that does not allow the Board to make changes in retiree eligibility criteria regarding PEBB benefits. House Bill 1040 was introduced this session regarding that retiree eligibility window. HCA produced a fiscal note regarding allowing that one-time enrollment window for school retirees and their dependents. This legislative report will somewhat mirror that fiscal note from January 2021.

Dave Iseminger: Over various bienniums, there have been retiree enrollment window bills. HB 1040 is the most recent in the current biennium, but prior bienniums have had different versions. Some included caps on the number of people who can enroll, some only included retirees from certain pension systems, some included all pension systems. There's a variety of ways this fiscal analysis can be done to show the broad impacts. There's a historical reason and a modern reason why I think this report has come up in the final conference budget. The historical reason is there are a variety of school employees who may not have understood or known to come towards the Health Care Authority as a potential benefit option when they entered retirement decades ago. They missed their eligibility window when they were transitioning from their employment status. With SEBB, the bridge to PEBB retiree coverage is much clearer. I think we've begun to see increased enrollment of K-12 retirees in the short period since SEBB launched.

The modern reason is with the establishment and offering of the MA-PD plans, there are now additional affordable options that were not in the portfolio when retirees were making their original eligibility and enrollment choices with regards to accessing PEBB benefits. With this increased diversity of plan availability and cost, the portfolio may be, again, a more attractive option than other options those former state and school employees are seeing elsewhere. I think it's the potential leveraging of the new plans that might be desirable to some former employees.

Elyette Weinstein: Am I correct in understanding that this study will focus on both PEBB and SEBB covered employees?

Dave Iseminger: Correct, Elyette. It will involve former school employees, former state agency employees, former higher education employees, the full smorgasbord of individuals who could be eligible under the existing retiree framework.

Tom MacRobert: I believe, Dave, you were contacted by some people about the inability at the time they retired to afford the health care benefits they would have been required to pay under the UMP plan so they chose another option or to go uninsured until they reached Medicare eligibility, at which time they felt they would be able to afford. Of course, then they found out they could no longer enroll in the HCA. I'm assuming this study is going to address the desire on the part of some people to get back into the Health Care Authority and it will address specifically what the costs would be to the state were they to have that option made available to them. Is that correct?

Dave Iseminger: Yes. The beginning of your question was that modern reason why I think this report is coming up, leveraging an opportunity for those lower cost plans that weren't there when the individual is entering retirement and having to make a choice as to accessing the portfolio or not. They may have chosen not to access the portfolio because there wasn't an option they felt met both their health care needs and their budget. But now with the MA-PD plans, that calculus can be very different. The report will focus a lot on what the potential obligations of the state would be for the explicit subsidy with increased enrollment under the various pension plans from the various sources of retirees in the system, whether it's K-12 or state agencies.

Tom MacRobert: Do we have an idea how many people might be affected by that?

Dave Iseminger: This is where the devil gets in the details, Tom. Tanya mentioned House Bill 1040. I believe that bill didn't hit all the pension plans, only the one set of plans.

Tanya Deuel: House Bill 1040, the most recent bill, only addressed the Teachers' Retirement System (TERS). When we looked at eligibility, it's hard to know who's drawing a pension. At the time we did the fiscal note, there were about 15,000 drawing a pension under TERS because you still must be withdrawing a state pension. We had to make assumptions for the purpose of the fiscal note, how many were already enrolled, who would come in, and who would add dependents, then it's simple on the financial piece as to remember the state only contributes the Medicare explicit subsidy. However, the Medicare explicit subsidy is funded by all three groups that participate in the retiree benefits. The funding rate must cover a portion of it, the K-12 remittance must cover a portion of it, and then our local government, through our employer groups, must pay a portion of retiree costs. The total cost is divided by the three groups.

Dave Iseminger: Tom, in the recent fiscal note, which was just TERS, we were looking at a range of 8,000 to 10,000 individuals that could be impacted, but that's a subset of the entire population. When we do this report, we'll describe the potential cause related to the full range of pension plans that could be open for eligibility. That gives you a snapshot at least. It's not a small number, we're talking five digits.

Tanya Deuel: Right because it would allow for dependents and spouses also.

2021 Legislative Session

Cade Walker, Executive Special Assistant, Employees and Retirees Benefits Division. Slide 2 – Number of 2021 Bills Analyzed by ERB Division, recaps the number of bills done by the Division.

Slide 3 – 2021 Legislative Session – ERB High Lead Bills, is our progress funnel. Two of the bills we were tracking made it to the Governor's desk for signature, Senate Bill 5322, Prohibiting Enrollment Between SEBB and PEBB Programs and Senate Bill 5195, Opioid Overdose Medication. SB 5169, Provider Reimbursement for Personal Protective Equipment also passed.

Slide 4 – Upcoming Session – Agency Request Legislation. SB 5322 Prohibiting Enrollment Between SEBB and PEBB Programs passed and was signed by the Governor. HCA is implementing this legislation for the 2022 plan year.

Slide 5 – HB 1052 – Group Insurance Contracts. This bill did not make it out of session. It was caught up in the Senate due to other legislation ahead of its consideration. HCA is in conversations with the Office of the Insurance Commissioner (OIC) to determine HCA's next steps. This bill will continue to be introduced by rule next year. We fully anticipate another full court press in supporting its passage, working again with the OIC.

Slide 6 – Topical Areas of Introduced Legislation. Two pieces of legislation passed related to the Paid Family & Medical Leave Program. One has been signed by the Governor and the other is waiting for his signature. HCA was tracking these bills to stay attuned to potential impacts to our long-term disability product, but neither piece would impact our LTD product.

Senate Bill 5195, Opioid Overdose Medication expands the requirement for providers to give an overdose medication prescription to individuals who presented to an ER or other facility with an opioid overdose. No significant impacts to HCA because of the availability of overdose medication currently paid for by our Programs.

Slide 7 - Topical Areas of Introduced Legislation (*cont.*). Senate Bill 5018 – Acupuncture and Eastern Medicine passed with no significant impact on our plans as these services were already covered.

House Bill 1196 – Audio-only Telemedicine also passed. 2SSB 5313 – Health Insurance Discrimination also passed, pertaining to expanding the accessibility for gender affirming services. No significant impact to our program because of our compliance and services already covered.

Elyette Weinstein: I have a question about SB 5020. Given your expertise, why do you think it wasn't passed? And secondly, what do you think might help it get passed next session? As you know, it's still alive for purposes of the Legislature.

Cade Walker: In my quick review of the bill [SB 5020-RX Drug Price Increases], it didn't get to committee. I appreciate you feel I have an expertise on this. I would suggest there are other folks more politically involved in the actual process outside of the agency, possibly Dave or maybe Ryan Pistoresi.

Dave Iseminger: Elyette, the legislative process is inherently a political process. Sometimes you never know why a bill does or doesn't pass. For House Bill 1052, it was a timing problem. It was in the queue and scheduled for a vote, but debate on other bills took longer and it didn't make the cut off. Sometimes it's as simple as that. During

this legislative session, I feel confident that the inherent nature of the tele-legislative process that bills got lost in the shuffle. When you are working remotely, the nature of lobbying and stakeholder engagement is very different. It's very easy for something to get lost in the shuffle.

Then there's policy differences. Maybe you don't have enough people who agree with your policy position to have majority support to pass a bill. Some of that is based on a misunderstanding of a bill or the words don't quite get there in some people's minds. It can be a host of reasons. I don't know that we have any real specific insights as to where it falls on that spectrum. It's hard to give specific guidance on the why and the how. There are bills that take decades to pass for a policy reason and others fly through on the first attempt.

Sometimes there are bills that the leadership of a party just don't want that bill to pass. I'm not saying in this instance, but they can set the calendar so it doesn't pass. It could be anything, and again, I'm not ascribing any of those reasons. I'm describing generally why a bill might not pass.

John Comerford: Cade, I've talked to Sue about this I think at the last meeting. The state passed the Washington Cares Long-Term Care trust bill and it impacts state employees. There are very tight windows in that. For instance, an exemption must be filed between November 1 to the end of the year. Has the state got any plans to help employees either get a long-term care insurance policy or figure out how to opt out?

Cade Walker: I think it's a great question. It wasn't brought up in this legislative session. I have some understanding about the new Long-Term Care trust and those issues as I've been working on them with the SEBB Program. But I will turn to Dave to see what he can share related to that for the opt out window at the end of the year.

Dave Iseminger: What I can add, John, is first a reminder that this new product benefit isn't something managed or administered by the Health Care Authority, but we are involved in it. I believe Chair Birch is a member of that body for that new product line, that again isn't administered at HCA. My understanding at this point is that as a state produced benefit, we're not headed in a direction of opting out state employees. That's often the case when there's a new program brought up for employers. Even if there are opt out provisions for other employers, the state generally participates in the benefits established by the state. I don't believe there's any strong intent or movement to proceed in an opt out direction for state employees.

Cade Walker: John, the opt out is on an individual basis so the state wouldn't be opting out anything.

