

# Public Employees Benefits Board Meeting

April 14, 2021

## Public Employees Benefits Board

April 14, 2021

12:00 p.m. – 5:00 p.m.

### Zoom Attendance Only

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

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**TAB 1**

**Public Employees Benefits Board**  
**April 14, 2021**  
**12:00 p.m. – 5:00 p.m.**

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

**TO JOIN ZOOM MEETING – SEE INFORMATION BELOW**

12:00 p.m.*	<b>Welcome and Introductions</b>		Sue Birch, Chair	
12:05 p.m.	<b>Meeting Overview</b>		Dave Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information/ Discussion
12:10 p.m.	<b>Approval of: July 15, 2020 Minutes July 22, 2020 Minutes January 27, 2021 Minutes</b>	TAB 3	Sue Birch, Chair	Action
12:15 p.m.	<b>Transition to Executive Session</b>			
12:25 p.m.	<b>Executive Session</b>		Tanya Deuel, ERB Finance Manager Financial Services Division  Lauren Johnston, SEBB Program Procurement Manager, ERB Division	
1:30 p.m.	<b>Break</b>			
1:40 p.m.	<b>Long-Term Disability (LTD) Insurance</b>	TAB 4	Kimberly Gazard, Contract Manager Portfolio Management & Monitoring Section, ERB Division	Action
2:10 p.m.	<b>Policy Resolutions</b>	TAB 5	Stella Ng, Senior Policy Analyst Emily Duchaine, Regulatory Analyst Policy, Rules, & Compliance Section, ERB Division	Action
2:50 p.m.	<b>2021–23 Biennial Budget Update</b>	TAB 6	Tanya Deuel, ERB Finance Manager Financial Services Division	Information/ Discussion
3:05 p.m.	<b>2021 Legislative Session</b>	TAB 7	Cade Walker, Special Executive Assistant, ERB Division	Information/ Discussion
3:20 p.m.	<b>Break</b>			
3:30 p.m.	<b>2021 Annual Rule Making</b>	TAB 8	Stella Ng, Senior Policy Analyst Policy, Rules, & Compliance Section ERB Division	Information/ Discussion
3:45 p.m.	<b>American Rescue Plan Act of 2021 – Premium Assistance for COBRA Continuation Coverage</b>	TAB 9	Emily Duchaine, Regulatory Analyst Policy, Rules, & Compliance Section ERB Division	Information/ Discussion

4:00 p.m.	<b>Behavioral Health Overview</b>	TAB 10	Lauren Johnston, SEBB Procurement Manager, ERB Division Emily Transue, MD, Medical Director CQCT Division	Information/ Discussion
4:30 p.m.	<b>Public Comment</b>			
5:00 p.m.	<b>Adjourn</b>			

**\*All Times Approximate**

The Public Employees Benefits Board Retreat will meet Wednesday, April 14, 2021. Due to COVID-19 and out of an abundance of caution, all Board Members and attendees will attend this meeting virtually.

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

Pursuant to RCW 42.30.110(1)(I), the Board will meet in Executive Session to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session will begin at 12:25 p.m. and conclude no later 1:30 p.m.

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

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

Direct e-mail to: [board@hca.wa.gov](mailto:board@hca.wa.gov).

Materials posted at: <http://www.pebb.hca.wa.gov/board/> by close of business on April 12, 2021.

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Join Zoom Meeting

<https://zoom.us/j/98207208948?pwd=KzdwZWJlK0JKZGFxMENKYzJ4ak1wdz09>

Meeting ID: 982 0720 8948

Passcode: 974789

One tap mobile

+13017158592,,98207208948# US (Washington DC)

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Dial by your location

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+1 669 900 6833 US (San Jose)

Meeting ID: 982 0720 8948

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

## PEB Board Members

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

## PEB Board Members

Name	Representing
Yvonne Tate 1407 169 <sup>th</sup> PL NE Bellevue WA 98008 V 425-417-4416 <a href="mailto:PEBBoard@hca.wa.gov">PEBBoard@hca.wa.gov</a>	Benefits Management/Cost Containment
John Comerford* 121 Vine ST Unit 1205 Seattle, WA V 206-625-3200 <a href="mailto:PEBBoard@hca.wa.gov">PEBBoard@hca.wa.gov</a>	Benefits Management/Cost Containment
Harry Bossi 19619 23 <sup>rd</sup> DR SE Bothell WA 98012 V 360-689-9275 <a href="mailto:PEBBoard@hca.wa.gov">PEBBoard@hca.wa.gov</a>	Benefits Management/Cost Containment
<b>Legal Counsel</b> Michael Tunick, Assistant Attorney General 7141 Cleanwater Dr SW PO Box 40124 Olympia WA 98504-0124 V 360-586-6495 <a href="mailto:MichaelT4@atg.wa.gov">MichaelT4@atg.wa.gov</a>	

\*non-voting members

3/12/21



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

## PEB BOARD MEETING SCHEDULE

### 2021 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 8<sup>th</sup> Avenue SE, Olympia, WA 98501.

January 27, 2021 (Board Retreat) 9:00 a.m. – 4:00 p.m.

