Washington State Health Care Authority

Public Employees Benefits Board

July 14, 2022

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Public Employees Benefits Board

July 14, 2022 **Zoom Attendance Only**
9:00 a.m. – 1:00 p.m.

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

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TAB 1

Washington State Health Care Authority

AGENDA

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

Subject to Section 5 of the Laws of 2022, Chapter 115, also known as HB 1329, the Board has agreed this meeting will be held via Zoom without a physical location.

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 June 30, 2021 Meeting Minutes**	TAB 3	Sue Birch, Chair	Action
9:15 a.m.	**Follow up from June 30, 2022 Meeting**		Dave Iseminger, Director ERB Division	Information/ Discussion
9:20 a.m.	**Uniform Medical Plan (UMP) 2023 Benefit Resolution**	TAB 4	Christine Davis, UMP Account Manager Portfolio Management & Monitoring Section, ERB Division	Action**
9:30 a.m.	**2023 PEBB Non-Medicare Rates Overview**	TAB 5	Tanya Deuel, ERB Finance Manager Financial Services Division	Information/ Discussion
10:00 a.m.	**Break**			
10:05 a.m.	**Medicare Portfolio Comparisons**	TAB 6	Ellen Wolfhagen, Senior Account Manager, ERB Division	Information/ Discussion
11:05 a.m.	**Medical Clinical Insights**	TAB 7	Emily Transue, MD, Medical Director Clinical Quality and Care Transformation Division (CQCT) Luke Dearden, PharmD, BCPS Clinical Pharmacist, CQCT	Information/ Discussion
11:45 a.m.	**Break and Transition to Public Comment**			Information/ Discussion
11:50 a.m.	**General Public Comment****			
12:55 p.m.	**Closing**		Sue Birch, Chair	
1:00 p.m.	**Adjourn**			

***All Times Approximate**
****In addition to the general public comment period, the Board Chair will ask for public comment related to each resolution scheduled for action, while the resolution is under consideration, before the Board takes any final action.**

The Public Employees Benefits Board will meet Thursday, July 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.

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 July 11, 2022.

Join Zoom Meeting

Join Zoom Meeting
https://us02web.zoom.us/j/86161955269?pwd=L2W2Miqnv2ygMdcg0vLVYlv2XmD__C.1

Meeting ID: 861 6195 5269
Passcode: 962756
One tap mobile
+12532158782,,86161955269#,,,,*962756# US (Tacoma)
+16699006833,,86161955269#,,,,*962756# US (San Jose)

Dial by your location
- +1 253 215 8782 US (Tacoma)
- +1 669 900 6833 US (San Jose)
- +1 346 248 7799 US (Houston)
- +1 669 444 9171 US
- +1 929 205 6099 US (New York)
- +1 301 715 8592 US (Washington DC)
- +1 312 626 6799 US (Chicago)
- +1 646 931 3860 US

Meeting ID: 861 6195 5269
Passcode: 962756
Find your local number: https://us02web.zoom.us/u/kYGBrzzVU

Closed captioning capability is available as part of the virtual meeting

Washington State Health Care Authority

PEB Board Members

Name	Representing
Sue Birch, Director Health Care Authority 626 8th 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 ST, 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 PEBBoard@hca.wa.gov	Benefits Management/Cost Containment

PEB Board Members

Name	Representing
Monica McLemore 10002 Aurora Ave N Seattle WA 98125 V 510-239-7162 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 23rd DR SE Bothell WA 98012 V 360-689-9275 PEBBoard@hca.wa.gov	Benefits Management/Cost Containment

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PO Box 40124
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*non-voting members

5/31/22

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Public Employees Benefits Board
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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

TAB 2

Washington State Health Care Authority

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

Washington State Health Care Authority

Draft

Public Employees Benefits Board Meeting Minutes

June 30, 2021
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
12:00 p.m. – 4:15 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
Leanne Kunze
Elyette Weinstein
Tom MacRobert
Scott Nicholson
Yvonne Tate
John Comerford
Harry Bossi

PEB Board Counsel

Michael Tunick, AAG

Call to Order

Sue Birch, Chair, called the meeting to order at 12:03 p.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, this meeting was virtual only.

Meeting Overview

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

Continuing my series about the regions we serve, today we highlight the Upper Peninsula. The presenters have an image of the lavender fields near Sequim in Clallam County. I'm going to share information about Clallam, Jefferson, and Kitsap Counties as you head over the Narrows Bridge, and up and out towards the ocean. Overall, in that three-county region, between the PEBB and SEBB Programs, HCA covers about 8% of the population. For Medicaid, there's about 21% of the population of those three counties covered by the Health Care Authority. Combined between PEBB, SEBB, and

Medicaid, HCA administers programs covering just under a third of the residents of that three-county region.

I always highlight demographics like unemployment, uninsured, and poverty rates within the areas we serve relative to statewide averages. Crossing the Narrows Bridge and heading towards the ocean is Kitsap County, with generally lower than average statewide unemployment, uninsured, and poverty rates. Jefferson County, next on your driving tour, has about equal to statewide averages on those three metrics. Traveling further north and west into Clallam County, you see significantly higher unemployment, uninsured, and poverty rates compared to statewide averages. When I say significant unemployment, statewide average is about 5.3%, but unemployment in Clallam County is 7.7%. The uninsured rate statewide is about 6.8% with Clallam County about 8.9%. The average state poverty rate is about 15% and Clallam County is just shy of 20%. Those are the demographics of the areas.

All three counties have lower rates of preventable hospital admissions, but significantly worse rates of high dose opioid prescriptions related to opioids. Talking primary care visits, there's a regional concern about access, and low rates of utilization of primary care provider (PCP) visits. For example, in Clallam County, the estimate is about 8% of the population we serve is reaching out and having a PCP visit, which is lower to peer groups, which are more around 20-22%. It indicates a common understanding that there's general difficulty in accessing and recruiting primary care services within rural settings. We are seeing that play out as one might normally expect.

My final highlight, there's been a lot of market changes in the region, particularly in Kitsap County in recent years, like affiliations, mergers, acquisitions, etc., and a variety of changes within the infrastructure of the health system that's introduced a variety of changes on pricing and payments, with volatility in those rates. At the same time, that's playing out now with those various changes in relationships of the provider networks there. It's important to note that to date, we're not seeing changes in the local referral utilization patterns or things significantly being transitioned over, having services provided in urban areas like Tacoma and Seattle. We're still seeing the referrals and most services continuing to happen out on the Peninsula.

I'll end my opening remarks with a land acknowledgement statement. I acknowledge our meetings to be supported physically here in Olympia on the traditional territory of the Coast Salish people. This area was the primary portage way to and from the Puget Sound. These lands were shared by several tribes, including those we know today as the Squaxin Island Tribe and the Nisqually Tribe. HCA honors and thanks their ancestors and leaders who have been stewards of these lands and waters since time immemorial.

Approval of March 17, 2021 Meeting Minutes

Tom MacRobert moved, and Leanne Kunze seconded a motion to approve the March 17, 2021 meeting minutes. Minutes approved as written by unanimous vote.

Executive Session

Pursuant to RCW 42.30.110(1)(l), the Board met 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.

Back to Public Session

2022 Annual Procurement Update and UMP Benefit Resolution

Beth Heston, PEBB Procurement Manager/Senior Account Manager, ERB Division, continued the discussion on annual procurement and the proposed changes to PEBB's medical plans for 2022.

Slide 3 – Changes to Uniform Medical Plan. Details about the changes are in the Appendix.

Slide 4 – Resolution PEBB 2021-16 - UMP Accumulators. Accumulators are the amounts accrued toward out-of-pocket maximums and benefits, or visit limits, such as deductibles, number of visits, and benefit usage. If a PEBB Program subscriber changes plans within PEBB UMP due to a special open enrollment or other circumstance, their accumulator transfers with them. There is a slight change to the resolution since the last meeting to make it clear that it only pertains to the PEBB Program and not across to the SEBB Program.

Dave Iseminger: The change to the Resolution was due to a question about changing UMP plans from PEBB to SEBB or SEBB to PEBB. The Resolution was clarified to address that question. A comparable resolution in the SEBB Program was passed last week. HCA will continue to see if we can do something comparable when people switch between the PEBB Program and the SEBB Program administered by the Health Care Authority.

Sue Birch: Vote - Resolution PEBB 2021-16 - UMP Accumulators

Resolved that, beginning January 1, 2022, when a subscriber enrolled in a PEBB Program Uniform Medical Plan (UMP) changes their enrollment to another PEBB Program UMP plan during the plan year (excluding Open Enrollment), the amounts accrued toward insurance accumulators (such as deductibles, out-of-pocket maximums, and benefit and visit limits) will transfer into their new UMP plan.

Yvonne Tate moved, and Leanne Kunze seconded a motion to adopt.

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2021-16 passes.

Beth Heston: Slide 5 – Additional Proposed Change for the Uniform Medical Plan Consumer Driven Health Plan (CDHP). HCA has been evaluating IRS Notice 2019-45 since its release in 2019. It allows high deductible and consumer driven plans to offer certain preventive services before the deductible is met in high deductible plans.

Slides 6 & 7 - IRS Allowed Changes to UMP. HCA is proposing the services listed on these two slides be allowed before the deductible is met on the Uniform CDHP. The

IRS periodically reviews the allowable services since the law doesn't define preventive care in detail. These determinations are made within the Secretary of the Treasury's authority under statute. Decisions are usually based on the cost of service; medical evidence to support high-cost efficiency of preventing or the exacerbation of a chronic condition, or the development of a secondary condition; and is there strong documented clinical evidence the service or use of the item will prevent the worsening of a chronic condition, or the development of a secondary condition. Those selected are the most cost effective and the most evidence based to change. The IRS and the Treasury looked at CDHP's high deductible plans in 2019 and expanded what preventive services could be covered. It's a choice by the health plan to cover these preventative medications and supplies for certain chronic conditions under preventive care services, i.e., before deductible on the UMP CDHP.

The list on these two slides shows the chronic condition, preventive care covered, where the terms of coverage fall within, and what coverage would be if approved.

Slide 8 – Proposed Resolution PEBB 2021-23 – UMP CDHP Preventive Care. HCA will bring this resolution to the Board for action on July 14.

Scott Nicholson: The IRS has allowed these types of conditions, or treatments for these conditions, to be provided without having to meet the deductible. Is there a more expansive list and we're just choosing? Or is this proposal only for a subset of that? Or is it everything that IRS is allowing, in this case, being moved forward?

Dave Iseminger: This is the medical part of the IRS notice. There were pieces that would fall under the medical benefit and the pharmacy benefit. We are still looking at the pharmacy component of that notice and anticipate that we'll likely, next Board season, bring something else that might focus on the pharmacy side. HCA didn't want to hold up the medical pieces any further. You might wonder, if the notice came out in 2019 and it's now 2021, why now? I believe the notice in 2019 came out in late June or early July, at the end of our rate season. We were unable to account for it in the 2020 rate development process. And with the pandemic, it didn't meet the prioritization review process for last year's rate setting for this year. There are items in the notice that HCA will look at, but we are comfortable bringing this list to the Board today.

Beth Heston: For this notice, the federal government did the research and became aware that cost barriers for care kept a lot of people with chronic conditions from using the effective care. The consequences of that can be severe, amputations, blindness, heart attacks, or strokes.

Dave Iseminger: Scott, I'll have the team follow-up to describe other parts within medical that are still under evaluation or what we aren't recommending, just to be 100% crystal clear on the medical review part of the notice.

Scott Nicholson: Thank you.

Harry Bossi: I think this is good to do. I just want to confirm, this is not an all-inclusive list, in that there are certain preventive services, medical visits that are already available prior to the deductible within the CDHP. This just elaborates certain other things that we will now approve prior to the deductible. Is that correct?

Beth Heston: Yes. There are lists of available treatments that have been incorporated in the past. This is a new list.

Slides 10 – Kaiser Foundation Health Plan of the Northwest (KPNW) changes Summary lists 2022 plan changes.

Slide 11 – KPNW Additional New Proposed Benefit Change. On June 3, the Oregon Legislature passed a law to place a $75 cap per month on insulin prescription refills which goes into effect January 1, 2022. Currently there is a $100 cap because of a similar law passed in the Washington Legislature last year. When Kaiser Northwest, which is based in Portland, heard about the new law in Oregon, they asked if HCA would be willing to change the out-of-pocket cap for each insulin prescription filled from $100 to $75 on just Kaiser Northwest's plan. The majority of actual member cost is usually well under either $100 or $75 on our ERB plans. This cap wouldn't change the insulin drug tier or related tier costs, but where the member currently pays an amount below $75, they would continue to owe the lower cost share. If the Board approves this proposal, it will accept this change in insulin prescriptions for Kaiser Northwest.