John Comerford: Oh, no, I understand that. My concern is I'm on the private side and I'm doing a lot of work in this area with private companies. It's a fiduciary issue to make sure they educate their employees in knowing that they can opt out. If they don't, then they'll be tied in this forever when they work with Washington State. I was wondering if there was any kind of a plan to educate public employees about the exemption.

Sue Birch: At this point, that has not been the topic at the trust board discussions. But as that matures, John, we can talk about this offline since it's separate.

John Comerford: I had Cade here and I thought since he was captive, I'd ask him about it.

Ryan Pistori: In response to the question on Senate Bill 5020, I was the lead bill analyst for HCA. I echo what Dave said. I wanted to reiterate that other states also introduced this legislation. It was being sponsored by national organizations and it also faces challenges in other states. One of the areas where they're going to take this feedback and help develop a new version in the future is addressing some of the concerns patient advocacy groups brought up during the public hearings. Not only in our state, but in Hawaii and a few in New England also saw a similar process. I think there's ongoing work to resolve those issues. I wouldn't be surprised to see something similar come back in future sessions.

Elyette Weinstein: Thank you. That was very helpful.

Sue Birch: Cade, on behalf of the Board, huge kudos to you for shepherding all this through with Dave and doing such a fine job in a very awkward legislative period. That quarantine threw everybody for some challenges, but thank you, Cade, for all you've done.

COBRA Subsidy Support for Benefits Administrators & Members

Jesse Paulsboe, Manager, Employer Outreach & Training Unit and **Stacy Grof-Tisza**, Manager, Customer Service Operations Unit, ERB Division. Slide 2 – Overview of the American Rescue Plan Act of 2021. For purposes of this presentation, Benefits Administrator is an umbrella term for personnel, payroll, and benefits office staff within the various PEBB Program employer groups and institutions. The American Rescue Plan Act of 2021 provides almost \$2 trillion in COVID-19 relief funding and includes provisions that affect health care coverage, including a 100% subsidy of the COBRA monthly premium for assistance eligible individuals (AEIs) from April 1 through September 30, 2021. For these individuals, the federal government will pay their monthly premiums and applicable premium surcharges for up to six months of COBRA coverage. AEIs are employees and dependents who lose or already lost health care coverage due to involuntary termination or reduction in hours, voluntarily or involuntarily, and are federally eligible for COBRA. Additionally, they cannot be eligible for Medicare or group health care coverage.

Slide 3 – Outreach & Training Unit (O&T). This team serves the PEBB Program as the primary support resource for Benefits Administrators (BAs). It consists of a reactive customer service element which helps educate BAs by responding to employer questions and concerns. The staff also develop and deliver program training, webinars, materials, and guidance to BAs. Together these two efforts ensure the employers achieve accurate eligibility and enrollment decisions for their employees' accounts.

Slide 4 – Implementation of the COBRA Subsidy shows the process required to satisfy the federal requirements of this act. O&T staff partnered with employers to obtain the required information.

Slide 5 – COBRA subsidy Implementation Timeline shows the short timeline HCA had to complete the required task. As of this morning, about 20% (154) of the total organizations have returned their spreadsheets.

Stacy Grof-Tisza: Slide 6 – COBRA Subsidy Readiness. Once the O&T Unit received the information from the Benefits Administrators identifying assistant eligible individuals (AEI), the Customer Service team will use that information to determine the AEI eligibility. At that point, the Benefits Administrator’s work is complete. If individuals have further questions about their COBRA eligibility, they can reach out to our Customer Service team on our 1-800 line.

Slide 7 – COBRA Subsidy Customer Service Implementation. This team is responsible for the administration and processing of the COBRA and continuation coverage forms. Work is underway to prepare for this new initiative which includes training staff on new eligibility and processes, prioritizing COBRA subsidy forms for staff to process, reviewing forms for eligibility once they are received, enrolling eligible AEIs, and sending approval letters or denial letters with appeal rights to ineligible applicants.

Slide 8 – COBRA Subsidy Eligibility identifies three different scenarios of continuation coverage where individuals would be eligible for the subsidy. Those who are currently eligible, still eligible but not currently enrolled, and newly eligible.

Slides 9 – 12 – COBRA Subsidy Eligibility Scenarios. These slides discuss the three different scenarios of who is eligible for this subsidy.

Slide 13 – Deadlines. For those eligible and wanting to enroll in the COBRA subsidy, HCA must receive the required forms no later than 60 days from the date of the initial subsidy eligibility letter. Members currently enrolled must submit a Request for Treatment as an AEI form. Even though members are currently enrolled in COBRA, HCA still needs this form completed due to additional information needed to determine eligibility that HCA and former employers may not have. For those still eligible but not currently enrolled and those who are newly eligible, they must submit the 2021 COBRA Subsidy Election Form for PEBB Continuation Coverage (COBRA) and the Request for Treatment as an AEI form.

Agenda Item

Ryan Pistorosi, Assistant Chief Pharmacy Officer, Clinical Quality and Care Transformation (CQCT) Division. Today’s presentation is an update on the 2020 Uniform Medical Plan (UMP) Preferred Drug List (PDL). The Board voted to transition to a value formulary in 2019.

Slide 2 – What is the Value Formulary? This slide defines the value formulary which is aimed at directing members and their health care providers to the highest value, most affordable prescription drugs on the UMP PDL. We took Tier 3 drugs that were previously at a much higher cost share and made them nonformulary in consultation with MODA because these were drugs with no additional benefit, safety, or efficacy when compared to the preferred alternatives. These are drugs in drug classes that have a lot of alternatives and drugs similar in terms of their safety and efficacy. To direct members towards the most value-based drugs, we’re moving these drugs to be

nonformulary because they often are significantly higher in cost than the preferred alternative. An example is using a brand name drug when generics are available. The generics are interchangeable, and the FDA has reviewed and approved them to be the same efficacy and safety. Brand name drugs cost more.

There is an exception process for the member when a formulary drug is deemed ineffective or not appropriate for an individual member.

Slide 3 – Why the Value Formulary? In 2018 HCA identified a member equity issue where some members were using Tier 3 drugs and knew about the tier exception process and were paying a lower cost share and other members didn't know about the process. HCA also wanted to address Board concerns that members would be protected and ensure they were getting therapeutic alternatives with a pathway that would allow them to receive the nonformulary drugs if they were the most appropriate for them.

Slide 4 – What We Did to Prepare. HCA worked with Washington State RX Services, or MODA, on training their customer service and getting them ready to handle member questions on the changes to their pharmacy benefit. We did a staggered approach, sending different letters in different stages so the Customer Service Team at MODA was not overloaded and the members who were calling did not have exceedingly long wait times to get a customer service representative. This same approach was implemented for the Oregon Educators Benefits Board (OEBB) health plans in 2018.

Slide 5 – Refill Protected Classes. The left column has the refill protected drug classes originally proposed in 2019 to the PEBB Board, as these are the drug classes refill protected on the Washington preferred drug list, which UMP participates in. MODA experienced in their transition with OEBB, they added in the additional drug classes as shown in the right column. HCA used that experience to help members using drugs in these drug classes.

Slide 6 – Communications lists the different resources HCA used to communicate to its members. Letters were sent to specific members.

Slides 7 & 8 - Member Experience. These slides show the members affected, requests, denial rates, etc. 40% of the denials were due to not meeting FDA approved criteria. For example, if they did not meet the FDA approved indications, if they did not meet the required age requirements for the drug, or if there were certain additional criteria, like with Xifaxan, which is approved by the FDA for a total of three courses per lifetime for irritable bowel syndrome for diarrhea. In case you were requesting it for a fourth time or greater, it is not considered FDA approved. HCA uses MODA's standard prior authorization criteria and that will continue to apply for these drug reviews.

Sue Birch: I think this is critically important and I want to make sure I fully get this. Of those denials, 9% were due to not meeting clinical policy criteria, but the rest were things we caught because these are denials, and in essence, medical sloppiness. Is that correct?

Ryan Pistorosi: Yes, I would say a lot of the drugs impacted were in that 40% we do not have a lot of utilization management on, given that they are not like the highest cost

or highest utilized drugs. These were certain older drugs and not necessarily used for, the high-cost disease states that we typically are reviewing like diabetes, rheumatoid arthritis, cholesterol medications, the ones that we spend a lot of time on. These were catching up to drugs that had not been reviewed recently and members would have been on and did not know there were preferred alternatives.

Sue Birch: Being a nurse in the system, I think this validates why we needed the value-based formulary. What you implemented caught sloppiness. This, in my opinion, helped people avoid possible negative outcomes. In hospitals, we worry about the infections we give people if they stay too long, seven- or ten-day admissions usually lead to what we call nosocomial infection. We induce more problems. In my opinion, this is the equivalent. You've just helped strain out of these denials, virtually 91% of sloppiness, or where harm could have come to people by doing a better job. I just want the Board to really note that this is a big deal. It's great.

Ryan Pistori: I think it's a great deal, too. Being able to catch these upon the review and applying the medical necessity criteria we think is very valuable to ensuring members are receiving the appropriate medications.