March 17, 2021 - Noon – 5:00 p.m.

April 14, 2021 - Noon – 5:00 p.m.

May 12, 2021 - Noon – 5:00 p.m.

June 9, 2021 - Noon – 5:00 p.m.

June 30, 2021 - Noon – 5:00 p.m.

July 14, 2021 - Noon – 5:00 p.m.

July 21, 2021 - Noon – 5:00 p.m.

July 28, 2021 - Noon – 5:00 p.m.

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

6/12/20

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

DATE: July 21, 2020

TIME: 11:23 AM

WSR 20-15-132



**TAB 2**

## PEB BOARD BY-LAWS

### **ARTICLE I**

#### **The Board and its Members**

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

### **ARTICLE II**

#### **Board Officers and Duties**

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

**ARTICLE III**  
**Board Committees**

**(RESERVED)**

**ARTICLE IV**  
**Board Meetings**

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

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

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

**ARTICLE V**  
**Meeting Procedures**

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

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

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

*Last Revised July 15, 2020*

**TAB 3**

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

July 15, 2020  
Health Care Authority  
Meeting Held Telephonically  
Olympia, Washington  
1:00 p.m. – 4:15 p.m.

**Members Present:**

Sue Birch, Chair  
Yvonne Tate  
Harry Bossi  
Tim Barclay  
Elyette Weinstein  
Tom MacRobert  
Leanne Kunze

**Members Absent:**

John Comerford

**PEB Board Counsel:**

Michael Tunick, Assistant Attorney General

**Call to Order**

**Sue Birch, Chair**, called the meeting to order at 1:05 p.m. Due to COVID-19 and the Governor's Proclamation 20-28, today we're meeting telephonically only. Sufficient members present to allow a quorum. Board self-introductions followed.

**Meeting Overview**

**David Iseminger**, Director, Employees and Retirees Benefits Division, provided an overview of today's meeting.

**Approval of April 2, 2020 Meeting Minutes**

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

**Follow Up From June 17, 2020 Meeting**

**Dave Iseminger**: I have one update today. I like to use this time to give you COVID-19 updates. Many of the questions asked last meeting are embedded in future presentations. So, today I want to let you know the current status of how the plans are

treating cost shares that are being waived for treatment of COVID. The plans had various timelines. Under all the plans in the PEBB Program, waiver is occurring for member cost shares for COVID treatment through December 31.

### **PEB Board By-Laws Update**

**Dave Iseminger**, Director, ERB Division. HCA is asking the Board to take action on updates to the PEB Board By-Laws. This is the same presentation as our last meeting with one modification. These updates are requested due to changes to statute. Specifically, there had been a K-12 non-voting member in statute that was removed effective January 1, 2020. There are also alignments with current law related to the Open Public Meetings Act and posting of agendas and minutes to modernize the By-laws. The Open Public Meetings Act hadn't recognized the internet until sometime in the last decade.

Slide 3 – PEB Board Action Required. There needs to be a two-thirds majority affirmative vote to amend the By-laws, requiring five votes versus the normal four. The proposed amendments are in the Appendix. I will highlight the one change made based on feedback. My recommendation is to approve the entire slate of proposed amendments in one vote.

Slide 4 – Feedback. One piece of feedback received resulted in a change to what was presented at the last meeting. It's a minor grammatical change to Slide 6, Article 1, Section 1 – Board Function in the Appendix. The red underlined portion is new language, red strike through is removed language. The phrase, “for higher education and State employees, State retirees, and school retirees” is how it will read if approved. The word “and” was added to the phrase “higher education and state employees.” In the prior version, we didn't acknowledge the phrase “higher education” was also new. Beyond that, everything is as presented at the last meeting.

### **Sue Birch: Vote to approve proposed By-laws amendments as written.**

Yvonne Tate moved, and Elyette Weinstein seconded a motion to approve the proposed By-laws as written.

Voting to Approve: 7

Voting No: 0

**By-laws approved as written.**

### **2021 PEBB Medicare Portfolio and Rate Resolutions**

**Tanya Deuel**, ERB Finance Manager, **Sara Whitley**, Financial Services Division, and **Ellen Wolfhagen**, ERB Division.

**Sara Whitley:** Today is about Medicare. Slide 2 – PEBB Medicare Portfolio, is an overview of the current PEBB Medicare portfolio. We'll also discuss the new proposed plans for 2021 to be offered via UnitedHealthcare. HCA's current portfolio includes Kaiser Washington and Kaiser Northwest Medicare Options. Kaiser Washington offers a Medicare Advantage plan, as well as an original Medicare Coordination of Benefits plan. Each is offered in various counties throughout Washington and enrollees are able



to select each plan from the county in which they live. Kaiser Northwest offers a Senior Advantage or a Medicare Advantage option as well. All three Kaiser options include creditable drug coverage, which is drug coverage administered by the plan that is at least as rich as Part D drug coverage offered via Medicare.