Dave Iseminger: This change is accounted for in the rates Tanya will present for action during her presentation. There is no impact or adjustment needed to the rates. The non-Medicare rates for action in July will also capture this change.

Beth Heston: Slide 13 – Kaiser Foundation Health Plan of Washington (KPWA) Changes Summary lists changes that will be included in the rates presented in July. If you accept the rates, you also accept these changes to the plan.

Elyette Weinstein: I don't understand the cap. How does it work with respect to the $100 and the $75? Is it a cap after which you don't pay anything? Or is it a cap after which you pay more?

Beth Heston: It's a cap which you only pay up to $75 on these particular plans. They're offered in Clark and Cowlitz Counties. In the rest of Kaiser Washington's area in Washington State, the cap is $100. The member never pays more than $100. That's the way it is in UMP as well because of state law.

Elyette Weinstein: Thank you very much.

Additional Medical Plan Offerings Update

Jean Bui, Manager, Portfolio Management and Monitoring Section. Today's presentation reviews the results of adding SEBB plans into PEBB. Slide 2 – Portfolio Design for PEBB Program. The creation of the SEBB Program provided an opportunity for HCA to possibly leverage some of those new plans for the PEBB Program. HCA began a two-year process to review this possibility for the 2022 and 2023 plan years.

Slide 3 – Reasons for the Alignment.

Slide 4 – Guiding Principles.

Slide 5 – Procurement Activities.

Slide 6 – Results. After HCA's review, we are not recommending plans be added to the PEBB Program at this time. HCA will enter the second review phase with the same commitment of providing access, choice, and value for our members.

Slide 7 – Next Steps. The Board will be updated on this work during the next Board season.

Chiropractic, Acupuncture, Massage (CAM) Utilization Summary & Benefit Proposal for Uniform Medical Plan (UMP)

Selena Davis, UMP Senior Account Manager, ERB Division, and **Sara Whitley**, Fiscal Information and Data Analyst, Financial Services Division. HCA's goal is to improve our chiropractic, acupuncture, and massage (CAM) therapy benefits specific to our UMP plans.

Slide 2 – Motivation for Proposal explains the why HCA is interested in this proposal.

Slide 3 – Guiding Principles – CAM Benefit Adjustment.

Slide 4 addresses the Guiding Principles in greater detail.

Slide 5 – Current PEBB UMP CAM Benefit Design.

Slide 6 – Proposed UMP CAM Benefit Design proposes increasing the annual visit limits with a copay of $15 for each CAM therapy.

Sara Whitley: Slide 7 – PEBB UMP Utilization Summary.

Slides 8 – 10 show the detailed utilization of each benefit individually. The slides include a count of distinct utilizers in each of the benefit visit categories based on average claims captured from 2017 to 2019. The bar chart is a graphical representation of the information contained within the table, showing what percentage of members are utilizing the benefit in each of those visit count categories in the table.

John Comerford: Sara, do we do any member satisfaction surveys on different products?

Dave Iseminger: John, we do CAP surveys, which are done by the plans. But not in the sense I think you're asking, about the general benefit design. Part of the CAP survey is satisfaction with the plan. There are a lot of different factors that go into it. There are a few of the people who, for example, when asked if they are satisfied with the high deductible health plan say, "No, because things aren't covered." But the nature of a high deductible health plan is you have to meet the high deductible first. It brings us back to thinking about health literacy. We get a bit of insight on overall plan satisfaction from those CAP surveys, but nothing that gets to the granular parts of benefit design.

John Comerford: Many businesses are doing that now to get a sense for what benefits are -- we see utilization here. But which benefits are most appreciated? Thank you.

Sue Birch: We can put that in a parking lot as a future issue, because that might be something interesting for us to do with our SmartHealth tiles and do some kind of survey about these CAM benefits. So, thanks for that, John. We'll take that under advisement.

Selena Davis: Slide 11 – CAM Benefit Adjustment Proposal recaps our presentation and our proposal of how to better meet our members' needs, maintain the value of these alternative therapies, limit out-of-pocket costs, and maintain cost neutrality.

Slides 12-13 – Proposed Resolution PEBB 2021-24 – UMP Chiropractic, Acupuncture, Massage Benefits.

Dave Iseminger: I want to acknowledge two things. First, we've highlighted back on Slide 11 that there is a need to maintain cost neutrality in UMP. I want to say this for the record, because budget provision language about changing the benefit design on the PEB Board requires a comprehensive cost analysis. We have done, for the record, that discussion with the PEB Board with the information that is proprietary in Executive Session. Although we don't want to bring that out into the public venue because of some of its proprietary nature, I did want to acknowledge, on the record, that there was an Executive Session conversation that helps address that budget provision language requirement.

The second piece that I want to highlight is in the resolution itself on Slide 12. The syntax will be familiar to the Board from a previous meeting when the Board took action on the long-term disability benefit. The opening clause does a repeal of the prior coverage decisions related to CAM therapies. Again, the PEBB Program has been around for over 40 years, and sometimes it's very difficult to find some of the original policy decisions documented extraordinarily well to do a specific repeal and replace. So, we're describing a general repeal. And you should be able to build from the ground up the entirety of the benefit structure in these two slides dealing with treatment limitations, cost share, network status, relationship to Medicare, IRS overlay of the UMP CDHP, all of those things. This is designed to describe the entirety of that benefit structure as if it's being born today. But the parts that are describing out-of-network services is really just a recodification of the existing structure, that the change is supposed to be in the in-network aspects as we have been presented.

Elyette Weinstein: When you say this CAM benefit will apply to all plans, does that include Medicare plans?

Dave Iseminger: Yes.

Elyette Weinstein: Thank you.

Tom MacRobert: I have a couple of questions. Let's say I'm a chiropractor, and if my understanding is correct, I will no longer need a referral from a doctor for my patient. That patient can come to me and say, "I need work on my shoulder." And when they have finished, I will pay that chiropractor a $15 copay and they will simply submit that to Regence for their payment. Is that correct?

Selena Davis: Currently, members can self-refer to chiropractic, and so that's correct. You would go to an in-network chiropractic, and it would be billed through the third-party administrator (Regence) as normal practice. They need a prescription -- massage benefit therapy is an in-network benefit only. You would need a prescription from a provider to use your massage benefit.

Tom MacRobert: But under this proposal, I will no longer need that, correct?

Selena Davis: Under this proposal, massage remains an in-network benefit. You would still need a prescription to get a massage, and it would be an in-network provider only. But you can self-refer to any chiropractor.

Tom MacRobert: So, you will still need a referral for massage, or massage and acupuncture?

Selena Davis: A referral for massage only.

Dave Iseminger: Tom, it's covered out-of-network for chiropractic and acupuncture if you see an out-of-network provider by the plan at the coinsurance cost shares as Selena described. But for massage, there currently is no out-of-network coverage by the plan. Under this proposal, that does not change. And the way you see that in the resolutions, for clarity, is on Slide 13 where the first bullet says, "out-of-network services will not have copays, and will have:" third sub-bullet, "coverage only for chiropractic and acupuncture services." That's saying there's only out-of-network coverage for chiropractic and acupuncture, if this passes, just like the world exists today.

Tom MacRobert: I am curious as to why you will still need a referral for massage. Because that did not used to be the case. Regence was the one that imposed that two years ago.

Dave Iseminger: Tom, we'll follow-up on this, but I believe that's been a long-standing requirement. The way that authorization is reviewed may have changed, but the lack of coverage, or non-coverage, for out-of-network massage, is not a recent benefit change.

Tom MacRobert: No, what has occurred is an increase. Originally, when you go all the way back to when this was originally part of the benefit package, you didn't need a referral. They have added that over time so that the actual amount of paperwork that has been required for the massage practitioner has increased. But originally, if you go all the way back to before Regence was involved, there was no requirement.

Sue Birch: Tom, I wish Dr. Transue was here, but I believe that because somebody may think massage will take care of something, and they might not clinically understand that there could be a tumor pressing on something or stress. I believe the clinicians would tell you that they want some handle on why we are moving into soft tissue work. Or why we are moving into massage therapy. I think because the basis of education is a little different for acupuncture and for chiropractic, and not diminishing massage at all, I believe that the medical providers need a bit of a handle on what's causing the need for this. Is it stress related? What is it? We can certainly get Dr. Transue to weigh in as well. But it's my understanding that's pretty standard in the health care arena to

need that. And it's not a prescription each time. Frequently, a provider will give a blanket order for up to 24 massages in a year.

Tom MacRobert: Yes, because one of the complaints I've heard from massage practitioners is the increasing amount of paperwork they're being required to do in order to see patients. It's not just that they have to do paperwork, but rather the amount of paperwork has increased, which significantly impacts them. Sometimes they have to go back to the doctors, which is an increased imposition on the doctors as well because they have to fill out the correct form and make the correct recommendation. It's what Dr. Transue actually said when they make the doctors the gatekeepers. Okay, we can take that to another discussion.

Dave Iseminger: Tom, we'll look at some things. We introduce these resolutions at one meeting and a follow-up action at the next meeting so we can address questions. We'll dig into this topic and see if Dr. Transue can attend to provide some clinical pieces. It very well could be the case that people are mixing up prior authorization requirements for massage and physical therapy (PT). I might even be conflating those prior authorization processes right now. I want to make sure we're able to step back to fully answer your question and distinguish it from PT if there's some confusion. We'll take this topic as a follow-up piece to bring back as we bring the resolution for final action.

Tom MacRobert: Okay, thank you.

Dave Iseminger: There is one other piece that's important for me to highlight on the bottom of Slide 13. It's the penultimate part of the resolution that says, "This benefit design applies only if approved by both PEB Board and the SEB Board." A similar proposal will be presented to the SEB Board, as well. Under our third-party administrator contract, HCA needs to have substantial similarity in the benefit design for their administration. This is one of those items related to that contingency clause. The timeline is being presented to you today, asking for action on July 14, presenting to the SEB Board on July 15, asking them for action on July 22. Assuming everyone along the way passes it, the journey between now and July 22, it will go into effect January 2022.

Comparing PEBB Program and Open Market Medicare Plans

Jean Bui, Manager, Portfolio Management & Monitoring Section. I'm presenting on behalf of Ellen Wolfhagen today.

Slide 2 – Background. Staff are often asked what the difference is between the plans available in the PEBB Program and what is advertised on television or radio. The consumer will likely pay more out-of-pocket for services, or have limited benefits, for the zero premium plans. Similarly, the plans often have annual premium increases. There's also no guarantee that the same county will be included in plan offerings from year to year, which would force members on the open market to have to change plans. Similarly, networks are subject to change without much notice. One of the key differences is that PEBB plan premiums and benefits are negotiated and stable from year to year.

Slides 3 – UnitedHealthcare Plans. The next few slides provide a high-level overview in which we've compared two different PEBB carriers' plan offerings with similar open

market offerings by the same carrier. At a later date, we can explore more detailed comparisons between benefit levels.

This comparison is between the MA-PD plan offerings in the PEBB Program through UnitedHealthcare and UnitedHealthcare's zero premium AARP plan, which is one of the most common. PEBB plans are national plans and there is no difference in cost, whether the services are in-network or out-of-network. For the open market plan, this is an HMO, or a regional network. There are higher costs if the services are out-of-network. The PEBB plans have a lower medical maximum out-of-pocket. For PEBB Balance it's $500, and for PEBB Complete $2,000, as compared to the AARP plan between $4,200 and $6,700 per year maximum out-of-pocket. PEBB primary care visits are a zero copay for PEBB Complete, $15 copay for PEBB Balance. The open market plan, primary care visits have a zero copay. A PEBB specialty care visit is a zero copay for PEBB Complete and a $35 copay for PEBB Balance. For the open market, it's a $40 copay with a referral required. One to take note of is the inpatient hospital stay. For the PEBB Complete it's a zero cost, and PEBB Balance, it's $500 per admittance, and that's regardless of the number of days. For the open market, the inpatient hospital stay charge is $400 per day.

Slide 4 – UnitedHealth Plans (*cont.*). There are some supplemental value-added benefits valued by many Medicare beneficiaries with some differences noted on this slide.