Slide 9 – Member Appeals and Complaints. Of the medications denied, appeal rights were given. These two graphs show member experience in 2020 around the appeals and complaints. The graph on the left side shows the total Tier 3 exception appeals in 2019 and the total formulary exceptions in 2020. The Tier 3 exception process wasn't being utilized well in 2019, and going through 2020, there were more denials, so subsequently more member appeals. There were 287 first level appeals and about 6.5% of those drugs that were denied through the formulary exception process generated appeals. Of those 287, 132 (46%) were overturned because they were able to present new medication to MODA for their clinical reviews or the members tried one of the other preferred alternatives. It may not have worked or there may have been safety concerns, and they went through the request again and were approved. Of the remaining 155 upheld denials, 15 moved to second level, and of those 15, three moved to an Independent Review Organization (IRO). There was an increase in the appeals for the formulary exception process.

The graph on the right side of Slice 9 looks at the total number of appeals on the clinical side for UMP with the yellow bars showing prior authorization step therapy or quantity level limits. These would have been the utilization management strategies in place for 2019 for those Tier 3 drugs. Between 2019 and 2020, there were fewer total appeals due to prior authorization step therapy and quantity level limits, which is restricted to the Value Tier, Tier 1, and Tier 2 drugs. We also saw a similar number of complaints in the not covered drugs and a decrease in others. Other types of clinical or administrative appeals were also seen. Overall, the total number of appeals between 2019 and 2020 was similar, although it was a shift from the standard utilization management to the formulary exception process.

Dave Iseminger: Ryan, I want to ask a question to drive it home. Normally when we see a jump in appeals, we have a concern because we think something happened. Here we know what happened, there were hundreds or even thousands of individuals who might have been eligible for the Tier 3 exception process, but never pursued it. Very likely, they didn't understand it or know it was available. So, this jump in appeals is

really because of the way the value formulary is implemented. Again, that member equity issue of people paying hundreds of dollars when they could have been paying a \$75 copay, but didn't, for whatever reason, go through the process. We now put them through that process. As a collateral piece, we see a jump in appeals. Is that a way to frame things and understand this?

Ryan Pistorosi: I think you said it better than me. This is something we would have expected given all these members were required to go through the process. You think about how many members we sent these letters to, how many authorization reviews were approved on the initial request, how many denials we saw, and then of those, how many members were maybe one drug away? They could appeal and provide new information and ask to get it approved. 46% of these first level appeals were overturned with new information or maybe trial of another drug. We would have expected this in requiring these numbers to go through this process.

Dave Iseminger: Those individuals for whom it was overturned are now paying a lower rate than they were before or getting coverage for a drug that was formerly not covered. It's interesting to think about it that way because normally when there's an appeal, we think what's the problem we're trying to address? We addressed the problem, which resulted in more appeals, a subset of appeals, but it was all with the goal of getting people to the most efficacious drug at a better out-of-pocket experience than what they were experiencing under the former formulary process.

Ryan Pistorosi: I agree.

Elyette Weinstein: I didn't catch what some of the acronyms stand for.

Ryan Pistorosi: Good point. PA stands for prior authorization and ST stands for step therapy, which requires a patient to use a specific drug before another one. It's like prior authorization but it doesn't have the clinical criteria. QLL is quantity level limits, putting utilization limits on drugs. For example, if you wanted to make sure no one was taking too many of a certain drug per month, you could put a quantity level limit. If a drug is sold in 10 milligram tablets and 20 milligram tablets, and if someone took two of the 10 milligram tablets, effectively a 20-milligram dose, they would be spending twice as much on the drug, if the 10 milligram and 20 milligram tablets cost the same. You put a quantity level limit on the 10 milligrams to say you can only get 30 of these per month. If you did need to use 20 milligrams, you'd have to use the 20-milligram version.

Sue Birch: I want to check on Board Members because I see heads and eyes spinning. Is this how the US health care system works? I am grateful to our pharmacy team that brought this forward because again, the medical errors, the gaming, and the capitalistic nature, you can see how our members can get rolled with this. I see Elyette, thumbs up. I want to applaud this analysis, Ryan. This is an important gatekeeping thing. It makes me very sad to think I have spent four decades being involved in a system, the health care macro system, that delivers this kind of unnecessary tool. This is really important for the protection of our members, not just financially but with the quality of their health care because you can imagine with those 10-milligram tablets and these limits, it gets dizzying. Can you imagine when it's a senior? Yes, I see heads shaking.

Ryan Pistorosi: That was an additional benefit of this that we had the opportunity to go through and do additional clinical reviews on all these drugs. Not only does it address the equity issue, or the member's cost, but we had pharmacists at MODA doing these reviews to make sure these were the right medications for the members.

Slides 10 & 11 will confirm members transitioning for these drugs were able to continue to take drugs and use drug classes, which we know was one of the Board's main concerns in 2019.

Slide 10 – Preferred Use (2019 to 2020), has a graph looking at three different subclasses of diabetes medications selected because diabetes had the highest number of impacted members, the highest number of drug classes impacted, and the highest amount of the formulary exception requests. It's a good illustration of the member experience. The columns show the number of members using preferred and non-preferred drugs in these drug classes. There are two columns for GLP-1 agonists, 2019 and 2020; two middle columns for DPP-4 inhibitors, 2019 and 2020, which are a slightly older class of anti-diabetes drugs; and two columns on the right for SGLT-2, inhibitors, 2019 and 2020, which are a newer diabetes drug class.

The GLP-1 agonist, went from about 73% preferred drug use in that class, to 93% in 2020. The number of members using this drug class rose. This number of preferred drugs in this drug class was expanded so members could continue to use more in this class. This illustrates why we saw more preferred drug use and an increase in utilization overall in 2020. This is one of the more popular drug classes and one we may even see expanded in 2021 for non-diabetes related indication. We're watching closely.

The DPP-4 number of preferred drugs also increased from 77% to almost 99%, but utilization dropped primarily because members using nonpreferred drugs may have opted to switch from this older drug class to one of the newer drug classes. We are not necessarily seeing members go without their drugs. We've seen a steady decline in this drug class the last few years with the rise of the GLP-1s and the SGLT-2s. Although the DPP-4s continue to decrease, this highlights the amount of preferred drug use is remaining flat, which means they continue to use the preferred drugs in this drug class.

The SGLT-2 inhibitors almost reached 100% for preferred drug use. There was increased utilization as well as members focusing on the preferred drugs in this class.

Dave Iseminger: Ryan, to double check my understanding, those non-preferred drug users who ultimately became a preferred drug user in 2020 are an example of someone who now pays less out of pocket every month for their diabetes drug. Is that right?

Ryan Pistorosi: That is correct.

Dave Iseminger: When you add up all those differences, it's easily over 1,000 people who, every month, have more disposable income today than they did before, and they're taking an equally efficacious drug today compared to what they were before. Correct? Everything I just said true statements?

Ryan Pistorosi: Right. If you think about these patients with diabetes, they likely have other chronic medical conditions. This is not the only drug they're taking. In fact, they may be taking multiple drugs for diabetes, even multiple of these drug classes. They may be taking medications for hypertension, for hyperlipidemia. They may have COPD or asthma. This is not looking at just a single person taking a single drug. These are members who are among our highest cost members that are spending the most on prescription drugs. Not only will it help them pay for this drug, but it could be helping them pay for other prescription drugs as well.

Dave Iseminger: For a finer point, you had an example of a diabetes drug where somebody was shifting and spending \$300 or more less every month by moving from non-preferred to preferred drug status. This can be a significant amount of money, especially as you said, when you have comorbidities and you're doing this across multiple medications, to the kind of kitchen table economics we often hear from our retiree community about their concerns. This is a direct infusion of kitchen table dollars because of this change by the Board.

Ryan Pistorosi: In fact, that drug that you were referencing from an earlier slide is in column number two. Those members using the green drug went through the formulary exception process and demonstrated they can't use any of the preferred drugs, so they are getting that drug at that Tier 2 cost share. All the drugs you see in the 2020 columns, are all at the Tier 2 cost share.

Elyette Weinstein: Am I correct in understanding that the slide we're looking at, Slide 10, these are all diabetes related drugs, are they not?

Ryan Pistorosi: Yes, all three of these are different subclasses of diabetes medications. You may be saying to yourself, if someone were taking a non-preferred drug in 2019 and switched to a preferred drug in 2019, wouldn't they be counted in both? That's technically correct. On Slide 11 – Scripts/1000 (2019 to 2020) shows a breakdown by the number of scripts per 1,000 members. The graphs are very, very similar to Slide 10. There are slight differences. In the GLP-1s, through the different metrics we used internally to evaluate the member experience and the utilization of these drugs, it tells a similar story that they continued to have access to drugs in these drug classes, and ultimately, these members were shifting to preferred drugs, which as Dave mentioned, is saving them money and helps the plan because they're paying for drugs that cost less for the plan and the agency overall.

Tom MacRobert: When you do your prescription drug analysis, is a lot of that work done with artificial intelligence or is it all human involvement?

Ryan Pistorosi: That's a great question. I would have to check with our actuarial analyses and our data team at MODA. I do know they have been looking at different ways of analyzing the prescription drug data, but all the information you see in the slides today is done internally. These are reports HCA developed, that we helped design with MODA.