The Uniform Medical Plan or UMP Classic Medicare option is our self-insured formation of benefits plan. Original Medicare fee for service pays primary on medical claims and UMP pays secondary. Our UMP Classic plan also includes creditable drug coverage, however, UMP pays primary on all pharmacy claims. There is no coordination of benefits with Medicare on the drug portion of the benefit.

The Premera Medicare Supplement Plans F and G are supplemental, or Medi-gap plans available for Medicare eligible enrollees, both retired and disabled. Supplement Plans quite literally help Medicare enrollees fill the gaps in Original Medicare coverage. They're not all-inclusive Medicare plans and do not include drug coverage.

The United MA-PD plans are proposed for 2021. These are employer group Medicare Advantage - Plus Prescription Drugs or Part D coverage plans. They include a national PPO network of providers with no difference in cost share for members being in or out of network care. As long as the provider accepts Medicare, they are considered in network for these plans. The United MA-PD plans offer lower premiums and out-of-pocket costs. These are not individual market plans, so there are no restrictions for enrollment, additional costs, or benefit restrictions for enrollees with preexisting conditions.

HCA has established contracts with United for this employer group plan, as we do with all of our carriers - Kaiser, Regence, Premera - in order to manage our member experience and ensure high plan performance. Our contracts include extensive performance guarantees with financial penalties linked to the management of operations, reporting, customer service, etc.

Slide 3 – History of Medicare Advantage. Medicare Advantage or Medicare Part C are managed care plans. Carriers establish at-risk contracts directly with CMS to administer Medicare Advantage plans. Based on that contract, CMS then pays the plan a risk adjusted capitated subsidy calculated on an annual basis that's intended to cover the cost of administering and covering all of Original Medicare, which is Parts A or hospital inpatient coverage and Medicare Part B, which is professional medical coverage.

Medicare Advantage Plans that include Part D drug coverage, or MA-PD plans, receive additional subsidies for administering the Part D benefit. In combination, these are intended to cover around 75% of the cost of the benefits. Managed care plans in Medicare were established around the 1970s and 1980s to address the rising costs of Medicare, which originally only included HMO plan options. As the plans evolved and enrollment increased, PPO options became available and national offerings have evolved to offer additional provider access to enrollees.

Medicare retirees have unique care needs and there are many clinical programs that offer coordination of care in the Medicare Advantage space that provides a means for increasing the quality of care that Medicare enrollees receive, as well as containing the

costs associated with that care. Both Kaiser plans are Medicare Advantage plans, include clinical programs, as well as the United plan, that are aimed at increasing the value and quality that's provided to our Medicare enrollees. These clinical programs are investments in the whole person health of a retiree with a goal of ensuring the plans are taking better care of our retirees, and over time, trends in hospitalizations and the cost of care decrease.

Slide 4 – PEBB Medicare Portfolio Development. Prescription drug costs in UMP Classic Medicare drive the cost of the plan and represent about 60% of the total plan cost, with that trend increasing over time. This is a function of UMP paying primary on drug costs, rather than secondary, as we do with coordination of benefits on the medical side. The plan absorbs the full impact of these costs.

The majority of that 60% of plan costs can be attributed to specialty drug spend. Specialty drug spend in 2019 represented about 1.4% of the total prescription counts but represented 57% of the total Medicare costs in our UMP plan. Many of the specialty drugs are in protected drug classes, which make it difficult for us to manage. Prescription drug prices are set at a certain rate, and because they're in protected drug classes, there is not much HCA can do to drive costs down. Historical increases in this trend has led to increases in premiums year over year for our retirees.

After stakeholdering and listening to retiree feedback on premium increases, we've utilized our purchasing powers with the state to procure lower cost, sustainable, high-value plans that maximize federal resources to help stabilize member premiums, while still providing high-value benefit options to our enrollees. Because UMP is a self-insured plan offering, HCA can't obtain the same federal resources as private carriers can by contracting directly with CMS.

Slide 5 – Characteristics of UMP Classic Medicare. Total plan costs are borne by the state. One of the advantages of having a self-insured plan is that we manage the benefit design and own any changes that take place in UMP Classic Medicare. It is a coordination of benefits, or COB plan, with original Medicare fee for service. Again, for medical claims, Original Medicare pays primary, UMP pays secondary. For pharmacy, UMP pays primary, there's no coordination of benefits.

**Ellen Wolfhagen:** Slide 6 – Original Medicare COB with UMP Classic, is an illustration only. If the provider's charge is \$150, first look at the Medicare amount allowed based on a set fee schedule set by CMS which is the same for those same kinds of services. Medicare pays 80%. In the illustration, the Medicare amount allowed is \$100, so Medicare would pay \$80. UMP looks at the remaining \$20 and determines how much the amount allowed would be, which is the same as the Medicare amount allowed. The UMP Classic benefit is 85% of that allowed amount, which is \$85. \$85 is greater than remaining \$20; and therefore, UMP Classic would pay the \$20 and the retiree will pay zero out of pocket.