Elyette Weinstein: I just want to make sure I understand. You're comparing the UnitedHealthcare Plan PEBB Complete and PEBB Balance, offered by the state, to UnitedHealthcare open market individual plans. I just want to make sure that I understand it's the same company.

Jean Bui: Exactly. Yes.

John Comerford: Jean, I also wanted to add that what you're looking at on the right-hand side is a Medicare Advantage plan, Part C of Medicare. What I was talking about at the last meeting was Medicare supplements or Medigap plans.

Jean Bui: John, further on in the presentation, we cover those plans.

John Comerford: Great, okay. Even on the Medicare Advantage side, there are companies that will have more benefits than the UnitedHealthcare AARP plan.

Jean Bui: As I mentioned, we wanted to do a high-level comparison to give an idea.

Slide 5 – UnitedHealthcare Drug Benefits shows the differences between the PEBB Complete and PEBB Balance and the open market (individual) plans.

Slides 6 – 8 - Premera Medicare Supplement Plans, also known as the Medigap plans are discussed on theses slides. I want to note that Plan F is no longer open to new enrollees, but Plan G is. The only difference between Plans F and G is the Part B deductible is not covered. The plans are subject to Medicare coverage rules.

These plans are designed to provide coverage for the costs not covered by Original Medicare, including Part A deductibles, copays, coinsurance. Premera offers some discounts, whether it's a PEBB Program member or on the open market, which includes $25 gym membership per month, vision, discounted hardware up to 30%, and hearing aids through Hearing Care Solutions, which can be significant.

Slide 9 – PEBB Plan Elements.

John Comerford: Jean, does this Medigap plan cover CAM benefits?

Jean Bui: Let me find out for sure and I'll bring that back.

John Comerford: The other question I have is what's the premium for the retiree on the Medigap policy?

Jean Bui: In PEBB, the premium is $99.

John Comerford: That's all the employee pays for the supplement is $99? It is almost half the cost of the private sector. Every year I shop not only for myself but for my clients. I'm on State Farm Plan G now and it costs me $169. It's got more benefits, I think, than this particular one has and it's $169 versus $99 here.

Sue Birch: I don't believe the Medigap has CAM coverage. I'm certain it doesn't. I really want to thank staff. This was a tremendous effort of accumulating a lot of information. It absolutely shows the gravitas of the PEBB purchasing power, and the staff's ability to really construct things, and again, negotiate some great benefits for our folks. So, thank you, Dave, Jean. And we wish Ellen was here, but we really appreciate all you put into this. This was no small feat to do this analysis.

Elyette Weinstein: What's clear to me is this Plan G, unless I'm missing something, doesn't cover drug costs? Or do they? Did I miss that?

Jean Bui: That's correct. There is no drug coverage with Plan G.

John Comerford: Drug coverage is under a plan D, you need to get a separate policy for that coverage.

Elyette Weinstein: Let's say my biggest costs are drugs, as an older person. I may spend only $99 for a premium, as you're saying, but as the drug costs keep going up, until you're sick these things look great. But then, when you need that service, often you haven't been paying attention to what's covered. And then they're not so hot.

Jean Bui: Elyette, what I can tell you is that when we do our materials for open enrollment, we do expansive comparison of the Medicare plan offerings available to PEBB Program members. They're very different. Especially this year, we're doing a lot more to explain those differences, and to help give members the tools they need for their particular situation, to choose the plan that fits their needs the best. One of the things we've focused on this year is providing that information for folks to make good choices.

Sue Birch: Again, huge accolades, and thanks for this body of work.

2022 PEBB Medicare Premium Resolutions

Tanya Deuel, ERB Finance Manager, Financial Services Division, will ask the Board to act on the 2022 PEBB Medicare Premiums introduced on June 9. There is one Medicare resolution regarding the Medicare explicit subsidy where HCA has included the full explicit subsidy amount of $183. The Board, however, could choose to lower that amount. The changes Beth spoke about are in the underlying rates, which the Board would be adopting today.

Sue Birch: Vote – Resolution PEBB 2021-17 – Medicare Premium

Resolved that, the PEB Board endorses the calendar year 2022 monthly Medicare Explicit Subsidy of $183 or 50% of premium, whichever is less.

Harry Bossi moved, and Scott Nicholson seconded a motion to adopt.

John Comerford: I'd like to go back and make sure I really understand this. So, the $99 the member is paying is in addition to the $183. So, the effective cost is really $282 for that product.

Tanya Deuel: John, for the Plan G that Jean references, $99 is after the Medicare explicit subsidy. The total composite rate is $193. The state contributes either $183 or 50% of the premium. In this plan's instance it is 50% of the premium. So, they get $94 towards their premium. Then the state adds an admin fee, which is usually around $5 bringing the single subscriber premium in a Plan G plan to $99. Those rates are all in your Appendix in the back if you need it for reference.

John Comerford: Okay. Again, the total Medicare cost to the state for Plan G is $198?

Tanya Deuel: $193.

John Comerford: $193. Okay, thank you.

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2021-17 passes.

Sue Birch: Vote – Resolution PEBB 2021-18 – KPNW Medicare Premiums

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

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2021-18 passes.

Sue Birch: Vote – Resolution PEBB 2021-19 – KPWA Medicare Premiums
Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of Washington Medicare plan premiums.

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2021-19 passes.

Sue Birch: Vote – Resolution PEBB 2021-20 – UMP Medicare Premiums
Resolved that, the PEB Board endorses the Uniform Medical Plan (UMP) Medicare plan premiums.

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2021-20 passes.

Sue Birch: Vote – Resolution PEBB 2021-21 – UnitedHealthcare Medicare Premiums

Resolved that, the PEB Board endorses the UnitedHealthcare Medicare Advantage plus Prescription Drug (MA-PD) plan premiums.

Yvonne Tate moved, and Scott Nicholson seconded a motion to adopt.

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2021-21 passes.

Sue Birch: Vote – Resolution PEBB 2021-22 – Premera Medicare Premiums
Resolved that, the PEB Board endorses the Premera Medicare Supplement plan premiums.

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2021-22 passes.

PEBB Continuation Coverage Policy Development

Emily Duchaine, Regulatory Analyst, Policy, Rules, and Compliance Section, ERB Division. Slide 2 – RCW 41.05.065(4) is provided for your reference as you consider the proposed resolution.

Slide 3 – Introduction of Proposed Resolution PEBB 2021-25 PEBB Continuation Coverage Eligibility for Employees' Dependents, which addresses PEBB continuation coverage, or dependents who lose PEBB dental benefits, because the employee they were covered under was kept in SEBB medical and was auto-disenrolled from PEBB dental.

Slide 4 – Dual Enrollment work Recap. Senate Bill 5322, prohibiting dual enrollment between School Employees Benefits Board and Public Employees Benefits Board Programs, signed by Governor Inslee on April 7, 2021 made this resolution necessary. The law goes into effect July 25, 2021. During the 2021 Open Enrollment for plan year 2022, employees currently dual enrolled can choose either the SEBB Program or the PEBB Program for their medical, dental, and vision plans for themselves and for all covered dependents. Employees who become newly eligible for PEBB benefits, or who experience a special open enrollment, and who are already enrolled in SEBB benefits, can choose to enroll in PEBB benefits and drop their SEBB benefits. Or they can waive their enrollment in PEBB and maintain their enrollment in SEBB. The Board passed Resolutions PEBB 2021-02 through PEBB 2021-09 on April 7, 2021, to enable the PEBB Program to act on behalf of the employee if the employee does not resolve their dual enrollment on their own during open enrollment.

Slide 5 – Resolution PEBB 2021-04 – Resolving Dual Enrollment When an Employee's Only Medical Enrollment Is In SEBB. While implementing this resolution, staff noted that there is a chance the employee may have dependents who will lose dental benefits. Because of that, we are recommending an additional resolution today.

Slide 6 - Proposed Resolution PEBB 2021-25 - PEBB Continuation Coverage Eligibility for Employees' Dependents. This proposed resolution would allow dependents, or the employee on behalf of the dependent, to continue PEBB dental benefits on a self-pay basis for up to 36 months after the dependent is auto-disenrolled. 36 months of self-pay aligns with the federal requirement when the federal qualifying event is the dependent child ceasing to be a dependent child.

Slide 7 – Proposed Resolution PEBB 2021-25 Example #1
Slide 8 – Proposed Resolution PEBB 2021-25 Example #2

Slide 9 – Federal COBRA Laws that affect this situation. The dependent in Example #2 who lost PEBB dental is not considered a qualified beneficiary under the Public Health Services Act. Only covered employees, federally recognized spouses, and dependent children of the covered employees are considered qualified beneficiaries. Although the dependent in Example #1 experienced a loss of coverage, losing coverage by itself is not considered a qualifying event under the Public Health Services Act. For children, the only qualifying events are death of the employee, or ceasing to satisfy the eligibility criteria under the plan. In Example #1, the PEBB employee didn't act to resolve their dual enrollment on their own and were auto-disenrolled from PEBB to be kept in SEBB.

The school employee also didn't take any action to add the child to the SEBB plan. The Board does have the authority to permit the PEBB Program to expand the right to elect continuation coverage. This is why we are asking the Board to pass a resolution allowing dependents to continue PEBB dental on a self-pay basis only under the specific circumstance where we auto-disenroll a child to resolve a dual enrollment situation.

Slide 10 – Next Steps.

Dave Iseminger: Staff have done some data analytics and we anticipate the population impacted to be relatively small. Between the PEBB and SEBB Programs we have 650,000 covered lives in our medical program, and an additional 50,000 covered lives who aren't in medical but are in dental or vision or some combination thereof. We think it's a couple of dozen individuals that could be in this scenario. We anticipate doing some additional targeted outreach. Our goal would always be to not have to apply these automatic rules created by the Board; but we know that, inevitably, there will be scenarios where somebody doesn't engage, and we need to act on the account. This gives an additional option in that rare occurrence where an individual loses coverage as a result of all of these policies. At least they have the ability to get coverage on a self-pay basis, along with any other opportunities to establish a more permanent legal relationship that would allow them to be enrolled as a dependent on the other account.

Elyette Weinstein: I am not clear with respect to Slide 6 what self-pay basis means. I understand you have to go without insurance, pay out-of-pocket, whatever it costs, and pay the bill. But I don't think that's what you mean by self-pay. I'm wondering what that coverage would look like.

Dave Iseminger: Self-pay basis is the language used at HCA to describe what we call continuation coverage. Continuation coverage is an umbrella term that captures COBRA coverage, as well as the COBRA-like coverage the Board established. We call all of that “continuation coverage” and the premium is self-paid. They are able to have coverage, but without any employer contribution or subsidy. You are paying the full premium on your own.

Elyette Weinstein: Okay, now I get it. So basically, you're paying the full premium. There's no employer contribution.

Dave Iseminger: Correct.

Sue Birch: This isn't a question as much as a comment. I want to applaud staff and leadership for bringing this forward. Because again, Washington is dedicated to keeping a health focus, and keeping people covered. It would be very easy for us to let this slip by. I know it's a small number of people, Dave, but it makes a big difference, especially when the services are needed. So, thank you for catching this detail.

SmartHealth

Kristen Stoimenoff, Manager, Washington Wellness Program, ERB Division. Slide 2 – Topics discussed in this presentation.

Slide 3 – SmartHealth. The numbers on this Slide are for 2020 and compiled by Limeade, our SmartHealth vendor. It represents all employees eligible for SmartHealth in both the PEBB and SEBB Programs.

Slide 4 – Good for Washington State Employers & Good for People shows turnover rates, employee engagement, job satisfaction of SmartHealth users, and participants who improved in the 34 high risk dimensions of well-being.

Slide 5 - Providing Support During COVID-19 Pandemic. HCA provided support to people in areas that have been uniquely important during the Covid 19 pandemic for both PEBB and SEBB Program members.

Slide 6 – Supporting Important Statewide Programs & Initiatives. This Limeade slide shows a few of the statewide programs and initiatives that SmartHealth supported last year.

The next few slides show where PEBB Program members are and have been over the last four years with regard to reaching various incentive levels.

Slide 7 – Incentive Levels identifies the three different levels.

Slide 8 – SmartHealth Levels Completed – 2018-2021. This table shows the percentage of people registered for SmartHealth and reached Level 1 and Level 2.