Slide 12 – Member Experience, highlights why we went to the 2020 UMP Preferred Drug List.

Scott Nicholson: I want to say thank you very much for this presentation. I thought it was amazing to see and echo what the Chair's comments were about how amazing this is to see what you're doing for members in this area. It's very complicated as seen in this presentation. And the fact you're able to guide people through this process and get to a great result is uplifting. I appreciate that.

Ryan Pistorosi: Great, thank you.

Sue Birch: Ryan and Dave, I think this really should be a case study to think about how we could introduce more of this value-based purchasing alignment with other large purchasers. To me, this is really showing the importance of being on top of how we manage things with our members. I would really encourage you to think about if we were to do a press statement on something like this, how in the heck would we help people understand the benefits and what this has done. I look forward to when we get real solid estimates on the total savings rolled up to a high level.

Dave Iseminger: We're doing our best to get there.

Sue Birch: And really, just beyond the finances, just the safety. I mean, did you know you're using a drug not approved by the FDA for purposes other than what you should? It's just staggering to think about how, again, our US health system runs.

John Comerford: Can I just take a moment to thank Dave and the staff for all the great work they do here? This is phenomenal information to have. More so than I see in any business that I work with, the kind of things you've done here with the state.

Elyette Weinstein: Well done.

Dave Iseminger: Thank you. I kind of joke, it's just another day at the Health Care Authority. There's always a lot to do and more to change, a lot to keep moving on, but I said this before with the value formulary when I came in and became the acting director in 2017 right as rate setting season was happening. I knew there were things that needed to be on my personal to do list as goals for the Division. I look back over the past couple of years, the value formulary is on that list. The introduction of MA-PD plans is on that list, both of those things directly expanding the disposable income for retirees, which I heard loud and clear during the summer 2017 rate increase conversation as I took over leadership of the PEBB Program. I look at the long-standing LTD design enrollment issues, which are now heavily underway. Then I look at the SEBB Program and we're talking about possible additional plans within the PEBB portfolio for choice. It's a lot of hard work by a lot of people. I appreciate the Board's support on various initiatives over the past couple of years. You're now starting to see some of our reporting back on how we've done and what it means for our members in their everyday lives. That's what drives us. Thank you for your support.

Public Comment

No public comment.

Next Meeting

June 9, 2021

12:00 p.m. – 3:00 p.m.

Preview of June 9, 2021 PEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the June 9, 2021 Board Meeting.

Meeting adjourned at 2:50 p.m.

TAB 4



Follow up from March 10, 2022 Board Meeting

Dave Iseminger
ERB Director
April 14, 2022

Medicare Subscriber Enrollment as of 2/28/2022

| Plan | Enrollment |
|-------------------------|--------------|
| UMP Classic | 42,389 (54%) |
| Kaiser Senior Advantage | 16,897 (22%) |
| Premera Plan F | 10,603 (13%) |
| Premera Plan G | 3,467 (4%) |
| UHC PEBB Complete | 3,041 (4%) |
| Kaiser Medicare Classic | 1,849 (2%) |
| UHC PEBB Balance | 132 (.2%) |

MA-PD Plan Enrollment Insights

- Based on UnitedHealthcare's experience with new employer group MA-PD offerings, enrollment of ~10,000 members 5 years after implementation is a reasonable estimate
- Current MA-PD *member* enrollment is ~4,900 lives
- The enrollment growth since January 2021, indicates the plans will achieve the assumed ~10,000 members by the end of 2025

Retail Pharmacy Market Insights

- As of January 1, 2022, Rite Aid retail pharmacies are in-network for the UMP Pharmacy benefit
- A public announcement several months ago indicated Rite Aid is being purchased by CVS, but negotiations are ongoing
- Thus, full details about possible changes resulting from this acquisition are not yet available
- Moda and Navitus will actively keep HCA apprised of impacts as they become known

Health Savings Account Administration

- Concerns about delayed account transfers
 - In Q4 2021 and early 2022, Health Equity had significant staff shortages in customer service delaying response times
 - During this time, account transfers to other HSA administrators took 4-6 weeks
- Concerns about investment fees
 - Monthly fee of .03% capped at \$10/month
 - There is no fee to invest in mutual funds, or to buy or sell shares

Questions?

Dave Iseminger, Director
Employees & Retirees Benefits Division
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TAB 5



Policy and Rules Development

Stella Ng, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
April 14, 2022

Emily Duchaine, Regulatory Analyst
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division

RCW 41.05.065 (1) and (2)

- (1) The public employees' benefits board shall study all matters connected with the provision of health care coverage, life insurance, liability insurance, accidental death and dismemberment insurance, and disability income insurance or any of, or a combination of, **the enumerated types of insurance for employees and their dependents on the best basis possible with relation both to the welfare of the employees and to the state.** However, liability insurance shall not be made available to dependents.
- (2) The public employees' benefits board shall develop employee benefit plans that include comprehensive health care benefits for employees. In developing these plans, the public employees' benefits board shall consider the following elements:
 - (a) Methods of maximizing cost containment while ensuring access to quality health care;
 - (b) Development of provider arrangements that encourage cost containment and ensure access to quality care, including but not limited to prepaid delivery systems and prospective payment methods;
 - (c) Wellness incentives that focus on proven strategies, such as smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education;...

RCW 41.05.065(4)

(4) Except if bargained for under chapter [41.80](#) RCW, the public employees' benefits board shall design benefits and determine the terms and conditions of employee and retired or disabled school employee participation and coverage, including establishment of eligibility criteria subject to the requirements of this chapter. Employer groups obtaining benefits through contractual agreement with the authority for employees defined in RCW [41.05.011](#)(6)(a) (i) through (vi) may contractually agree with the authority to benefits eligibility criteria which differs from that determined by the public employees' benefits board. The eligibility criteria established by the public employees' benefits board shall be no more restrictive than the following:...

RCW 41.05.050(1)

(1) Every: (a) Department, division, or separate agency of state government; (b) county, municipal, school district, educational service district, or other political subdivisions; and (c) tribal governments as are covered by this chapter, shall provide contributions to insurance and health care plans for its employees and their dependents, the content of such plans to be determined by the authority. Contributions, paid by the county, the municipality, other political subdivision, or a tribal government for their employees, shall include an amount determined by the authority to pay such administrative expenses of the authority as are necessary to administer the plans for employees of those groups, except as provided in subsection (4) of this section.

PEB Board Policy Resolutions

PEBB 2022-03

Medicare Advantage
Prescription Drug (MA-PD)
Plan Enrollment During
Gap Months

PEBB 2022-04

Deferring PEBB Retiree
Insurance Coverage When
the Subscriber Becomes
Eligible for the Employer
Contribution

PEB Board Policy Resolutions (*cont.*)

PEBB 2022-01

Employees Returning to
Work From Active Duty

PEBB 2022-02

Employees May Waive
Enrollment in Dental

Follow-up Questions from March 10, 2022 Board Meeting

Why does the federal government not allow Medicare enrollees to enroll or disenroll from Medicare Advantage plans at anytime. Why are they restricted to Special Election Periods?

Congress intended Medicare enrollees to make plan changes during the Annual Election Period when implementing the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Permitting beneficiaries to discontinue Part D coverage at anytime during the year, without a corresponding election period to enroll in such coverage, could result in a gap in coverage and a Medicare Part D late enrollment penalty.

Resolution PEBB 2022-03

Medicare Advantage Prescription Drug Plan Enrollment During Gap Month(s) (Revised)

If a subscriber elects to enroll in a Medicare Advantage Prescription Drug (MA-PD) plan, and the required forms are received by the PEBB Program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in Uniform Medical Plan (UMP) Classic during the gap month(s) prior to when the MA-PD coverage begins.

Resolution PEBB 2022-03

Medicare Advantage Prescription Drug Plan Enrollment During Gap Month(s)

Resolved that, if a subscriber elects to enroll in a Medicare Advantage Prescription Drug (MA-PD) plan, and the required forms are received by the PEBB Program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in Uniform Medical Plan (UMP) Classic during the gap month(s) prior to when the MA-PD coverage begins.

Resolution PEBB 2022-04

Deferring PEBB Retiree Insurance Coverage When the Subscriber Becomes Eligible for the Employer Contribution

Resolved that, PEBB retiree insurance coverage will be automatically deferred when the subscriber becomes eligible for the employer contribution towards PEBB benefits. The subscriber will be exempt from the deferral form requirement.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Title 20 Chapter IX Part 1002 Subpart D Health Plan Coverage
§ 1002.168

If the employee's coverage was terminated at the beginning of or during service, must his or her coverage be reinstated upon reemployment?

(a) If health plan coverage for the employee or a dependent was terminated by reason of service in the uniformed services, that coverage must be reinstated upon reemployment. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment, if an exclusion or waiting period would not have been imposed had coverage not been terminated by reason of such service.

Resolution PEBB 2022-01

Employees Returning to Work From Active Duty (Revised)

Resolved that, when an employee who is called to active duty in the uniformed services under USERRA loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Employer-paid PEBB benefits will begin the first day of the month in which they return from active duty.