Slide 7 – UMP Classic Medicare & UHC MA-PD Structure. This is just an illustration of some of the crossover between UMP Classic and the new MA-PD plans. Under UMP Classic, the retiree pays a coinsurance. Under MA-PD, the retiree would pay a copay.

Slide 8 – June 17 – Follow Up. The structure of UMP Classic and the MA-PD plans is very different. Because the costs are handled differently, it's difficult to make one-to-one comparisons. But the co-pays are set fees and are predictable. The coinsurance amount is a percentage of what is allowed, so they're hard to predict because those costs may not be known by the retiree at the time of service. A lot of thought goes into individual plan selection usually driven by individual needs and circumstances, both economic and clinical, as well as preferences for kinds of facilities, treatment options, and providers. It's important to note that the provider access under MA-PD is exactly identical to UMP. Any provider a retiree is currently seeing in UMP is in network for the MA-PD plans.

Slide 9 – June 17 – Follow Up (*cont.*). Since the percentage of cost may not be known up front, it's hard to forecast what the actual coinsurance costs would be. With co-pays, those fees are set so it is possible to determine those costs. With these cost uncertainties in mind, HCA looked to provide a rich benefit design where most things are covered fully in order to protect against extreme costs.

Slide 10 – June 17 – Follow Up (*cont.*). This Slide is an illustrative scenario to look at an episode of care involving a cancer diagnosis. Again, this is just an illustration. Although it's hard to detail an episode of care, Dr. Transue, HCA's Medical Director, confirmed this is a reasonable summary for cost comparison purposes. We're looking at five visits of primary care, four visits of specialty care, a three-day inpatient hospital stay, six chemotherapy infusions, and a 90-day supply of specialty chemotherapy maintenance drugs. The difference between the infusions and the maintenance drugs is the infusions tend to be in a hospital or clinical setting and the specialty maintenance drugs tend to be oral medications that can be taken at home.

**Dave Iseminger:** I want to draw attention to two pieces of information on Slide 10. The first is the timeframe that Ellen's referring to in this illustrative scenario is January, which is important because that sets the stage that the deductible has not been met. For this scenario, we're pretending this is the first episode for seeking care in the plan year. It gets much harder to have an illustrative example adding in the variable of how far and how much out of pocket or deductible has been met. The second piece is the note at the bottom of Slide 11, which attempts to estimate the member cost for UMP and MA-PD plans because the nature of the question asked at the last meeting was specific comparing UMP and MA-PD. That is why we haven't included a further analysis of the rest of the portfolio.

**Elyette Weinstein:** I didn't hear exactly what you said about in-home infusion versus hospital infusion.

**Ellen Wolfhagen:** I was saying infusions are usually done either in a hospital or clinical setting as opposed to the maintenance drugs, which are usually oral drugs, which can be taken at home.

Slide 11 – Illustrative Comparison. This slide walks through the charges based on the information on Slide 10 and provides an estimated out-of-pocket cost. Estimated total medical costs for UMP Classic is the \$250 deductible, no out-of-pocket medical for PEBB Complete, and a \$500 admission charge for PEBB Balance, plus the specific co-pays for the specialty visits, and primary care visits for \$635. The estimated total

pharmacy costs are \$225, \$300, and \$300. The estimated total costs does not equal those two boxes at the bottom because it includes the premium that has to be paid, which is the line at the top of the chart. We rounded the numbers at the bottom to make round numbers. I also want to note that all Medicare enrollees pay a Part D premium, which we didn't include in this illustration.

Slide 12 – Additional Follow-Up Topics. There are no enrollment restrictions or additional costs for retirees who enroll with preexisting conditions. Customer service concerns are addressed through performance guarantees and reporting, and include measures such as time to answer calls, the percentage of calls resolved in one call, and call abandonment, or hang ups. There will be a dedicated call center for the PEBB plans.

Part D for prescription appeals come from denials of prior authorizations. About one in four members with a prior authorization denial pursue an appeal, and of these, the vast majority become approved. Prior authorization denials can be due to a lack of provider response or incomplete information, failure to respond to CMS requests timely, etc.

**Sara Whitely:** Slide 13 – 2021 Medicare Rates. Slide 14 – Retiree Premium Calculation is an overview of how a retiree premium is calculated. The equation is: Total Bid Rate – Medicare Explicit Subsidy = Retiree premium.

Slide 15 – State Medicare Explicit Subsidy – Illustration. Plan Premium – State Medicare Explicit Subsidy = Retiree Premium. For 2021, the Medicare explicit subsidy is proposed to be set at \$183, or 50% of the premium, whichever is less, to arrive at our retiree premium. There are two illustrations, Plan 1 and Plan 2. The Plan 1 premium is \$400. We then calculate the state Medicare explicit subsidy to be \$183, or 50% of the premium, whichever is less. In this case, \$183 is less than 50% of the premium, which is \$200. \$400 less \$183 brings us to our retiree premium of \$217 for Plan 1. In the case of Plan 2, the total plan premium is \$200. When we calculate the state Medicare explicit subsidy, 50% of the premium, or \$100, is less than \$183. \$200 less \$100 brings us to a retiree premium of \$100. These examples are for informational purposes.