Slide 9 – Well-being Assessment Trends – 2018-2021. This slide shows incentives reached on a weekly basis. 2021 statistics were smaller than the previous years possibly due to COVID and its impact. HCA did not have in-person Benefits Fairs during 2020 Open Enrollment where we do a lot of education. There were no onsite well-being assessment challenges as in past years. Staff have also not done onsite wellness coordinator visits in a while. Wellness programs have been different since COVID. HCA will continue to send messages in multiple ways and through multiple vehicles to connect with members.

Slide 10 - $125 Incentive Trends – 2018-2021.

John Comerford: How often do you communicate with the participants in the program? How do you communicate with them?

Kristen Stoimenoff: We communicate in lots of ways like newsletter articles, providing wellness coordinators at different agencies with items to send to their employees and/or post on their websites. Staff put information on our HCA website and on social media. Staff send to anyone signed up on GovDelivery to receive emails directly from the Health Care Authority. Anyone registered for SmartHealth will get emails directly from SmartHealth telling them about new activities that are available, reminding them about incentive deadlines, etc.

John Comerford: Are retirees included in the program?

Kristen Stoimenoff: Retirees who are not in Medicare Part A and Part B are eligible for SmartHealth incentives. So, if a retiree waived PEBB medical retiree coverage, they're not eligible for incentives.

John Comerford: Thank you very much.

Kristen Stoimenoff: Slide 11 – Activities with the Most Participation. This slide compares the top twelve activities with the most participation in 2020 and 2021.

Slide 12 – Enhancing Benefit Awareness. We help employees learn about their PEBB benefits. They are targeted very specifically. When you log into SmartHealth, you get activities for your plan only, if they are plan specific. It shows a few examples around benefit awareness. Options for Knee, Hip, and Spine Care is specific to the UMP Centers of Excellence Program. Only UMP members will see that. Members were able to link directly to whatever was available to them through Kaiser and through UMP.

Slide 13 – Connecting Members with Their Benefits shows another way we've tried to make it easier for employees to connect to their specific plan benefits. Kaiser, for example, has a tile toward the bottom of the SmartHealth screen. When you open it, you will see links to specific Kaiser activities created specifically for those members.

Slide 14 – SmartHealth PEBB Materials. The first flyer explains how SmartHealth supports whole person well-being, how to qualify for the Amazon gift card, and the $125 wellness incentive. The next three flyers are from toolkits developed specifically for quarter three. Our team works with our communications team to put together these flyers and articles that relate to topics specifically included in SmartHealth. The flyers are sent to our wellness coordinators at the employer groups and others who are champions of well-being in their organizations and encourage them to send them on to their employees.

Slide 15 – What's Next? Last year, HCA created a flyer for the SEBB Program called "Reward Yourself with SmartHealth." It was helpful in generating additional participation. We're doing it for the PEBB Program this year, too. Last year's giving campaign was well attended and helps people, and us, to do a little bit of good in our communities. We will continue connecting employees with those state business resource groups that really help people get involved in a variety of issues.

Public Comment

No public comment.

Next Meeting

July 14, 2021
12:30 p.m. – 3:30 p.m.

Preview of July 14, 2021 PEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the July 14, 2021 Board Meeting.

Meeting adjourned 3:26 p.m.

TAB 4

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Uniform Medical Plan (UMP) 2023 Benefit Resolution

Christine Davis, UMP Account Manager
Portfolio Management & Monitoring Section
Employees and Retirees Benefits Division
July 14, 2022

Resolution for Board Action Today

- PEBB 2022-14 UMP Accumulators

UMP Accumulators

- For Plan Year 2023, an option to transfer medical and pharmacy cost-share accumulators (deductibles and out-of-pocket maximums only) when subscribers move between the PEBB and SEBB Programs during a plan year.
  - UMP subscriber movement within the PEBB Program was addressed by a Board resolution last year
- This will only apply when a subscriber changes between the PEBB & SEBB Programs but stays in a UMP plan.
- This change would need to be passed by both the PEB Board and SEB Board for UMP.

Resolution PEBB 2022-14
UMP Accumulators

Resolved that, beginning January 1, 2023, when a subscriber enrolled in a SEBB Program Uniform Medical Plan changes their enrollment to a PEBB Program Uniform Medical Plan during the plan year (excluding Open Enrollment), accumulated deductibles and out-of-pocket maximum expenses (medical and pharmacy) will transfer.

Questions?

Christine Davis, UMP Account Manager
Portfolio Management and Monitoring Section
Employees and Retirees Benefits Division
Christine.Davis@hca.wa.gov

TAB 5

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

2023 PEBB Non-Medicare Rates Overview

Tanya Deuel
ERB Finance Manager
Financial Services Division
July 14, 2022

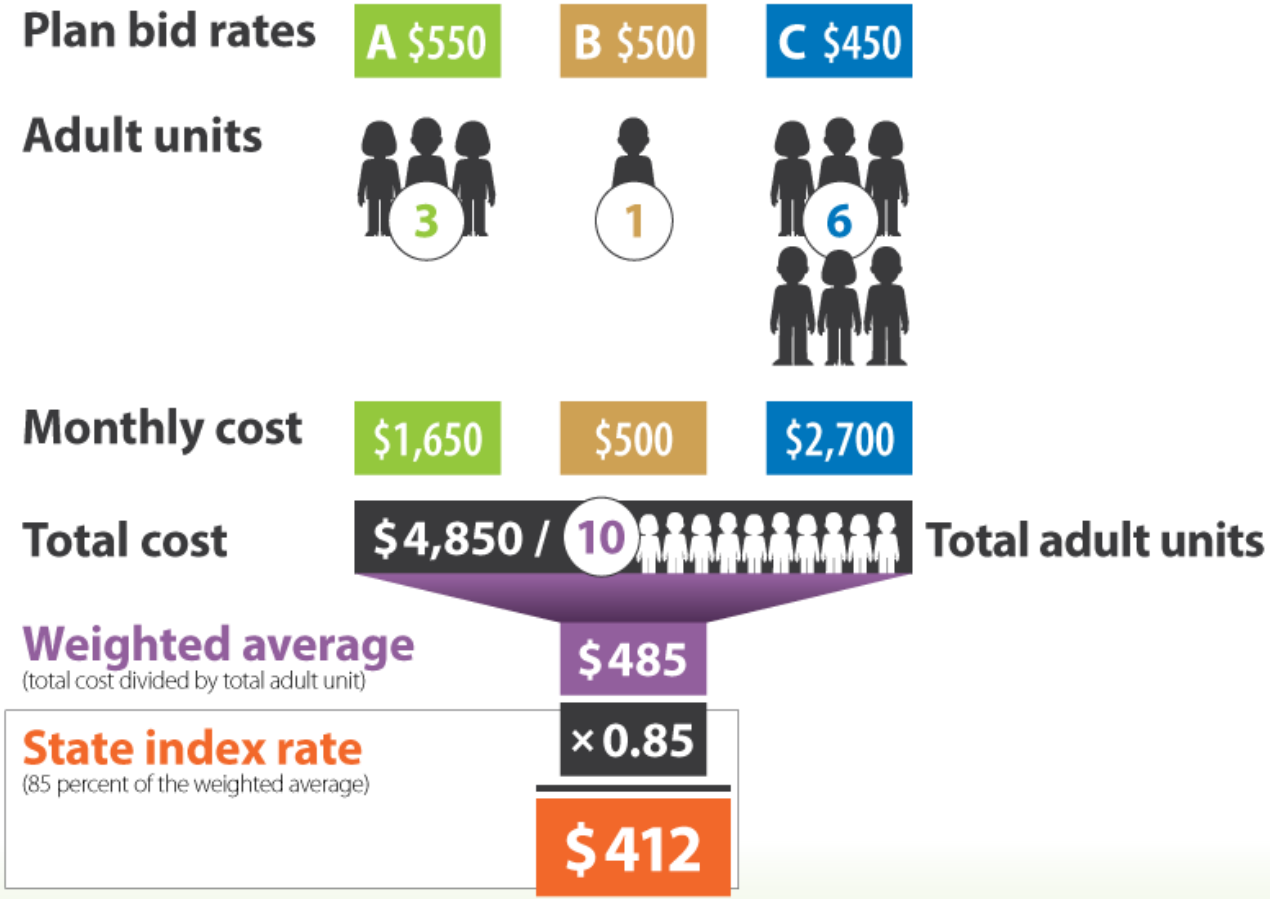
Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Employee Premiums

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Calculating the State Index Rate

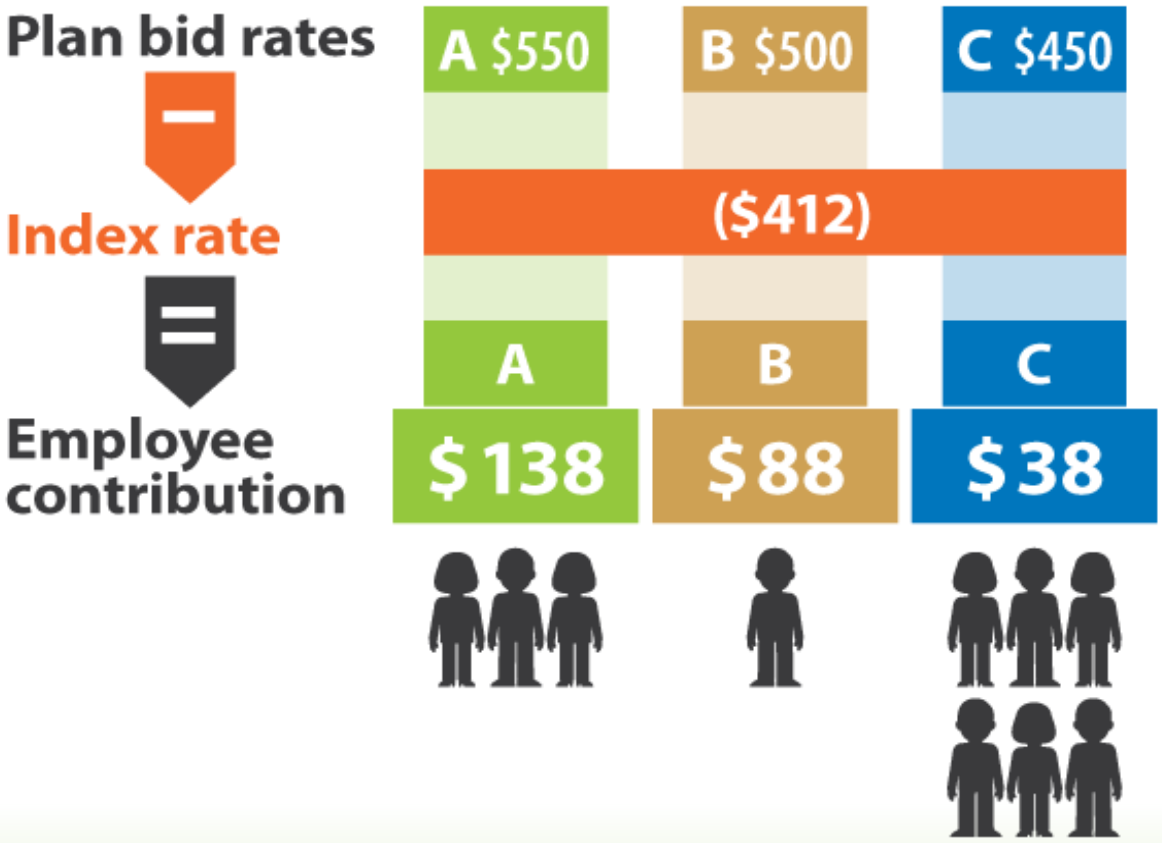
Sample Illustration



Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Determining Employee Premiums

Sample Illustration



Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Determining Employee Premiums by Tier

Sample Illustration

Plan			A	B	C
Employee contribution			$138	$88	$38
Tiers					
Tier 1	1		$138	$88	$38
Tier 2	2	+$10	$286	$186	$86
Tier 3	1.75		$242	$154	$67
Tier 4	2.75	+$10	$390	$252	$115

*Tiers 3 and 4 do not change when you go from one child to more than one child

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Employee & Employer Premium Contributions

	Proposed 2023 Employee Contribution (Single Subscriber)	Proposed 2023 Employer Contribution (aka State Index Rate)	Proposed 2023 Composite Rate
Kaiser NW Classic	$172	$665	$837
Kaiser NW CDHP	$25	$665	$690
Kaiser WA Classic	$167	$665	$832
Kaiser WA Value	$94	$665	$759
Kaiser WA SoundChoice	$46	$665	$711
Kaiser WA CDHP	$25	$665	$690
UMP Classic	$135	$665	$800
UMP Plus	$97	$665	$762
UMP Select	$59	$665	$724
UMP CDHP	$29	$665	$694