Resolution PEBB 2022-01

Employees Returning to Work From Active Duty

Resolved that, when an employee who is called to active duty in the uniformed services under USERRA loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Employer-paid PEBB benefits will begin the first day of the month in which they return from active duty.

RCW 41.05.742 Single Enrollment Requirement

Beginning with the 2022 plan year, individuals are limited to a single enrollment in medical, dental, and vision plans in either the school employees' benefits board or the public employees' benefits board. The school employees' benefits board and the public employees' benefits board shall adopt policies to reflect this single enrollment requirement.

RCW 41.05.065(8)

(8) Employees shall choose participation in one of the health care benefit plans developed by the public employees' benefits board and **may be permitted to waive coverage under terms and conditions established by the public employees' benefits board.**

Resolution PEBB 2022-02 Employees May Waive Enrollment in Dental

Resolved that, an employee who is eligible for the employer contribution toward PEBB benefits and who waives enrollment in a PEBB medical plan when they are enrolled in TRICARE, Medicare, or other employer-based group medical, and are not enrolled in SEBB medical, may waive their PEBB dental only if they are enrolled in both a SEBB dental plan and SEBB vision plan as a SEBB eligible dependent.

Next Steps

- Issue guidance to employing agencies on these resolutions
- Incorporate resolutions into PEBB Program rules

Questions?

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Appendix

Resolution PEBB 2020-05 Medicare Advantage - Prescription Drug (MA-PD) Plan Enrollment (as passed on 5/28/2020)

Resolved that, if a subscriber selects a PEBB Program MA-PD plan, any non-Medicare enrollees on the account will be enrolled in the Uniform Medical Plan (UMP) Classic.

Resolutions Edited Since the March 10, 2022 Board Meeting

Resolution PEBB 2022-03

Medicare Advantage Prescription Drug Plan Enrollment During Gap Month(s)

(Revised Proposed Resolution PEBB 2022-03)

If a subscriber elects to enroll in a Medicare Advantage Prescription Drug (MA-PD) plan, and the required forms are received by the PEBB Program after the date the PEBB retiree insurance coverage is to begin, the subscriber and their enrolled dependents will be enrolled in Uniform Medical Plan (UMP) Classic during the gap month(s) prior to when the MAPD coverage begins.

Resolution PEBB 2022-01 Employees Returning to Work From Active Duty (Revised Proposed Resolution PEBB 2022-01)

Resolved that, when an employee who is called to active duty in the uniformed services under USERRA loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Employer-paid PEBB benefits will begin the first day of the month in which they return from active duty.

Original March 10, 2022 Board Materials

Proposed Resolution PEBB 2022-03 Medicare Advantage Prescription Drug Plan Enrollment During Gap Month(s) (As presented on March 10, 2022)

If a subscriber elects to enroll in a Medicare Advantage Prescription Drug (MAPD) plan, and the required forms are received by the PEBB Program after the date the PEBB retiree insurance coverage is to begin, the subscriber will be enrolled in Uniform Medical Plan (UMP) Classic during the gap month(s) prior to when the MAPD coverage begins.

Retiring Employee Requesting to Enroll in MAPD After Their Current Coverage Ends

Example #1

(As presented on March 10, 2022)

Example: Joan's retirement date is July 1, 2023. The PEBB Program receives her retiree election forms on August 17, 2023. For medical, Joan selected United HealthCare PEBB Complete, a Medicare Advantage Prescription Drug (MAPD) plan. Because Joan's enrollment in PEBB retiree insurance coverage must be July 1, 2023 (consistent with her retirement date) and enrollment in the MAPD plan must be prospective, there is a two-month gap in coverage.

Which plan is Joan enrolled in during the gap months? Joan will be enrolled in the Uniform Medical Plan (UMP) Classic for the months of July and August before United HealthCare PEBB Complete begins.

Retiring Employee Requesting to Enroll in MAPD Plan After Their Current Coverage Ends Example #2 (As presented on March 10, 2022)

Example: George is currently enrolled in a Kaiser Foundation Health Plan of Washington Classic plan and his retirement date is July 1, 2023. The PEBB Program receives his retiree election forms on August 17, 2023. For medical, George selected United HealthCare PEBB Balance, a Medicare Advantage-Prescription Drug (MAPD) plan. Because George's enrollment in PEBB retiree insurance coverage must be July 1, 2023 (consistent with his retirement date), and enrollment in the MAPD plan must be prospective, there is a two-month gap in coverage.

Which plan is George enrolled in during the gap months? George will be enrolled in the Uniform Medical Plan (UMP) Classic for the months of July and August before United HealthCare PEBB Complete begins.

Retiring School Employee Requesting to Enroll in MAPD Plan After Their Current Coverage Ends

Example #3

(As presented on March 10, 2022)

Example: Frances is currently enrolled in a Premera Blue Cross High PPO plan and her retirement date is July 1, 2023. The PEBB Program receives her retiree election forms on August 17, 2023. For medical, Frances selected United HealthCare PEBB Balance, a Medicare Advantage-Prescription Drug (MAPD) plan. Because Frances's enrollment in PEBB retiree insurance coverage must be July 1, 2023 (consistent with her retirement date), and enrollment in the MAPD plan must be prospective, there is a two-month gap in coverage.

Which plan is Frances enrolled in during the gap months? Frances will be enrolled in the Uniform Medical Plan (UMP) Classic for the months of July and August before the United HealthCare PEBB Balance plan begins.

Proposed Resolution PEBB 2022-04 Deferring PEBB Retiree Insurance Coverage When the Retiree Becomes Eligible for the Employer Contribution Example #1

(As presented on March 10, 2022)

Example: Charlie is a retiree enrolled in PEBB retiree insurance coverage. On March 1, 2023, Charlie is rehired as an employee at the Department of Licensing and becomes eligible for the employer contribution towards PEBB benefits.

When is Charlie's PEBB retiree insurance coverage deferred? Charlie will be exempt from the deferral form requirement and his PEBB retiree insurance coverage will be automatically deferred on March 1, 2023. Charlie will be enrolled in PEBB benefits as an employee effective March 1, 2023.

Proposed Resolution PEBB 2022-01 Employees Returning to Work From Active Duty (As Presented on March 10, 2022)

When an employee who is called to active duty in the uniformed services under USERRA loses eligibility for the employer contribution toward PEBB benefits, they regain eligibility for the employer contribution toward PEBB benefits the day they return from active duty. Health plan coverage will begin the first day of the month in which they return from active duty.

Proposed Resolution PEBB 2022-01

Example #1

(As Presented on March 10, 2022)

Example: Darren works at the Department of Fish and Wildlife. He returned to his job on Wednesday, August 17, 2022, after six months of active duty. When Darren went on active duty, he was eligible for the employer contribution toward PEBB benefits.

When are employer paid coverages reinstated?

Employer-paid coverages are reinstated August 1.

Proposed Resolution PEBB 2022-01

Example #2

(As Presented on March 10, 2022)

Example: Jenny works half time (4 hours a day) at the Secretary of State. She returned to her job on Friday, April 29, after eighteen months of active duty. When Jenny went on active duty, she was eligible for the employer contribution toward PEBB benefits.

When do employer-paid coverages begin?

Employer-paid benefits begin April 1.

Proposed Resolution PEBB 2022-02 Employees May Waive Enrollment in Dental

An employee who is eligible for the employer contribution toward PEBB benefits and who waives enrollment in a PEBB medical plan when they are enrolled in TRICARE, Medicare, or other employer-based group medical, and are not enrolled in SEBB medical, may waive their PEBB dental only if they are enrolled in both a SEBB dental plan and SEBB vision plan as a SEBB eligible dependent.

Proposed Resolution PEBB 2022-02

Example #1

Example: Jeanette is a custodian at the University of Washington and is enrolled only in PEBB dental. She waived PEBB medical because she is enrolled in TRICARE.

Jeanette is married to Taylor, who is a teacher at Roosevelt Middle School. Taylor enrolled Jeanette in SEBB dental and SEBB vision during annual open enrollment in 2022.

Can Jeanette waive her PEBB dental? Yes. This resolution would enable Jeanette to waive her PEBB dental without having to enroll in SEBB medical, but in order to do so, she must be enrolled in both SEBB dental and SEBB vision as a SEBB eligible dependent.

TAB 6



2022 Annual Rule Making

Stella Ng, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
April 14, 2022

Rule Making Timeline

- | | |
|--------------|--|
| May 2022 | File proposed amendments (CR-102) and distribute new rules for public comments |
| June 2022 | Conduct public hearing and adopt final rules (CR-103) |
| January 2023 | Permanent rules effective |

Focus of Rule Making

- Administration and benefits management
- Regulatory alignment
- Implement PEB Board policy resolutions

Administration and Benefits Management

- Make global changes to include the addition of Limited Purpose Flexible Spending Arrangement
- Include information on the methods to use when a subscriber wishes to cancel supplemental dependent life insurance and accidental death and dismemberment (AD&D) insurance coverage

Administration and Benefits Management (*cont.*)

- An employee who is on a leave of absence and maintains eligibility for the employer contribution will have their premiums waived for their employee-paid LTD insurance for the first 90 days
- Amend PEBB Program appeal rules related to brief adjudicative proceedings and formal administrative hearings

Regulatory Alignment

- Clarify employees cannot enroll in a medical FSA and a limited purpose FSA in the same plan year
- Clarify the special open enrollment applies when an employee's dependent has a change in their own employment status that affects their (the dependent's) eligibility or another dependent's eligibility (such as a dependent child) for the employer contribution toward the dependent's employer-based group health plan

Questions?