Slide 16 – Medicare Retiree Rates and Slide 17 – Medicare Retiree Premiums lists the information for our senior advantage / Medicare plans.

Slide 18 – Impact of State Medicare Explicit Subsidy UMP Classic Medicare, compares Plans Years 2016 through 2021.

### **Sue Birch: Vote – Premium Resolution PEBB 2020-08 – Medicare Subsidy**

**Resolved that**, the PEB Board endorses the calendar year 2021 monthly Medicare Explicit Subsidy of \$183 or 50% of the premium, whichever is less.

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

Voting to Approve: 7

Voting No: 0

**Sue Birch:** Premium Resolution PEBB 2020-08 passes.

**Sue Birch: Vote – Premium Resolution PEBB 2020-09 – KPNW Medicare Premium**

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

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

Voting to Approve: 7

Voting No: 0

**Sue Birch:** Premium Resolution PEBB 2020-09 passes.

**Sue Birch: Vote – Premium Resolution PEBB 2020-10 – KPWA Medicare Premiums**

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

Elyette Weinstein moved, and Leanne Kunze seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

**Sue Birch:** Premium Resolution PEBB 2020-10 passes.

**Sue Birch: Vote – Premium Resolution PEBB 2020-11 – UMP Medicare Premium**

**Resolved that**, the PEB Board endorses the Uniform Medical Plan (UMP) Medicare plan premiums.

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

Voting to Approve: 7

Voting No: 0

**Sue Birch:** Premium Resolution PEBB 2020-11 passes.

**Sue Birch: Vote – Premium Resolution PEBB 2020-12 – UHC Medicare Premiums**

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

Harry Bossi moved, and Tim Barclay seconded a motion to adopt.

**Elyette Weinstein:** I'd like to speak to this. I believe the Health Care Authority when it reiterates that it will not propose shutting down UMP Classic health care plan options. HCA doesn't have to do that. The proposal before us would push us further down the

private corporatization path, which will cause UMP Classic to die, slowly, by a thousand cuts. All you need to do is sit back and watch as adverse selection does the job for us. The private health care corporations will continue to trot out shiny new low-cost plans that will mostly attract younger and healthier state retirees who don't need high-cost specialty drugs and services -- yet. Meanwhile, the Legislature may decrease or eliminate UMP's Medicare drug subsidies. Over time, it is likely that only those retirees who need special, costly treatments, or medication will remain in UMP Classic. This will drive premiums up even more and eventually no one will be able to afford them.

The death of UMP Classic would eliminate competition for the private health care corporations. I don't trust them to safeguard the public health and welfare. They're not evil but private corporations are not designed to prioritize public health and welfare over the profit of their shareholders. Their main duty is to maximize shareholder return. Unions and advocacy groups knew this and they fought tirelessly for government employer sponsored health care over decades and decades. They knew that government employers were best suited to provide adequate and reliable health care absent a single payer government model.

On the other hand, a look at the behavior of America's private corporate sector, which was supposed to be protecting us, provides a sobering view of how private corporations prioritize profits over public welfare, especially during a period of lax government oversight since 1980, which can also result from cuts in state funding, which are increasing, and state funding is falling. Public subsidies though go to companies too big to fail.

Sadly, even though they worked for and earned adequate medical coverage, our state retirees who are old, poor, people of color - this is an economic justice issue - will pay a price while health care privatization and corporatization prosper. We are on our way toward fulfilling the prophecy of the New York Times opinion writer who predicts that, "The future holds fewer choices for expendable Americans such as retired state workers, while it enriches corporate investors and executives."

I cannot join other PEB Board Members who march towards this unjust future. With the support of my retiree Executive Board, I will vote no.

**Tim Barclay:** One bit of feedback on your comments, Elyette. I would say that the potential for adverse selection to create what you called a slow death for the UMP program, I don't necessarily agree with you on that, in that it's certainly within, I think, the Health Care Authority's purview to create a risk adjustment mechanism similar to what we do in the active employees' plans if we felt such a selection bias was starting to happen. With the actives, the risk adjustment that takes place in the rate setting mitigates and offsets that potential selection that can take place where the healthy people migrate to the CDHP versus the people who stay in UMP Classic. If we saw that sort of selection bias taking place in Medicare, we could similarly implement a risk adjustment, which would then not penalize the sicker people for being sicker and congregating in one particular plan. I would point out that one issue I think we have within our power going forward is to make sure we don't unfairly ratchet up the premiums on the people who stay in the UMP plan if we choose to do that.