- *Consumer Directed Health Plans' (CDHP) composites include Health Savings Account (HSA) deposits*
- *Rounded to the nearest dollar*
- *Composites include the state active reduction of $1.00 Per Adult Unit Per Member (PAUPM) for the employer group surcharge*

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Employee Premium Contributions

	Subscriber		2022 to 2023 Change in Subscriber Rate		Enrollment (PEBB Actives)	
	2022	Proposed 2023	%	$	Subscribers	% of Total Enrollment
Kaiser NW Classic	$159	$172	8.2%	$13	1,478	1.1%
Kaiser NW CDHP	$26	$25	-3.8%	($1)	301	0.2%
Kaiser WA Classic	$204	$167	-18.1%	($37)	10,947	8.1%
Kaiser WA Value	$113	$94	-16.8%	($19)	11,786	8.8%
Kaiser WA SoundChoice	$50	$46	-8.0%	($4)	5,296	3.9%
Kaiser WA CDHP	$24	$25	4.2%	$1	2,582	1.9%
UMP Classic	$110	$135	22.7%	$25	71,142	52.9%
UMP Plus	$78	$97	24.4%	$19	15,212	11.3%
UMP Select	$39	$59	51.3%	$20	3,957	2.9%
UMP CDHP	$24	$29	20.8%	$5	11,716	8.7%

- *Rounded to the nearest dollar*
- *Composites include the state active reduction of $1.00 PAUPM for the employer group surcharge*

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

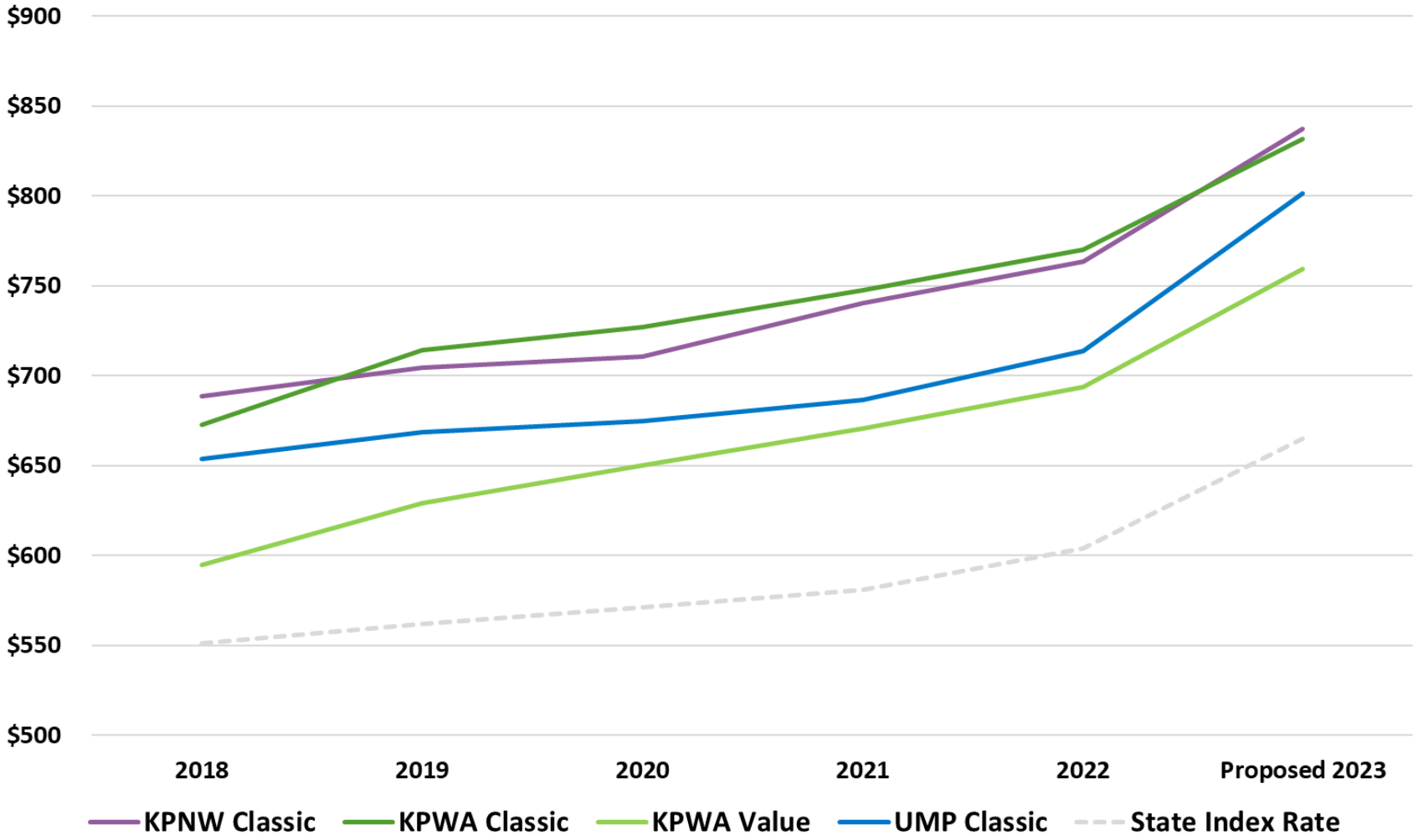
Employee Contributions by Tier

	Subscriber	Subscriber & Spouse/SRDP*	Subscriber & Child(ren)	Subscriber, Spouse/SRDP*, and Child(ren)
Kaiser NW Classic	$172	$354	$301	$483
Kaiser NW CDHP	$25	$60	$44	$79
Kaiser WA Classic	$167	$344	$292	$469
Kaiser WA Value	$94	$198	$165	$269
Kaiser WA SoundChoice	$46	$102	$81	$137
Kaiser WA CDHP	$25	$60	$44	$79
UMP Classic	$135	$280	$236	$381
UMP Plus	$97	$204	$170	$277
UMP Select	$59	$128	$103	$172
UMP CDHP	$29	$68	$51	$90
	Subscribers may be subject to the following surcharges			
Tobacco Surcharge	$25	$25	$25	$25
Spousal Surcharge	N/A	$50	N/A	$50

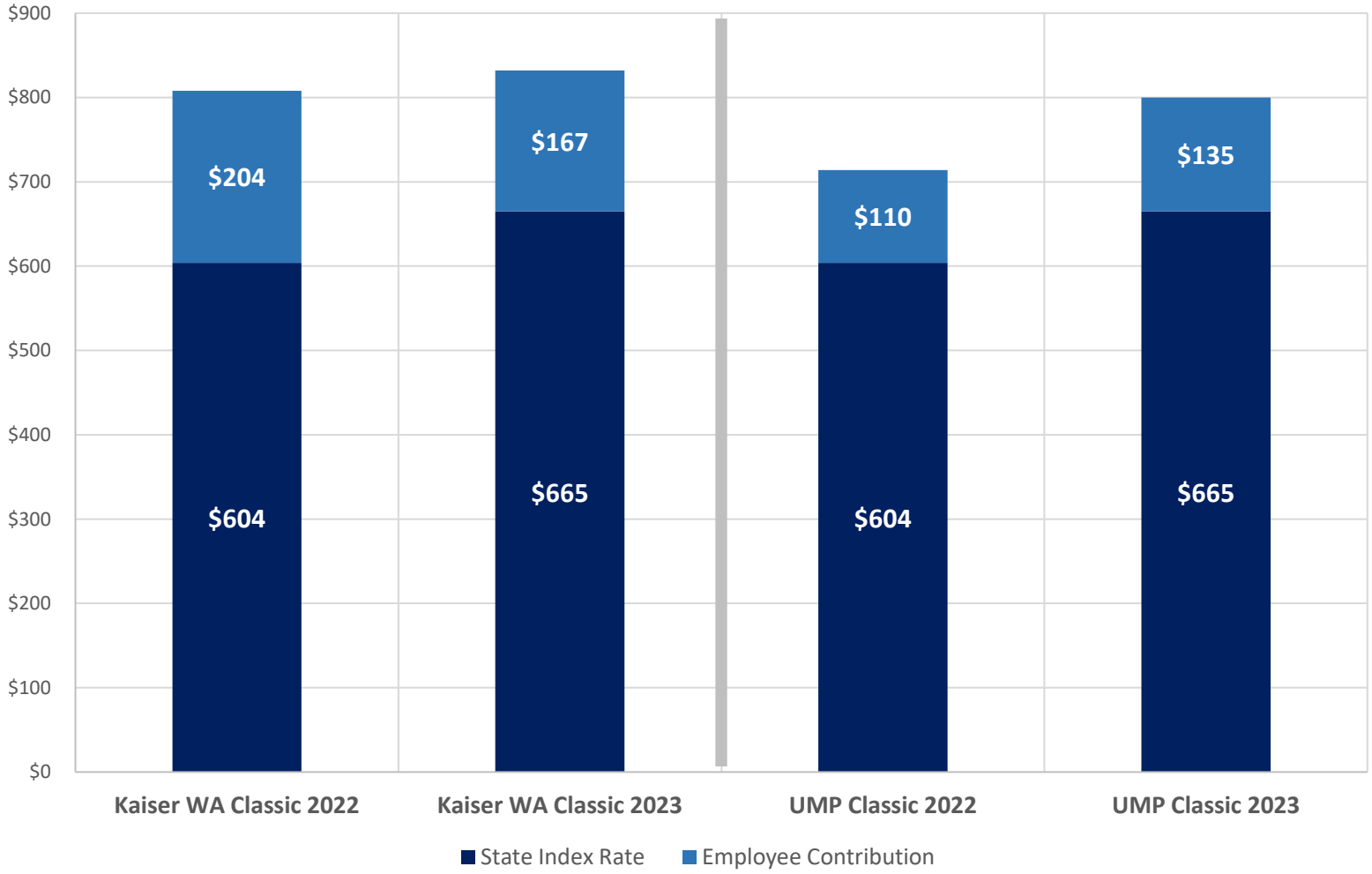
- *Subscriber, Spouse/State-Registered Domestic Partner*, and Child(ren) include $10 spouse charge*
- *Rounded to the nearest dollar*
- *Composites include the state active reduction of $1.00 PAUPM for the employer group surcharge*

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Historical PEBB Rates



State Index Rate Impact on Employee Contributions



Non-Medicare Retiree Rates

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Non-Medicare Retiree Rates by Tier

	Subscriber		Subscriber & Spouse/SRDP*		Subscriber & Child(ren)		Subscriber, Spouse/SRDP*, and Child(ren)		2022 to 2023 Change in Subscriber Rate	
	2022	Proposed 2023	2022	Proposed 2023	2022	Proposed 2023	2022	Proposed 2023	%	$
Kaiser NW Classic	$768	$842	$1,531	$1,679	$1,341	$1,469	$2,104	$2,306	9.6%	$74
Kaiser NW CDHP	$644	$700	$1,277	$1,394	$1,133	$1,235	$1,708	$1,871	8.8%	$57
Kaiser WA Classic	$813	$837	$1,621	$1,668	$1,419	$1,460	$2,228	$2,292	2.9%	$23
Kaiser WA Value	$722	$764	$1,439	$1,523	$1,260	$1,333	$1,976	$2,093	5.8%	$42
Kaiser WA SoundChoice	$659	$716	$1,313	$1,426	$1,150	$1,249	$1,804	$1,959	8.6%	$56
Kaiser WA CDHP	$641	$700	$1,273	$1,393	$1,130	$1,234	$1,703	$1,869	9.1%	$58
UMP Classic	$719	$805	$1,432	$1,606	$1,254	$1,406	$1,968	$2,206	12.1%	$87
UMP Plus	$687	$767	$1,369	$1,529	$1,199	$1,338	$1,881	$2,100	11.6%	$80
UMP Select	$648	$729	$1,290	$1,453	$1,130	$1,272	$1,773	$1,996	12.6%	$81
UMP CDHP	$639	$704	$1,270	$1,402	$1,127	$1,242	$1,700	$1,882	10.3%	$66
	Subscribers may be subject to the following surcharges									
Tobacco Surcharge	$25	$25	$25	$25	$25	$25	$25	$25		
Spousal Surcharge	N/A	N/A	$50	$50	N/A	N/A	$50	$50		

- *Rounded to the nearest dollar*

* *State-Registered Domestic Partner (SRDP)*

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PEBB Risk Pools

Non-Medicare Risk Pool
(RCW 41.05.022)

- State & Other* Employees
- State & Other* Non-Medicare Retirees
- Non-Medicare School Retirees

Medicare Risk Pool
(RCW 41.05.080)

- State & Other** Medicare Retirees
- Medicare School Retirees

* Includes political subdivision employees, non-represented educational service districts employees, and COBRA and LWOP enrollees (and dependents)
** Includes political subdivision retirees and dependents

Medicare vs. Non-Medicare Retirees

- Under state law (RCW 41.05.022 & RCW 41.05.080), employees and non-Medicare retirees are not included in the same risk pool with Medicare retirees
- CMS does not subsidize employees or non-Medicare plan offerings (i.e., the significant CMS subsidies that disadvantage UMP Classic Medicare are not available for any plans in the non-Medicare risk pool)

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Other Benefits

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Dental Premiums

	Subscriber Rate		2022 to 2023 Change in Subscriber Rate	
	2022	2023	%	$
DeltaCare	$39.53	$41.50	5.0%	$1.97
Uniform Dental Plan	$48.64	$48.56	-0.2%	($0.08)
Willamette Dental Group	$44.45	$44.45	0.0%	$0.00

- *Premiums are paid 100% by the employer for all tiers*

Life and AD&D, and Long-Term Disability (LTD) Premiums

- Basic Life and AD&D, and Employer-Paid LTD:
  - Employer funded
  - No rate change for 2023
- Supplemental Life and AD&D, and Employee-Paid LTD:
  - Employee funded
  - No rate change for 2023

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Proposed Resolutions

Proposed Resolution PEBB 2022-17 KPNW Non-Medicare Premium

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

Proposed Resolution PEBB 2022-18 KPWA Non-Medicare Premium

The PEB Board endorses the Kaiser Foundation Health Plan of Washington employee and Non-Medicare retiree premiums.