Stella Ng, Policy and Rules Coordinator
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TAB 7



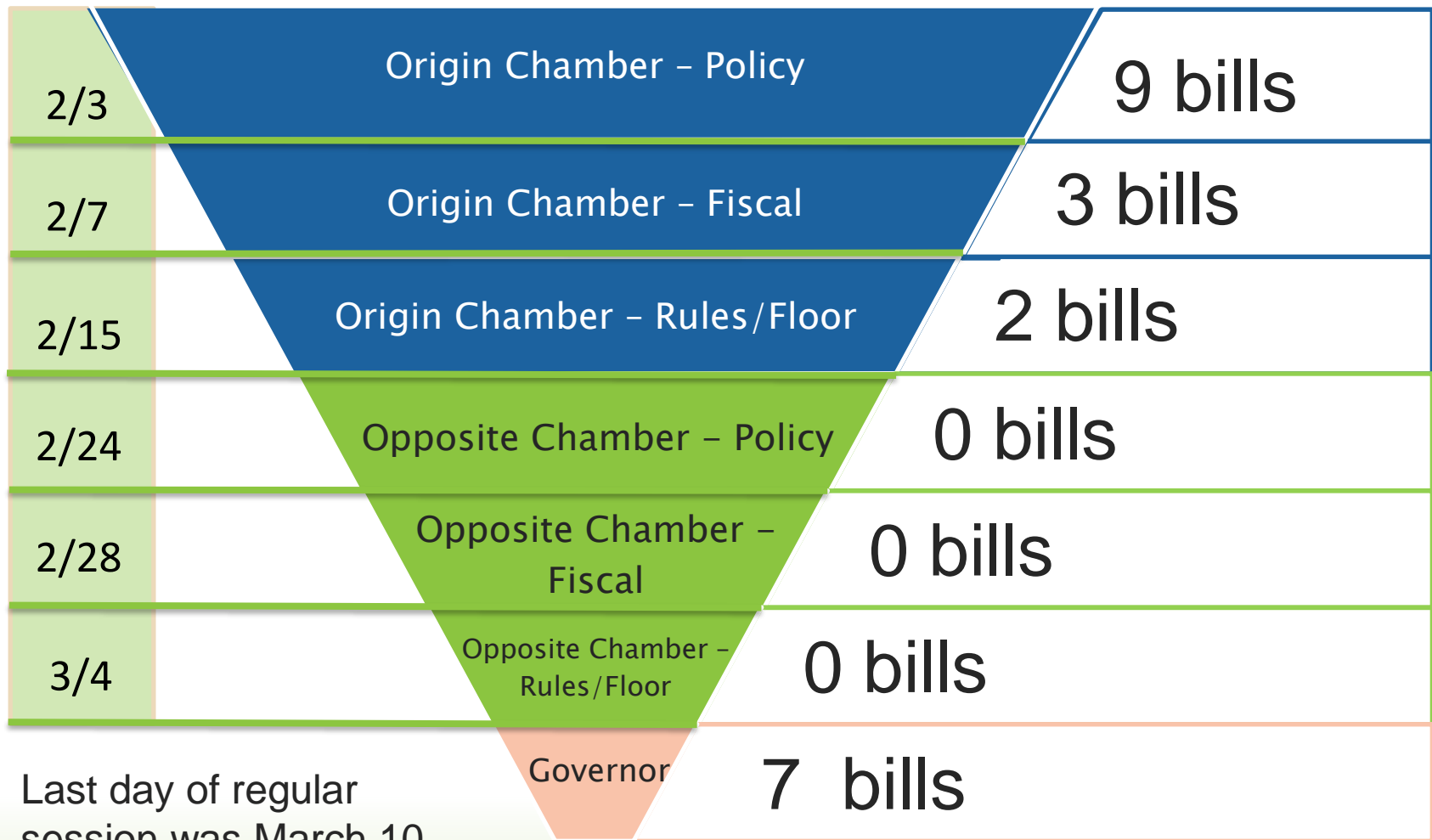
2022 Legislative Session Wrap up

Cade Walker, Executive Special Assistant
Employees & Retirees Benefits (ERB) Division
April 14, 2022

Number of 2022 Bills Analyzed by ERB Division

| | ERB Lead | ERB Support | |
|----------------------|----------|-------------|-----|
| High Priority | 31 | 24 | 55 |
| Low Priority | 17 | 97 | 114 |
| | 48 | 121 | 169 |
| Fiscal Notes | 38 | 32 | |

2022 Legislative Session – ERB High Lead Bills



ERB High Priority Lead Bills - Passed

- 1052 – Group insurance contracts
 - Signed
- 1688 – Out-of-network health care
 - Signed
- 1689 – Biomarker testing prior authorization
 - Signed
- 5532 – Rx drug affordability board
 - Signed

ERB High Priority Lead Bills – Passed (*cont.*)

- 5546 – Insulin affordability
 - Signed
- 5610 – Rx drug cost sharing
 - Signed
- 5702 – Donor human milk coverage
 - Signed

Other Passed Legislation

- 1329 – Public meetings
- 1651 – Postpartum contraception
- 1675 – Dialysate & dialysis devices
- 1728 – Insulin work group reauthorization
- 1761 – Opioid reversal by Emergency
Department nurses
- 1851 – Abortion care
- 1881 – Birth doulas

Other Passed Legislation (*cont.*)

- 1893 – EMTs/public health
- 5508 – Insurance guaranty fund
- 5518 – OT licensure compact
- 5539 – ESD funding
- 5765 – Midwifery
- 5793 – State boards, etc./stipends

Questions?

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TAB 8



2024 Uniform Dental Plan (UDP) Dental Design

Ellen Wolfhagen
Senior Account Manager
Employees and Retirees Benefits Division
April 14, 2022

Objectives

- Follow up from March Board Meeting
- Present specific proposals of benefit design enhancements for the Uniform Dental Plan (UDP)
- Have an initial prioritization discussion
- Explain how prioritization relates to the decision package process

Follow Up Questions from March Board Meeting

PEBB Dental Portfolio Comparison

| | Uniform Dental Plan (UDP) | Willamette | DeltaCare |
|-------------------------|---------------------------|----------------------|----------------------|
| Plan Type | PPO | Managed Care | Managed Care |
| Required Provider | Any dentist | Primary Care Dentist | Primary Care Dentist |
| Out-of-Network Coverage | Yes | No | No |
| Member Pays | | | |
| Deductible | \$50/\$150 | \$0 | \$0 |
| Class I | \$0 | \$0 – \$30 | \$0 – \$30 |
| Class II | 20% | \$10–\$125 | \$10–\$50 |
| Class III | 50% | \$100 – \$175 | \$115 – \$175 |

Medicaid and UDP

Medicaid and UDP

- Currently Medicaid covers pediatric and basic adult needs
 - Age limitations, many services not covered
- UDP covers a variety of services for all ages
- Dental coverage is optional under Medicaid
 - Funding fluctuates; no member cost shares
- UDP is state funded; member cost shares
- Provider networks and rates differ

UDP and Medicaid Comparison

UDP

- Deductible - \$50/\$150
- Plan Maximum
- Class I (preventive) – 100%
- Class II (fillings) – 80%
- Class III (crowns, bridges, etc.) – 50%

Medicaid

- Deductible - None
- No Plan Maximum (as long as client eligible for Medicaid)
- Class I – 100%
- Class II – 100%
- Class III
 - Anterior porcelain crowns for permanent teeth ages 15-20 – 100%
 - Posterior porcelain crowns for permanent teeth not covered
 - Posterior stainless-steel crowns – 100%

UDP and Medicaid Comparison (*cont.*)

UDP

- Bridges and Implants – 50%
- Dentures – Partial and Full 50%
- TMJ – 70% (lifetime \$500)
- Orthodontia - \$1,750 plan payment lifetime maximum

Medicaid

- Bridges and Implants – not covered
- Dentures – Partial and Full - 100%
- TMJ – not covered
- Orthodontia – 100% up to age 21

Current UDP Plan Design

- Deductible - \$50/person – up to \$150/family
- Class I (preventive services) – 100% coverage
- Class II (fillings) – 80% coverage
- Class III (crowns, bridges, etc.) – 50% coverage
- TMJ – 70% coverage and \$500 lifetime limit
- Annual *plan* payment - \$1,750

2024 UDP Options

- Annual plan maximum adjustment
- Composite materials for fillings
- Incentivize preventive services
- No deductible for children's benefits
- TMJ lifetime benefit limit adjustment

Current PEBB Program Membership

- Total Members 311,416
- Active Members 225,659
- Retirees 85,757
- Children up to age 15 42,407

Annual Plan Maximum

Current UDP Annual Plan Maximum Details

- \$1,750 annually
- This is the amount the *plan* pays; the member must pay any amount over that
- UDP has different coverage percentages depending on whether provider is Premium or Preferred

Current UDP Annual Plan Maximum Details (*cont.*)

- While preventive services are covered at 100%, they currently count towards the plan maximum; this could have a big impact if one were to use more expensive services earlier in the year and then have preventive visits later in the year.