**Leanne Kunze:** While I wholeheartedly agree with the concerns that are listed, with Member Weinstein's comments, I see that as looking at the current status of health care in our country. It feels like this particular motion, the scope is much more narrow than that level of policy. And while I want to, of course, demonstrate support for the need for better policy on the national level, I do believe that we have the opportunity to demonstrate more like what Tim was saying. I, at this point, would likely be voting yes and at the same time wanting to recognize the larger concerns from policy that we likely need to be working on at a federal level.

**Tom MacRobert:** I share the concerns that were just expressed. I'm very fearful that Medicare Advantage plans by demand are profit motivated and are beholden to their shareholders. I have a great deal of concern about moving in that direction. I look at that comparative chart and realize it's very hypothetical. But nonetheless, if UnitedHealthcare has the richness of benefits that were described to us, and I look at the cost of Uniform Medical and the cost of UnitedHealthcare's plan, it's packed. I could, based on just kind of what we have discussed, get the same quality of benefits for half the price. What's to stop a stampede of people moving from Uniform Medical to UnitedHealthcare if they save 50% of their costs while the benefits are "the same." What are the hidden costs that we are not aware of?

**Sue Birch:** Is that a question to a particular staff, Tom, or is that just a comment?

**Tom MacRobert:** It's a comment.

**Elyette Weinstein:** First of all, while -- and Tim, I really respect your expertise and integrity, as you know, but I am not totally sure that government, which Pierson and Hacker has said in their books about government, they're political scientists at Berkeley, "Government at all levels, including the state, is in a time of drift." If you look at how the government has even handled the COVID crisis, we are all over the map. Without the help of the federal government, I don't know where we're going to be at, and I'm not sure our state will continue to have the will to provide help to UMP. We may have a new governor. We may have a new Legislature. We may have a whole new scene. This is a time of great uncertainty.

The other thing I would like to mention is that, whether we like it or not, federal funds, as well as federal policy, does trickle down to the state level. We are not a bulwark, as the Confederacy found of the federal government. Especially since a conflict of laws, rules, and federal policy can have a great deal of effect on state policy. That concludes my comments.

Voting to Approve: 4

Yvonne Tate, Harry Bossi, Tim Barclay, Sue Birch

Voting No: 3

Elyette Weinstein, Tom MacRobert, Leanne Kunze

**Sue Birch:** Premium Resolution PEBB 2020-12 passes.

## **Sue Birch: Vote – Premium Resolution PEBB 2020-13 – Premera Medicare Premiums**

**Resolved that**, the PEB Board endorses the Premera Medicare Supplement plan premiums.

Yvonne moved, and Elyette Weinstein seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

**Sue Birch:** Premium Resolution PEBB 2020-13 passes.

### **2021 Rates Overview**

**Tanya Deuel**, ERB Finance Manager, Financial Services Division. I will walk through the Plan Year 2021 active employee and Non-Medicare retiree rates.

Slide 3 – Calculating the State Index Rate. We've walked through this illustration quite a few times now, but it's a great reminder for this presentation specifically. This is an illustrative example of how we calculate the state index rate, which is the employer contribution towards medical benefits. It is a percentage established in the Collective Bargaining Agreement for health care, which says the state will contribute 85% of the weighted average projected health care costs.

There are three plan bid rates as examples: Plan A, Plan B, and Plan C. Plan A shows a \$550 bid rate, Plan B shows a \$500 bid rate, and Plan C shows a \$450 bid rate. Plan A shows three adult units enrolled in that plan, Plan B shows one, and Plan C shows six. If you multiply that down, the \$550 plan bid rate for Plan A, times three adult units, equals a monthly cost for that plan of \$1,650. Follow that math across Plan B and Plan C. Now add the total monthly cost for all three plans, which were multiplied by the number of adult units enrolled, to get a total cost of \$4,850. Divide that by the total 10 adult units that were enrolled in those three plans to get a weighted average of \$485. The state index rate, which is the employer's contribution towards health care is set at 85%. Take that total weighted average, times 85%, to get an employer contribution of \$412. Keep that \$412 in mind as we go to Slide 4.

Slide 4 – Determining Employee Premiums. On this slide, you see the three plan bid rates for Plans A, B, and C, which were on Slide 3. The \$412 calculation as the employer's contribution towards health care is then subtracted from each of those three plans. Regardless of the plan costs, the state is going to contribute the same average amount for each of those plans, meaning the employee contribution is the difference. The \$550 minus \$412 means those three employees each would pay \$138. In Plan B the bid rate is \$500, the state would again contribute the same \$412. So that one employee enrolled in Plan B would contribute \$88. Same math for Plan C.

Slide 5 – Determining Employee Premiums by Tier. This Slide shows the Tier structure in the PEBB Program. For Plan A, the single employee contribution we just calculated on the previous slide was \$138. For the single tier, Tier1, would pay \$138. For Tier 2, an employee and their spouse or state registered domestic partner, would be times two,



add the \$10 spouse charge, to get a contribution of \$286. Tier 3, employee and child or children, regardless of the number of children enrolled in your plan, multiply the single subscriber amount of \$138 times 1.75 to get a contribution of \$242. For Tier 4, the full family tier, multiplies by 2.75, plus the \$10 spouse charge, to get a total cost of \$390. That same multiplier would be for each of the plans across the top of the slide.