Proposed Resolution PEBB 2022-19 UMP Non-Medicare Premium

The PEB Board endorses the Uniform Medical Plan (UMP) employee and Non-Medicare retiree premiums.

Next Steps

We will ask the Board to take action on these premium resolutions at the July 20, 2022 meeting.

Questions?

Tanya Deuel, ERB Finance Manager

Financial Services Division

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Appendix

Kaiser Foundation Health Plan of WA

First Fill Program:

- For maintenance drugs only
- First prescription may be filled at any in-network pharmacy
- Subsequent refills must be filled via mail order or at a Kaiser Permanente retail pharmacy*
- Safety: pharmacists can ensure members avoid negative drug interactions and other risks
- More cost effective to members
  - Use of generics when medically appropriate
  - Can negotiate better drug prices

*Does not apply to medications for sudden conditions or drugs that cannot be mailed.

TAB 6

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Medicare Portfolio Comparisons

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

Overview

- Medicare and the PEBB Portfolio
- Comparing individual market plans and group-sponsored plans
- Prior Authorization, Claims, & Appeals: UnitedHealthcare (UHC) Plan Insights
- Provider Network Insights
- PEBB Program Medicare Offering Benefit Designs
- Retiree Engagement

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PEBB Medicare Portfolio

Uniform Medical Plan (UMP) Classic Medicare

- Self-insured coordination of benefits (COB) plan
- Original Medicare FFS pays primary on medical claims, UMP pays secondary
- Creditable drug coverage, UMP pays primary on pharmacy claims

Kaiser WA and Kaiser NW Medicare

- Kaiser WA – Medicare Advantage (MA) and Original Medicare COB plans
- Kaiser NW – SeniorAdvantage (MA)
- Creditable drug coverage

UnitedHealthcare PEBB Balance and PEBB Complete

- Employer group Medicare Advantage plus Prescription Drug (Part D) coverage (MA-PD)
- National PPO network of providers, no difference in cost share for in-/out-of-network care
- Lower premiums and out-of-pocket costs
- No enrollment restrictions or additional costs for retirees with pre-existing conditions

Premera Medicare Supplement Plans F & G

- Supplemental (Medigap) plans for Medicare eligible enrollees (retired or disabled)
- Helps enrollees fill the "gaps" in Original Medicare
- Do not include drug coverage

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Original Medicare & the PEBB Portfolio

Coordination of Benefits (COB) with Original Medicare
(UMP Classic Medicare)

Medicare Part A (Hospital)
+ Medicare Part B (OP/Prof)
Original Medicare

- Health plans coordinate the payment of medical claims with Original Medicare

Medical Claims
- Medicare = Primary
- UMP = Secondary

Pharmacy Claims
- UMP = Only payer

Medicare Advantage
(Kaiser WA and Kaiser NW MA)

- Covers all Original Medicare
- Plans receive risk adjusted Federal subsidy dollars from CMS to administer the medical benefit of the plans
- Popular option for retirees seeking additional benefits not covered by Original Medicare
- Offer Creditable Drug Coverage, HCA receives RDS*

Medicare Advantage plus Part D
(UHC MA-PD plans)

- Covers all Original Medicare + Medicare Part D drug coverage
- Plans receive risk adjusted revenue + additional revenue for Part D benefit
- Part D revenue intended to cover approximately 75% of Part D drug costs
- Employer group plans allow for customization of benefit/formulary

Medicare Supplement
(Premera Plans F & G)

- Supplemental (Medigap) plans for Medicare eligible enrollees (retired or disabled)
- Plans help cover out-of-pocket costs for Original Medicare
- Do not include drug coverage

*Retiree Drug Subsidy (RDS)

PEBB Medicare Portfolio

	UMP Classic Medicare	Kaiser WA & Kaiser NW MA	UHC MA-PD	Premera Plan F and Plan G
Medical	COB with Original Medicare	Medicare Part C (Part A + Part B + supplemental benefits)		Help to cover out-of-pocket costs of Original Medicare
Pharmacy	Creditable Drug Coverage		Part D drug coverage	No drug coverage

Comparing Individual Market Plans and Group-sponsored Plans

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Key Differences: Commercial AARP UHC Plans and PEBB's Group-sponsored UHC MA-PD Plans

	Commercial Market AARP Plans	PEBB Group-sponsored MA-PD Plans
Plan Network Design	Mostly HMO (closed networks)	PPO – Any Willing Medicare Provider
Maximum Out-of-pocket (Medical)	$5,000 - $6,500 (In-network)* $10,000 (Out-of-network)*	$500 (PEBB Complete) $2,000 (PEBB Balance)
Copays (Primary Care)	$0 (In-network)* $25 (Out-of-network)*	$0 (PEBB Complete) $15 (PEBB Balance)
Copays (Specialty)	$35-$45 (In-network)* $65 (Out-of-network)*	$0 (PEBB Complete) $30 (PEBB Balance)
Pharmacy Deductible	$225 for Tiers 3-5**	$100 for Tiers 3-5
Maximum Out-of-pocket (Pharmacy)	No Maximum Limit**	$2,000
"Donut Hole" Coverage Gap	25% Member Coinsurance**	Just pay applicable cost share until Pharmacy Out-of-pocket Max reached

* AARP UHC underwritten "Choice" & "Patriot" PPO Plans (See Appendix)
* * AARP UHC underwritten "Choice" PPO Plan ("Patriot" has no drug coverage) (See Appendix)

Additional Key Differences

- Under HCA's contract with UHC, there is a dedicated UHC customer service team for our PEBB Program retirees
- HCA staff are available to help members navigate coverage issues, a service for *all* PEBB retiree plans (not just UMP)
- Neither of these are available to an individual enrolled in a private individual MA or MA-PD plan

More Key Differences

- HCA administers eligibility and enrollment, so a carrier cannot simply drop a PEBB Program retiree's coverage
- PEBB Program retirees can change plans each year within the PEBB offerings without restrictions that exist for individual market plan switching
- HCA's contract management team actively monitors and intervenes with all carriers to ensure they achieve contracted levels of customer service

Prior Authorization, Claims, and Appeals: UMP and UHC Plan Insights

UMP Medical Prior Authorization Process

- Submit an electronic prior authorization request through Availity Essentials
- Can submit by fax if online not available
- Regence decision issued within 15 calendar days
- Expedited decisions issued within 72 hours

UMP Medical 2021 Prior Authorizations

	UMP Classic Medicare
Total Prior Authorizations Requested	1,858
Approved	1,667
Denied	191

UMP Pharmacy Prior Authorization Appeal Process

- Appeals received by phone, fax, email, or US mail
- Receipt acknowledgement of appeals within 72 hours
- Moda decision within 30 days; can be extended by Moda an additional 16 days
- Expedited appeals decided within 72 hours

2021 UMP Pharmacy (Moda) Prior Authorization Appeals

	UMP Classic Medicare		
Total Prior Authorizations Denied	**2,323**		
	Requested	**Initial Decision Overturned**	**Initial Decision Stands**
1st Level Appeals	**72**	**37**	**35**
2nd Level Appeals	**3**	**2**	**1**
External Appeals	**4**	**2**	**2**

UHC Prior Authorization Process

- Prior Authorization request submitted
- If required information is not provided or forthcoming, authorization will be denied
- Strict CMS timelines protect patients
- Provider submission may delay review; but UHC can’t delay as they must approve/deny within CMS timelines

Medicare Rules on Timely Prior Authorization and Appeal Decisions

- Medical – After receiving request, plan must decide *as quickly as the member's health requires*
  - no later than 72 hours for expedited requests
  - 30 days for standard requests
  - 60 days for payment requests
- Part D Prior Authorizations
  - Within 24 hours for expedited request
  - Within 72 hours for standard request

2021 UHC Medical Appeals

This data is not the total number of denied prior authorizations and claims, it is only the **appeals** of those denials

	UHC PEBB
Total Appeals Requested	**22**
Initial Decision Overturned	**19**
Initial Decision Stands	**3**

2021 UHC Pharmacy Prior Authorization Appeals

	UHC PEBB		
Total Prior Authorizations Denied	192		
	Requested	**Initial Decision Overturned**	**Initial Decision Stands**
1st Level Appeals	**44**	**36**	**8**
External Appeals	**0**	**0**	**0**

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Provider Network Insights

Who Determines the Network?

- HCA does not do direct provider contracting for PEBB plans – *even for UMP*
  - Instead, Regence & Moda (for UMP), Kaiser NW, Kaiser WA, and UHC manage their own provider networks
- Providers can join or leave a network with adequate notice
  - Neither HCA nor a carrier can require future participation in any plan, including UMP

UHC Providers

- PEBB Program retirees are concerned about if they will be able to continue seeing their current providers under a UHC PEBB plan
- The key question to ask is “if my provider accepts the plan,” rather than “is my provider in-network”
- Regardless of UHC network status, the member cost share for covered services is identical – an enhancement compared to UMP Classic Medicare

UHC Providers (*cont.*)

- Most non-contracted providers accept the plan, treat patients, and bill UHC even though they have *not* signed a UHC network contract
  - Providers that do not have a network contract cannot appear in UHC's online provider directory
  - UHC's call center can confirm if a provider accepts its PEBB plans even if they do not show up in the online provider directory

- Throughout the year, UHC reaches out to providers to include them in the network or encourage them to accept the plan

UMP Retiree Subscriber WA Locations

- King County – 18.2%
- Pierce County – 8.8%
- Thurston County – 8.7%
- Snohomish – 6.7%

- 89% of UMP Medicare Retirees are within WA counties

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Current PEBB Medicare Plans' Availability

Provider Directories

For the most current information on what PEBB plans a provider accepts, call *the plan* directly

Plan	Phone Number	Website
KPNW Senior Advantage	1-877-221-8221	Healthy.kaiserpermanente.org/doctors-locations
KPWA Medicare Advantage	1-866-648-1928	wa-doctors.kaiserpermanente.org
UHC PEBB Balance and PEBB Complete	1-855-873-3268	retiree.uhc.com/wapebb/find-a-provider
UMP Classic Medicare	1-888-849-3681	Ump.regence.com/pebb/finding-doctors

PEBB Program Medicare Offering Benefit Designs

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UMP and KPNW Senior Advantage