Preventive Service Visits

- Cleanings
- Exams
- X-rays
- Periodontal maintenance
- Fluoride application

Currently covered at 100% (Class I)

Current UDP Annual Plan Maximum Example

Katy needs extensive dental work done in January. She has a series of appointments for X-rays and oral surgery in January. The total *allowed amount* bill is \$3,500.

In April, Katy returns for periodontal maintenance (deep cleaning). She must pay the full \$200 allowed amount out-of-pocket.

Example of Katy's Claims

| Service | Allowed Amount | UDP % of Allowed Amount | UDP Paid | Member Pays |
|-------------------------|----------------|-------------------------|-----------------------------------|--|
| January | | | | |
| X-rays | \$100 | 100% (Class I) | \$100 | \$0 |
| Oral Surgery | \$3,400 | 50% (Class III) | \$1,650 (remainder of \$1,750) | \$1,750 (50%, includes \$50 deductible) |
| April | | | | |
| Periodontal Maintenance | \$200 | 100% (Class I) | \$0 | \$200 |

Proposed Annual Plan Maximum Benefit Change

Remove **preventive services** from the annual plan maximum.

- Continue annual plan maximum at \$1,750 level
- Create incentive for using preventive services
- Improve overall health by establishing good oral health routines
- Improve health equity by treating dental preventive services the same as medical preventive services

Example of Katy's Claims Under Proposed Change

| Service | Allowed Amount | UDP % of Allowed Amount | UDP Paid | Member Pays |
|-------------------------|----------------|-------------------------|---|---|
| January | | | | |
| X-rays | \$100 | 100% (Class I) | \$100 | \$0 |
| Oral Surgery | \$3,400 | 50% (Class III) | \$1,675 (50%) (\$75 plan max remaining) | \$1,725 (50%, includes \$50 deductible) |
| April | | | | |
| Periodontal Maintenance | \$200 | 100% (Class I) | \$200 | \$0 |

Comparing Katy's Out-of-Pocket Costs

| | Annual Plan Maximum Used | Annual Plan Maximum Remaining | Katy's Out-of-Pocket Costs to Date |
|-------------------------|--------------------------|-------------------------------|------------------------------------|
| Current Benefit Design | \$1,750 | \$0 | \$1,950 |
| Proposed Benefit Design | \$1,675 | \$75 | \$1,725 |

It is April in the scenario and those having periodontal maintenance are typically recommended to have 3-4 visits per year. Katy can pursue those visits without a concern about paying \$400-\$600 additional out-of-pocket costs.

UDP Annual Plan Maximum Benefit Change Insights

| Specific Proposed UDP Benefit Design Change | 2021 PEBB Program Utilization of Class I |
|--|---|
| Provide 100% coverage for Class I (preventive) services and <i>exclude</i> them from the annual Plan Maximum | 73,162 members were not seen in 2021 239,038 members had a Class I visit in 2021, which reduced their available Plan Maximum |

Composite Fillings

Current UDP Posterior Composite Fillings Coverage Details

- Considered an elective procedure; coverage limited to percentage of **amalgam** allowed amount
- Depending on the number of surfaces filled, posterior fillings are generally Class II services
 - Class II services currently covered at 80%
- Crowns are Class III
 - Class III services currently covered at 50%

Current UDP Posterior Composite Fillings Coverage Example

- Joe requires a filling for a back molar
- Joe's out-of-pocket costs, if his dentist provides both amalgam and composite options:

| | Billed Amount | Network Allowed Amount | PEBB Allowed Amount | Plan Payment (80% of \$125) | Joe's Out-of-Pocket Amount |
|-------------------|---------------|------------------------|---------------------|-----------------------------|----------------------------|
| Amalgam Filling | \$200 | \$125 | \$125 | \$100 | \$25 |
| Composite Filling | \$200 | \$150 | \$125 | \$100 | \$50 |

Proposed Composite Filling Benefit Change

- Change Class II coverage to include 80% plan coverage for posterior composite fillings
 - In the prior example, Joe's out-of-pocket would change to **\$30** (based on the plan paying 80% of the Network Allowed Amount of \$150)
- Class II coverage at 80% would also remain for posterior amalgam fillings

UDP Composite Fillings Benefit Change Insights

| Specific Proposed UDP Benefit Design Change | 2021 PEBB Program Utilization of Composite Fillings (Procedure Numbers) |
|--|--|
| Provide 80% coverage of the network allowed amount for posterior composite fillings (Class II) | <p>86,357 members had Class II fillings</p> <p>3,597 posterior amalgam fillings</p> <p>98,186 posterior composite fillings</p> |

Incentive Plan Design Promoting Preventive Services

Current UDP Coverage Limits

- Class I (preventive) 100%
- Class II (fillings) 80%
- Class III (crowns, etc.) 50%

Incentivize Preventive Services

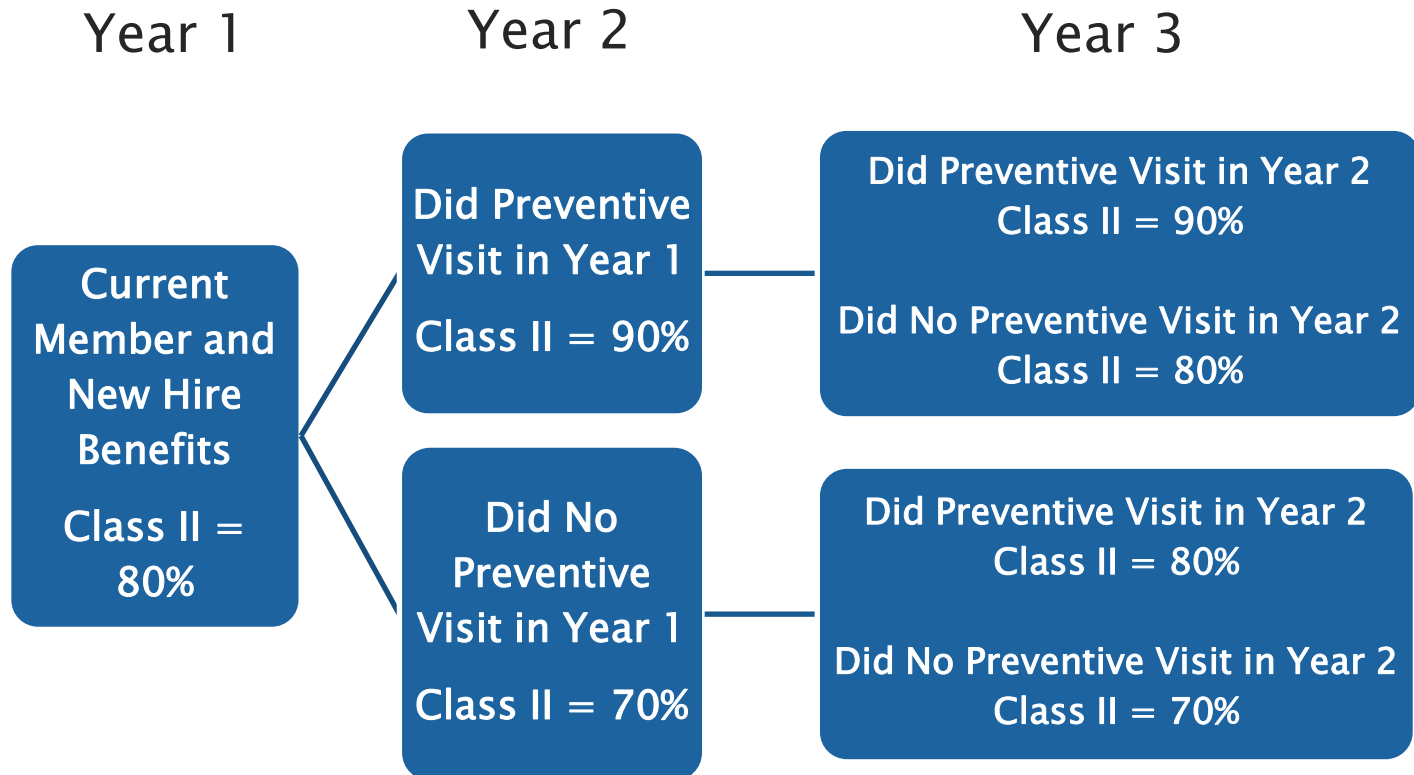
| Concept | 2021 PEBB Utilization |
|--|---|
| Use preventive services and increase coverage for Class II benefits in the <i>following</i> year | There were 239,038 members who had at least one Class I visit in 2021 |
| Have no preventive visit and <i>decrease</i> coverage for Class II benefits in the following year | 73,162 out of 312,200 members were not seen at all in 2021 |