Slide 6 – Employee / Employer Premium Contributions. This is the first preview into the employer and employee premium contributions for Plan Year 2021. The plan names listed are sorted by carrier, followed by the Proposed 2021 Employee Contributions (Single Subscriber) and the state index rate (employer contribution for Plan Year 2021) at \$581. As we just discussed, the \$581 is the same amount regardless of plan. And then you'll see the total composite rate listed. The equation is the total composite rate minus the state index rate (\$581) to show the remainder which is what the employee pays.

**Elyette Weinstein:** I'm not clear – the employee does not pay the composite rate?

**Tanya Deuel:** No. The composite rate is the bid rate the plans proposed during negotiations as their total cost for that plan for a single employee. For example, UMP Classic, the total rate we developed says it would be \$686 to cover, on average, the single person in UMP Classic. Subtract the \$581 that the state's going to contribute, again, that's that weighted average amount set in the Collective Bargaining Agreement. The remainder of \$105 is what the employee would pay.

**Elyette Weinstein:** Thank you.

**Tanya Deuel:** Slide 7 – Employee Contributions by Tier. This slide walks through each of the employee contributions by tier. The plans are listed in the same order as the previous slides, then comparing Plan Year 2020 with proposed Plan Year 2021 rates by tier. You will find the comparisons for subscriber, followed by the subscriber and spouse, the subscriber and children, and finally the subscriber, spouse, and children tier. The last column shows the 2020 to 2021 change in subscriber rates. This percentage and dollar change is a single subscriber tier (first two columns). The average composite increase on the employee premiums is 2.4%. When you look here, we saw average increases on the total bid rate, not just the employee portion, of about 1.5% to 5% this year. When we get to the Non-Medicare slides next, you will get a good sense of plan by plan, where those plans bid rates fell. Due to the nature of the state index rate, and how the calculation works, the percentages here might look larger than the total average bid rate increase. When you have an increase on a smaller number, you're going to get a larger percent increase than the total bid rate.

Slide 9 – Non-Medicare Retiree Rates by Tier. This slide is structured similar to the slides we just saw but is for Non-Medicare retirees who do not receive a contribution from the state towards their health care costs. Instead, the benefit Non-Medicare retirees see is eased by being rated with active employees. Their rates are typically lower than they would be if they were on their own.

The last column on this slide is the 2020 to 2021 change in subscriber rates, which is close to what you would see as the total bid rate change, plan by plan. The numbers look a lot smaller than we saw on the previous slide and are well within range of the

typical increase we see year over year, typically between a 3% and 5% increase. Quite a few are on the lower end of increases. The Non-Medicare retirees pay the full bid rate plus a self-pay administrative charge ~\$5, which is included in the premium shown.

**Tim Barclay:** Can you remind me how many people are actually in the Kaiser Northwest CDHP plan on the Non-Medicare side?

**Tanya Deuel:** On the active employees?

**Tim Barclay:** Yes.

**Tanya Deuel:** We will have someone in the room pull it up.

**Tim Barclay:** Just keep that in mind. The next question, which you don't have to answer now, but I'm curious. My assumption is that the number is very small. I just want you to go back and look and tell me how much that rate increase is based on the experience of that small cohort of people. It's just surprising to me that their CDHP jumped out of whack with Kaiser Washington and the UMP plans. I'd like to better understand how they got there.

**Tanya Deuel:** They definitely have a smaller amount of enrollment in that plan. Their bid rate did increase within the 3% to 5% range I described. It was at the top of that increase on just the bid rate. Before this meeting, I looked over the last four years, specifically, on Kaiser Northwest CDHP. They've had some significant decreases in employee contributions on a percentage and their bid rates themselves actually increased on the lower end of percentages the last few years versus some of the other plans in the portfolio. With the state index rate only increasing a little less than 2% this year, and their bid rate increasing 5%, we're seeing that increase in the employee contribution. Since most of the enrollment is in UMP Classic, it really drives up state index rates.

**Dave Iseminger:** The combined member enrollments of both subscribers and dependents is approximately 580 members as of last month.

**Tim Barclay:** I guess that makes sense. The question to think about is, does it really make sense to have one of our three CDHP plans priced significantly different than the other two? Is there justification for that rate differential? Again, I don't expect you to answer that off the cuff now. It's something I'd like you to ponder before we meet next.