	UMP Classic	Kaiser NW Senior Advantage
Medical Deductible	$250	$0
Max Medical Benefit Out-of-Pocket	$2,500	$1,500
In Patient Services	$200/day (per admission)	$500/admission
Outpatient Services	15%	$50
Outpatient Mental Health Care	15%	$30/individual, $15/group
Primary Care Office Visit	15%	$30
Specialty Care	15%	$30
Urgent Care	15%	$35 office, $50 ER
ER Copay	$75 + 15%	$50
Supplemental Benefits		
Chiropractic Care	$15/24 visits	$35/12 visits
Acupuncture	$15/24 visits	$35/12 visits
Massage Therapy	$15/24 visits	$25/12 visits
Routine Vision Exams and Hardware	$0 annual exam ($30 copay for contact lens fitting) hardware up to $150 every 2 years	$25 annual exam, hardware up to $150 every 24 months
Routine Hearing Exams & Hearing Aids	$0 annual exam, hardware one per ear every 5 years	$35 annual exam, up to the allowed amount one per ear any consecutive 60 months
Gym Membership	Not covered	Silver and Fit, $0

UMP and KPNW Senior Advantage - Pharmacy

	UMP Classic Medicare	Kaiser NW Senior Advantage
Pharmacy Deductible	$100	$0
Max Pharmacy OOP	$2,000	No OOP Limit

Value Tier (UMP only)	5% up to $10	N/A
Tier 1 - Generic	10% up to $25	$20
Tier 2 - Preferred Brand Name	30% up to $75	$40
Tier 3 - Non-Preferred Brand Name	N/A	50% up to $200
Specialty	N/A	50% up to $200

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UMP and KPWA Medicare Advantage

	UMP Classic	Kaiser WA Medicare Advantage
Medical Deductible	$250	$0
Max Medical Benefit Out-of-Pocket	$2,500	$2,500
In Patient Services	$200/day (per admission)	$200/day (per admission)
Outpatient Services	15%	$200
Outpatient Mental Health Care	15%	$0
Primary Care Office Visit	15%	$20
Specialty Care	15%	$20
Urgent Care	15%	$20
ER Copay	$75 + 15%	$65
Supplemental Benefits		
Chiropractic Care	$15/24 visits	$15, 12 visits (Non-spinal) unlimited visits for spinal
Acupuncture	$15/24 visits	$15/visit, 12 visits
Massage Therapy	$15/24 visits	$30/visit, 10 visits
Routine Vision Exams and Hardware	$0 annual exam ($30 copay for contact lens fitting) hardware up to $150 every 2 years	$15 annual exam, hardware up to $300 every 24 months
Routine Hearing Exams & Hearing Aids	$0 annual exam, hardware one per ear every 5 years	$20 annual exam, up to the allowed amount one per ear any consecutive 60 months
Gym Membership	Not covered	Silver and Fit, $0

UMP and KPWA Medicare Advantage - Pharmacy

	UMP Classic Medicare	Kaiser WA Medicare Advantage
Pharmacy Deductible	$100	$0
Max Pharmacy OOP	$2,000	No OOP Limit

Value Tier (UMP only)	5% up to $10	N/A
Tier 1 - Generic	10% up to $25	$20
Tier 2 - Preferred Brand Name	30% up to $75	$40
Tier 3 - Non-Preferred Brand Name	N/A	50% or $250
Specialty	N/A	N/A

UMP and 2023 UHC PEBB Complete

	UMP Classic	UHC PEBB Complete
Medical Deductible	$250	$0
Max Medical Benefit Out-of-Pocket	$2,500	$500
In Patient Services	$200/day (per admission)	$0
Outpatient Services	15%	$0
Outpatient Mental Health Care	15%	$0
Primary Care Office Visit	15%	$0
Specialty Care	15%	$0
Urgent Care	15%	$15
ER Copay	$75 + 15%	$65
Supplemental Benefits		
Chiropractic Care	$15, 24 visits	$0, 24 visits
Acupuncture	$15, 24 visits	$0, 24 visits
Massage Therapy	$15, 24 visits	$0, 30 visits
Routine Vision Exams and Hardware	$0 annual exam ($30 copay for contact lens fitting) hardware up to $150 every 2 years	$0 annual exam (including contact lens fitting) hardware up to $300 every 2 years
Routine Hearing Exams & Hearing Aids	$0 annual exam, hardware one per ear every 5 years	$0 annual exam, hardware up to $2,500 from United Hearing every 5 years
Gym Membership	Not covered	Renew Active, $0

UMP and 2023 UHC PEBB Balance

	UMP Classic	UHC PEBB Balance
Medical Deductible	$250	$0
Max Medical Benefit Out-of-Pocket	$2,500	$2,000
In Patient Services	$200/day (per admission)	$500/admission
Outpatient Services	15%	$500/admission
Outpatient Mental Health Care	15%	$15 group/$30 individual
Primary Care Office Visit	15%	$15
Specialty Care	15%	$30
Urgent Care	15%	$15
ER Copay	$75 + 15%	$65
Supplemental Benefits		
Chiropractic Care	$15, 24 visits	$15, 24 visits
Acupuncture	$15, 24 visits	$15, 24 visits
Massage Therapy	$15, 24 visits	$15, 30 visits
Routine Vision Exams and Hardware	$0 annual exam ($30 copay for contact lens fitting) hardware up to $150 every 2 years	$0 annual exam (including contact lens fitting) hardware up to $300 every 2 years
Routine Hearing Exams & Hearing Aids	$0 annual exam, hardware one per ear every 5 years	$0 annual exam, hardware up to $2,500 from United Hearing every 5 years
Gym Membership	Not covered	Renew Active, $0

UMP and 2023 UHC PEBB Plans - Pharmacy

	UMP Classic Medicare	UHC PEBB Complete	UHC PEBB Balance
Pharmacy Deductible	$100	$0 (Tier 1) $100 (Tiers 2-4)	
Pharmacy Max Out-of-pocket	$2,000	$2,000	
Value Tier	5% up to $10	N/A	
Tier 1 – Generic	10% up to $25	up to $5	
Tier 2 – Preferred Brand Name	30% up to $75	up to $45	
Tier 3 – Non-Preferred Brand Name	N/A	up to $100	
Specialty	N/A	up to $100	

UMP and Premera Plan G

	UMP Classic	Premera Plan G
Medical Deductible	$250	Part B deductible $233 (Plan Year 2022)
Max Medical Benefit Out-of-Pocket	$2,500	$233 (Plan Year 2022)
In Patient Services	$200/day (per admission)	$0
Outpatient Services	15%	$0
Outpatient Mental Health Care	15%	$0
Primary Care Office Visit	15%	$0
Specialty Care	15%	$0
Urgent Care	15%	$0
ER Copay	$75 + 15%	$0

Follow-up: Outpatient Rehabilitation Therapies

	UMP Classic Medicare	KPNW Senior Advantage	KPWA Medicare Advantage	UHC PEBB Balance	UHC PEBB Complete	Premera Plan G
Physical, Occupational, & Speech Therapies	15% coinsurance 60 combined visit limit	$35 copay / Medicare-covered visit or per day in a CORF ($0 / telehealth visit)	$30 copay / Medicare-covered visit $0 for services provided in a Comprehensive Outpatient Rehabilitation Facility (CORF)	$15 copay / Medicare-covered visit	$0 / Medicare-covered visit	$0 after Part B deductible / Medicare-covered visit

-Medicare requires prior authorization for PT/OT/ST.

Follow-up: Chiropractic & Acupuncture Therapies (Medicare-covered)

	UMP Classic Medicare	KPNW Senior Advantage	KPWA Medicare Advantage	UHC 2023 PEBB Balance	UHC 2023 PEBB Complete	Premera Plan G
Chiropractic	$15 copay 24 visit limit	$20 copay / Medicare-covered visit $35 copay / routine visit 12 visit limit*	$15 copay / Medicare-covered visit $15 copay / nonspinal manipulation services 12 visit limit	$20 copay / Medicare-covered visit $15 per routine visit 24 visit limit	$0 / Medicare-covered visit $0 / routine visit 24 visit limit	$0 after Part B deductible / Medicare-covered visit
Acupuncture	$15 copay 24 visit limit	$20 copay / Medicare-covered visit $35 copay / routine visit 12 visit limit*	$15 copay / Medicare-covered visit $15 copay / routine visit 12 visit limit	$15 copay / Medicare-covered visit $15 copay / routine visit 24 visit limit	$0 / Medicare-covered visit $0 / routine visit 24 visit limit	$0 after Part B deductible / Medicare-covered visit

-Medicare may require prior authorization for covered chiropractic and acupuncture services
-Medicare covers acupuncture for treatment of chronic low back pain only (20 visit limit), and chiropractic services for manual manipulation of the spine for subluxation.
*Complimentary Health Plan (CHP) providers only

Follow-up: Massage and Naturopathic Services (non-Medicare-covered)

	UMP Classic Medicare	KPNW Senior Advantage	KPWA Medicare Advantage	UHC PEBB Balance	UHC PEBB Complete	Premera Plan G
Massage Therapy	$15 copay 24 visit limit Preferred providers only, with prescription	$25 copay 12 visit limit*	$30 copay / provider-referred visit 10 visit limit	$15 copay 30 visit limit	$0 30 visit limit	Not covered
Naturopathic Services	15% coinsurance	$25 copay*	$15 copay 3 visit limit per medical diagnosis	$30 copay	$30 copay	Not covered

*Complimentary Health Plan (CHP) providers only

Retiree Engagement

Informed Decision Making

- Continuing to improve how we present information; for example, last year HCA made changes to the Retiree Guide to make plan comparisons easier
- Engaging retirees to ensure they have the information necessary to make decisions

Recent/Upcoming Retiree Engagements

- July 6 – RPEC District 8 meeting
- July 14 – Preparation meeting with RPEC-organized coalition to establish in-person listening sessions
- August 22 – WSSRA webinar
- September 12-14 – WSSRA Convention
- September 21-22 – WEA Leadership Council
- September 27-29 – RPEC Convention

Future Opportunities

- The prior slide includes meetings/events already on HCA staff calendars
- Contact Ellen.Wolfhagen@hca.wa.gov with invitations for other engagement opportunities
- HCA will also be reaching out to additional stakeholder groups
- After the engagements are completed in 2023, meet with retiree stakeholder groups to review what HCA heard

Goals of Retiree Engagements

- Engage retirees so they can share information about the PEBB Medicare portfolio
- Provide information and answer questions about the funding and financial structure of UMP Classic Medicare and Medicare Advantage plans
- Describe how PEBB retiree plans are different from individual market retiree plans

Goals of Retiree Engagements (*cont.)*

- Use retiree insights to improve future retiree communications
- Share the challenges inherent in managing the retiree portfolio
- Rebuild and strengthen the relationship between HCA and PEBB retirees

Board Follow up

- Invite Board members to attend at least one retiree engagement
- Present initial insights from Summer/Fall 2022 retiree engagements at the January 2023 Retreat
- Provide periodic updates during additional Board meetings on the concerns raised in retiree engagements

Questions?