Preventive Service Visits

- Cleanings
- Exams
- X-rays
- Periodontal maintenance
- Fluoride application

Currently covered at 100% (Class I)

Incentive Plan Example



- Class I always covered at 100%; Class III always covered at 50%
- New Hires always start Class II coverage at 80%

Child Deductibles

Current UDP Deductibles

- Every member is subject to the \$50 deductible (which does not apply to preventive services)
- If there are 4 or more individuals covered together, the maximum combined family deductible is \$150

Proposed Child Deductible Benefit Change

- Eliminate the \$50 deductible for children up to the age of 15
- Family deductible would remain at \$50 per person up to \$150/year; but an account with a subscriber, spouse, and one child under age 15 would have only a \$100/year overall deductible

UDP Child Deductible Benefit Change Insights

| Specific Proposed UDP Benefit Design Change | 2021 PEBB Program Utilization of Deductible |
|---|---|
| Eliminate \$50 deductible for children (up to age 15) | 8,834 |

| Age of Members | Class I Preventive | Class II Fillings | Class III Crowns, etc. | TMJ |
|----------------|--------------------|-------------------|------------------------|-----|
| Up to 15 | 35,756 | 8,672 | 136 | 26 |

Temporomandibular Joint (TMJ) Limit

Current UDP TMJ Coverage

- Non-surgical TMJ benefits (e.g., spacers, retainers) are covered at 70%
- There is a *lifetime* limit of \$500

Proposed UDP TMJ Benefit Change

- Increase the lifetime non-surgical TMJ member benefit from \$500 to \$5,000
- Set an annual member benefit limit of \$1,000

UDP TMJ Benefit Change Insights

| Specific Proposed UDP Benefit Design Change | 2021 PEBB Program Utilization |
|---|-------------------------------|
| Provide 70% coverage for non-surgical TMJ treatment, with an annual maximum of \$1,000 and a <i>lifetime</i> maximum of \$5,000 | 819 |

Prioritization Discussion

Prioritization: Using Population Impacts

| Proposed Benefit Change | 2021 PEBB Program Population Impacts |
|---|--------------------------------------|
| Exclude Preventive visits from Annual Plan Maximum | 246,638 (79%) |
| Cover Composite fillings same as Amalgam | 103,026 (33%) |
| Incentive Plan for Class II changes based on prior year Class I utilization | 90,538 (29%) |
| Eliminate Children's Deductible (up to age 15) | 39,810 (13%) |
| TMJ Annual and Lifetime Increase | 819 (0.3%) |

Prioritization: Using Estimated Premium Impacts (lowest impact to highest impact)

| In PEBB Program | In SEBB Program |
|---|---|
| TMJ Annual and Lifetime Increase | TMJ Annual and Lifetime Increase |
| Eliminate Children's Deductible (up to age 15) | Eliminate Children's Deductible (up to age 15) |
| Cover Composite fillings same as Amalgam | Incentive Plan for Class II changes based on prior year Class I utilization |
| Incentive Plan for Class II changes based on prior year Class I utilization | Cover Composite fillings same as Amalgam |
| Exclude Preventive visits from Annual Plan Maximum | Exclude Preventive visits from Annual Plan Maximum |

Who Pays Premiums Reminder

- For employees, 100% employer paid
 - Any increase in state costs requires a decision package, even if in isolation a single change may not change the funding rate, because the cumulative effect of benefit changes could change the funding rate
- For retirees, COBRA, and other self-pay members, premium impacts would be borne by the member

Funding For All Five Benefit Proposals

- Overall *estimated* PSPM* increase for each program of ~\$5-\$7
- Reminders
 - Estimates based on 2021 pandemic period utilization
 - Actual premium increases may vary
 - As a self-insured plan, ultimately the State has claims liability

*PSPM = Per Subscriber Per Month

Initial Premium Insights on TMJ & Child Deductible Proposals

- The combined premium impacts of these two benefit change proposals are estimated as:
 - under \$0.50 PSPM for the SEBB Program
 - under \$0.25 PSPM for the PEBB Program
- For the State and SEBB Organizations from a budget funding rate perspective, these two changes combined are unlikely to impact the funding rate

Initial Premium Insights on Incentive, Composite Fillings, & Annual Plan Maximum

- The premium impacts of *each* of these three benefit change proposals, for *each* of the PEBB & SEBB Programs, is estimated as:
 - Between \$1.25 and \$2.25 PSPM
- For the State and SEBB Organizations from a budget funding rate perspective, any of these changes individually would impact the funding rate

Prioritization Discussion

- Any proposed options that Board Members think should not be further evaluated?
- Which proposed options do Board Members think should be prioritized the most and why?

Next Steps

- May Board Meeting
 - Board consensus on recommendations
 - Additional information as requested

Questions?

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Appendix

Market Comparison – Annual Plan Max

| Annual Plan Maximum | Uniform Dental Plan | Delta Book of Business | WEA Plan (Pre-SEBB) |
|--|--|--|--|
| <p>The most the Plan will pay during a coverage period, at which point the member will assume the full responsibility for payment of covered services.</p> | <p>\$1,750 regardless of network status (PPO, Premier, and Out-of-Network)</p> | <p>43% of Book of Business has a \$2,000 maximum</p> | <p>\$2,000 PPO, \$1,750 Premier and Out-of-Network</p> |

Market Comparison – Composite Fillings

- UDP: Currently considered elective in posterior teeth (stainless steel or prefabricated crowns are covered under Class II)
- Large employers
 - Included in smaller fully insured groups
 - Not included in larger self-insured plans
- WEA (Pre-SEBB): covers posterior composite fillings (base 70%, subject to increase in incentive plan to 100%); crowns and onlays were covered under Class II

Market Comparison – Plan Coverage

| Coverage Amount | Uniform Dental Plan | Delta Book of Business | WEA Plan (Pre-SEBB) |
|--|--|--|---|
| The amount the Plan pays towards covered services. | Class I – Preventive Services 100% | Class I – Preventive Services 100% | Class I – Preventive Services 70% – 100% |
| | Class II – Restorative (Fillings) 80% | Class II – Restorative (Fillings) 80% | Class II – Restorative (Fillings, Crowns) 70% – 100% |
| | Class III – Major (Crowns, Bridges, Implants) 50% | Class III – Major (Crowns, Bridges, Implants) 50% | Class III – Major (Bridges, Implants) 50% |

Market Comparison – Child Deductibles

| Annual Deductible | Uniform Dental Plan | Delta Book of Business | WEA Plan (Pre-SEBB) |
|--|--|---|---------------------|
| The amount the member must pay before the plan begins to pay for covered services. | No deductible for preventive services \$50/individual \$150/family | Industry standard – \$50/\$150 (Waived for Preventive services) | No deductible |

Market Comparison – TMJ Coverage

| Uniform Dental Plan | Delta Book of Business | WEA Plan (Pre-SEBB) |
|-------------------------------------|---|--|
| 70% up to \$500 Lifetime maximum | 50% up to \$1,000 Annual maximum; \$5,000 Lifetime maximum Boeing and Alaska Airlines have NO coverage | 50% up to \$1,000 Annual maximum; \$5,000 Lifetime maximum |

TAB 9



Public Employees Benefits Board (PEBB) Modernization Project Updates

Chatrina Pitsch
PEBB IT Project Director
Enterprise Technology Services
April 14, 2022

What is PEBB Modernization?

An initiative to significantly enhance the PEBB My Account (PMA) online enrollment system for the PEBB Program.

The system will be used by payroll and benefits staff in lieu of Pay1 for benefits management.

Some of the features it will offer are:

- Enhanced online system for benefits management.
- User-friendly self-service functionalities for employees.
- Reduced reliance on paper forms, decreasing errors.
- Advanced tools to continue to safeguard PEBB Program member data and meet security standards.

Objectives

- Introduce project changes
 - Project scope
 - Project timeline
- Explain next steps

PEBB Program Current Systems

PEBB My Account

- Limited changes during open enrollment
- Statement of Insurance
- Premium attestation updates

PAY1

- Carrier communication for eligibility and enrollment
- Accounting
- Member correspondence
- Reports

What Changed

- PAY1 Maintenance and Operations team has two open positions
- COBOL programmers are in demand
 - COBOL isn't taught in most computer science departments anymore
 - Aging workforce moving towards retirement
 - Positions aren't appealing as systems are being modernized/replaced

What Changed: Scope

- Original scope:
 - User-friendly, reduced paper with improved data quality, significantly increased enrollment capability, and increased safeguards for member data
- Increased scope:
 - PEBB eligibility and enrollment files will be created and sent by PEBB My Account instead of PAY1
 - Creating a system with a single set of subscribers

What Changed: Timeline

- Original launch date: May 9, 2022
- Updated launch date: Spring 2023
- What's needed to determine an exact date?
 - Further technical design and development estimates
 - Planning for user acceptance and end-to-end testing
 - The timeline is contingent on the hiring of the PAY1 Maintenance and Operations

Questions?

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