Ellen Wolfhagen, Senior Account Manager
Employees and Retirees Benefits Division
Ellen.Wolfhagen@hca.wa.gov

Appendix

UHC: Individual Market vs. PEBB Plans

Name of plan	AARP Medicare Advantage Walgreens	AARP Medicare Advantage Choice	AARP Medicare Advantage Plan 2	AARP Medicare Advantage Plan 3	AARP Medicare Advantage Plan 1	AARP Medicare Advantage Patriot	PEBB Complete	PEBB Balance
Type of plan	HMO-POS	PPO with lower out of network benefits	HMO	HMO	HMO	PPO	PPO with the same benefits in and out of network	PPO with the same benefits in and out of network
2022 Premium for Plan	$0	$19	$24	$45	$88	$0	$148.68	$125.99
PCP Copay	$0	$0 in/$25 Out	$10	$0	$0	$0 in/$25 Out	$0	$15
SCP Copay	$40	$45 in/$65 Out	$45	$40	$35	$35 in/$65 Out	$0	$30
Urgent Copay	$40	$40	$40	$40	$40	$40	$15	$15
Inpatient Hospital	$400 per day, days 1-4	$390 per day, days 1-5, in-network/$500 per day days 1-20 OON	$440 per day, days 1-4	$375 per day, days 1-4	$250 per day, days 1-7	$395 per day, days 1-4, in-network/$500 per day days 1-20 OON	$0	$500 per stay
Out of pocket Max	$6,500	$6,500 in/ $10,000 Out	$6,700	$5,900	$4,200	$5,500 in/ $10,000 Out	$500	$2,000

UHC Plans: Pharmacy Comparison

Name of plan	AARP Medicare Advantage Walgreens	AARP Medicare Advantage Choice	AARP Medicare Advantage Plan 2	AARP Medicare Advantage Plan 3	AARP Medicare Advantage Plan 1	AARP Medicare Advantage Patriot	PEBB Complete	PEBB Balance
Prescription Drugs								
Drug Deductible	$0	$0 for tiers 1-2 $225 for tiers 3-5	$0 for tiers 1-2 $200 for tiers 3-5	$0 for tiers 1-2 $225 for tiers 3-5	$0 for tiers 1-2 $185 for tiers 3-5	No Drug Coverage	$0 for tiers 1-2 $100 for tiers 3-5	$0 for tiers 1-2 $100 for tiers 3-5
Max out of pocket	No Max	No Max	No Max	No Max	No Max	N/A	$2,000	$2,000
Tier 1 - Preferred Generics	$0 at preferred pharmacy/$10 at non-preferred	$0	$0	$0	$0	N/A	10%, $25 max	10%, $25 max
Tier 2 - Generic Drugs	$0 at preferred pharmacy/$20 at non-preferred	$12	$12	$12	$12	N/A	10%, $25 max	10%, $25 max
Tier 3 - Preferred Brands	$47	$45	$47	$45	$45	N/A	30%, $47 max	30%, $47 max
Tier 4 - Non-preferred Drug	$100	$95	$100	$95	$95	N/A	50%	50%
Tier 5 - Specialty Drugs	33%	29%	29%	29%	30%	N/A	50%, $100 max	50%, $100 max
Select Insulin Drugs	$35	$35	$35	$35	$35	N/A	$10	$10
Coverage Gap	CMS Minimum	CMS Minimum	CMS Minimum	CMS Minimum	CMS Minimum	N/A	Cost shares above	Cost shares above

***The PEBB formulary is only four tiers but to show apples and apples we demonstrated how it would look in five tiers**

**** The PEBB Complete and Balance cost shares are the current 2022 plan design; See slide 49 for the 2023 proposed copay design**

Reminder: UHC PEBB Complete & Balance – Pharmacy Benefit Design Change

	2022	2023
Pharmacy Deductible	$0 (Tier 1) $100 (Tiers 2-4)	$0 (Tier 1) $100 (Tiers 2-4)
Pharmacy Max Out-of-pocket	$2,000	$2,000
Value Tier	N/A	N/A
Tier 1 – Generic	10% up to $25	up to $5
Tier 2 – Preferred Brand Name	30% up to $47	up to $45
Tier 3 – Non-Preferred Brand Name	50%	up to $100
Specialty (limited to a 30-day fill)	50% up to $100	up to $100

TAB 7

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Medicare Clinical Insights

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Continuity of Care

- Keeping the same provider(s)
- Utilization management/prior authorization
  - Medications
  - Procedures
  - Experimental and investigational treatments

Continuity of Providers

- Payer side
  - Needs to be willing to pay provider
    - Network contract or non-network payment
- Provider side
  - Needs to accept payment from plan
    - With or without joining network
  - Needs to be willing to see patient

Continuity of Providers (*cont.*)
Provider types **covered** by traditional Medicare

- Payer side
  - KP: Generally limited to KP providers except when none available
  - UHC: Pays any provider who accepts traditional Medicare (includes most UMP providers)
    - Providers can choose to join network or not; no difference in costs to member

Continuity of Providers (*cont.*)

Provider types **not covered** by traditional Medicare

- Massage, naturopaths, etc.
- Payer side
  - KP: Complementary and alternative medicine providers covered, but generally limited to KP contracted providers
  - UHC: Complementary and alternative medicine providers covered, but must be affiliated with UnitedHealthcare

Continuity of Providers (*cont.*)

- Provider side
  - Needs to accept payment from plan (with or without joining network)
    - HCA working to better understand factors that may influence this
  - Needs to be willing to see patient
    - Generally, not an issue if patient is already established with provider (i.e., patient-based rather than plan-based)

Continuity of Care
Utilization Management/Prior Authorization (PA)

- Pharmacy: Review later in presentation
- Procedures (surgeries, etc.)
  - Providers normally send PA request to the new plan during transitions
  - Coverage is generally extended across an active plan of care (transplant, etc.)
- Experimental/Investigational therapies
  - In general, not covered by any plan (including UMP)
  - There may be variability in exceptions

What is a Formulary?

- Long list of drugs or products covered by a health plan, typically separated into several tiers with different cost shares
  - UMP Preferred Drug List has approximately 2,300 products listed
- Formularies are living documents and change when drugs are added or removed from the market
- Although formularies differ between health plans, Medicare plans are required to cover at least 2 drugs in each drug category

Value Formulary Follow Up

- In 2020 UMP implemented a value formulary which directed members to the highest value prescription drugs, without reducing quality of care.
  - This effort primarily focused on non-specialty drug classes
- For UMP Medicare, increases in specialty drug spend has overshadowed the impact of the value formulary on trend growth.
- No formulary management effort will be enough to overcome the structural disadvantage of the existing UMP Medicare Plan.

Value Formulary follow up (*cont.*)

- It is not possible to quantify a *specific* cost impact of the value formulary due to many confounding factors
  - Rapid increase in specialty drug PMPM spend which contributes to about 58% of total UMP Medicare plan spend
  - Expansion of protected drug classes when the value formulary was implemented
  - Changes in drug costs and rebates
  - Preferred Drug List changes
  - Evolving disease state guidelines and prescribing patterns
  - Shifts in plan membership with diverse health needs
  - COVID-19 pandemic

Benefits of UMP's Value Formulary

- Resolved member equity issue
  - Members do not need to know about an exception process to access reduced cost shares
- Provided savings directly to members
  - Before implementation, many members were paying a 50% coinsurance for non-preferred drugs
  - Members now pay 30% up to a maximum of $75 per 30 days for the same or similar drug
- Likely reduced the pace of pharmacy trend growth, particularly for non-specialty drugs

Continuation of Therapy: When Changing from UMP to a UHC plan

- Part D sponsored formularies require coverage for almost all drugs in the following classes:
  - Immunosuppressants
  - Antidepressants
  - Antipsychotics
  - Anticonvulsants
  - Antiretrovirals (HIV)
  - Antineoplastics
- If a member has already gone through step therapy on any of the above drugs while in UMP, they should not need to satisfy step therapy again.

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Continuation of Therapy (*cont.*)

Additional Drug Classes	Continuation of Therapy (UHC)
Antivirals Compounded drugs Gout drugs Immunomodulatory/Hepatitis C agents Insulin Rare disease medications Thyroid drugs	UHC will work together with UMP to transfer active medication approvals, allowing for uninterrupted coverage.
ADHD drugs Antiarrhythmics Anticoagulants Antiparkinsons Cardiovascular drugs – Brand Irritable Bowel Disease drugs Pancreatic enzymes	UHC will work together with UMP to transfer active medication approvals, allowing for uninterrupted coverage except possibly for: alosetron, benztropine, chlordiazepoxide/clidinium, clonidine ER, diphenoxylate/atropine, disopyramide, methamphetamine, Pancreaze, Pradaxa, and trihexyphenidyl.

Continuation of Therapy (*cont.*)

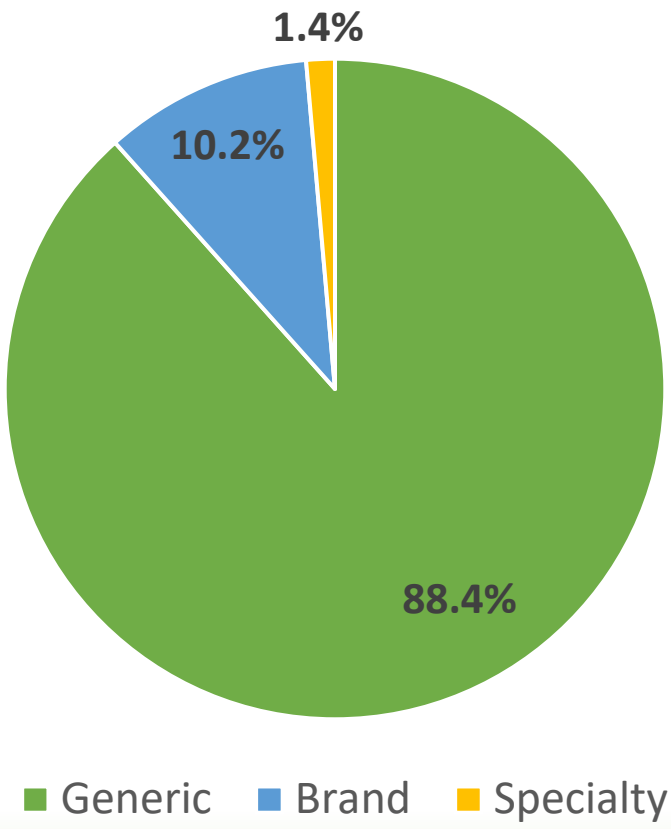
- New prescriptions for the 20 drug classes on the prior slides may require step therapy or prior authorization in a UHC plan, just like in UMP

- For context, the 20 drug classes on the prior slides were those drug classes handled with extra protections when implementing the UMP Value Formulary in 2020

Utilization by Member

- 53,576 total UMP Medicare members
- 97% of members have used the prescription drug benefit in 2022
- 95% have used at least one generic product
- 38% have used at least one brand product
- 3.4% have used at least one specialty product

Utilization by Prescription Count (UMP 2022)



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Generic Drugs – Top 10 Used (30-day Fill)

UMP Drug Utilization	UMP	UHC	KPWA	KPNW
Atorvastatin (28%)	$0	$0	Up to $20	$0
Levothyroxine (21%)	10%	Up to $5	Up to $20	Up to $15
Lisinopril (17%)	5%	Up to $5	Up to $20	Up to $15
Amlodipine (16%)	5%	Up to $5	Up to $20	Up to $15
Losartan (15%)	5%	Up to $5	Up to $20	Up to $15
Metoprolol succinate (14%)	5%	Up to $5	Up to $20	Up to $15
Gabapentin (10%)	10%	Up to $5	Up to $20	Up to $15
Simvastatin (9%)	$0	$0	Up to $20	$0
Rosuvastatin (9%)	$0	Up to $5	Up to $20	$0
Hydrochlorothiazide (9%)	5%	Up to $5	Up to $20	Up to $15

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Brand Drugs - Top 10 Used (30-day Fill)

UMP Drug Utilization	UMP	UHC	KPWA	KPNW
Eliquis (9%)	$75	$45	50% up to $250	Medically necessary process; if approved $40
Basaglar Kwikpen (4%)	$10	$100 (alternative available at $10)	$35 (as of 2023)	$35 (as of 2023)
Jardiance (2%)	$75	$45	$40	$40
Ozempic (1%)	$75	$45	50% up to $250	$40
Novolog (1%)	$10	$100 (alternative available at $10)	$35 (as of 2023)	$35 (as of 2023)
Farxiga (1%)	$75	$45	50% up to $250	Medically necessary process; if approved 50% up to $200
Xarelto (1%)	$75	$45	$40	$40
Victoza (1%)	$75	$45	50% up to $250	$40
Flovent (1%)	$10	$45	$40	$40
Synthroid (1%)	Requires exception; If approved $75	$45	50% up to $250	Covered as Generic (levothyroxine)

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Specialty Drugs – Top 10 Used (30-day Fill)

UMP Drug Utilization	UMP	UHC	KPWA	KPNW
Humira (0.4%)	$75	$100	$40	50% up to $200
Repatha Sureclick (0.4%)	$75	$45 (preferred brand)	50% up to $250	Medically necessary process; if approved $40
Enbrel (0.3%)	$75	$100	$40	50% up to $200
Abiraterone (0.2%)	$25 (generic specialty)	$5 (generic)	$20	$15
Dupixent (0.1%)	Requires exception; if approved $75	$100	50% up to $250	Medically necessary process; if approved 50% up to $200
Revlimid (0.1%)	$75	$100	$40	50% up to $200
Xeljanz XR (0.1%)	$75	$100	$40	$40
Otezla (0.1%)	$75	$100	$40	50% up to $200
Imbruvica (0.1%)	$75	$100	$40	50% up to $200
Stelara (0.1%)	$75	$100	$40	50% up to $200

Finding Drugs for Each Plan

Plan	Phone Number	Website
UMP	1-888-361-1611	ump.regence.com/pebb
KPNW Senior Advantage	1-877-221-8221	my.kp.org/wapebb
KPWA Medicare Advantage	1-866-648-1928	wa-my.kp.org/pebb
UHC PEBB Balance and PEBB Complete	1-855-873-3268	retiree.uhc.com/wapebb

Questions?

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