**Tanya Deuel:** We can do that. Slide 10 – Dental, Life, and Long-Term Disability. Slide 11 – Dental Premiums, which are 100% employer paid for active employees. This slide compares Plan Year 2020 rates to Plan Year 2021 rates for the Uniform Dental Plan, DeltaCare, and Willamette Dental Group. Our fully insured Dental Care and Willamette plans are in a rate guarantee, as well as our administrator for the Uniform Dental Plan. The rate guarantee for the Uniform Dental Plan on the administrative piece stays flat. However, this is a self-insured dental plan and we do look at claims, so the rate will slightly increase for Plan Year 2021.

Slide 12 – Life, AD&D, and LTD Premiums. Again, these are employer funded and have no rate changes for Plan Year 2021. Optional Life and LTD are paid by the

employee. There is no rate change for Plan Year 2021, however, if a member does change their waiting period, or their age band changes, they may experience a rate change for those optional benefits.

Slide 13 – Proposed Premium Resolutions. These resolutions are carrier specific, not plan specific. There is a resolution for each of the carriers, meaning if you didn't want to have one of the plans within the carrier, all of the plans would not be passed through.

Proposed Premium Resolution PEBB 2020-14, Non-Medicare Premiums. The PEBB Board endorses the Kaiser Foundation Health Plan of the Northwest employee and Non-Medicare retiree premiums. Next would be the same resolution but for the Kaiser Foundation Health Plan of Washington (Proposed Premium Resolution PEBB 2020-15 – Non-Medicare Premium), followed by Proposed Premium Resolution PEBB 2020-16 for the Uniform Medical Plan. At our July 22 meeting we will bring these resolutions back to the Board for action and provide any stakeholder feedback we receive. And I will bring back information specific to Tim's question on Kaiser Northwest CDHP.

**Sue Birch:** Thank you for that thorough presentation. I'm guardedly optimistic that these rates are looking relatively flat. I have to say for the years of all of this work, I feel like we're starting to get traction on making things more affordable and/or to reduce the increases that we've seen. Let's hope we're going to move in a downward direction for the years to come.

### **2020 Uniform Medical Plan (UMP) Preferred Drug List (PDL)**

**Ryan Pistorosi**, PharmD, MS, Assistant Chief Pharmacy Officer, Clinical Quality and Care Transformation (CQCT) Division. I am providing an update on the 2020 UMP Preferred Drug List (PDL). Slide 2 – UMP Formulary Update. This slide lists what was reviewed at the January 2020 Retreat. HCA provided information on how our members were accessing Moda for questions, the call times and wait times. Today I'll provide an update on that for the first quarter of 2020 to give you a more complete picture. At the January Retreat, we shared some data around the number of members who were being proactive and requesting an exception request so they could have a smooth, seamless transition for 2020. However, January was too early to present any type of comprehensive result around the PDL.

Slide 3 – Ongoing Pharmacy Management. Today's update is in the context of the overall pharmacy management. HCA continues to evaluate, update, and manage the 2020 PDL. We continue to bring drug classes to the Washington State Pharmacy and Therapeutics and to Moda P&T Committees to evaluate new drugs and new cost management strategies, to solicit new rebate offers and to update those rebate offers to get better deals as drug prices continue to increase. We continue to update, review, and create clinical policies to ensure the appropriate use of prescription drugs within the plan, and that this 2020 update is really a new tool we haven't had before that helps us direct members to the highest value drugs on the PDL, while still allowing access to these non-covered drugs when medically necessary and appropriate for their condition.

Slide 4 – Preferred Drugs vs. Non-Preferred Drugs. This slide is a longitudinal analysis provided to help understand how members have been switching from preferred drugs to non-preferred drugs. I want to alert you to the two lines. The upper line is the preferred alternative, when members switch from one drug to another they're switching to a

preferred drug. From 2016 to 2020, it appears relatively flat. It also shows the cost per day of the medication per 1,000 members. If you take one tablet once a day, that represents a day. If you take four tablets a day, those four tablets would equal one day. A day's supply is a standard measure used in pharmacy to better estimate utilization to account for that variation in different amounts of tablets, or different amounts of insulin, or other types of drugs. The cost for one of these days of a preferred drug is \$1.15 and the cost per day for the non-preferred drug in this analysis was \$39.68. There is a stark difference between the preferred and non-preferred drugs and we're trying to use this tool to help direct our members to these preferred alternatives first. In the case they aren't medically appropriate or there are other issues, they're still allowed the access to the non-preferred drug.

Slides 5 and 6 - Preferred Drugs vs. Non-Preferred Drugs (*cont.*) These two slides are a more in-depth look, but for the most part, these are the trend lines over the last five years. 2020 covers only January through April. The top line on Slide 5 has adjusted the scale to focus in on what we see as change. There has been a steady increase year over year, but for 2019 to 2020, we've seen about a 3.8% increase, which is about 962 days per 1,000 members. In 2020, we are already seeing there has been an increase in the rate which members are switching to a preferred alternative from their previous drug.

Slide 6 shows the graph on the non-preferred drugs. There was a shift in 2016 to 2017, going from 558 to 266, which reflects insulin changes made back then, and relatively flat from 2017 to 2019. We are starting to see a decrease in 2020, but we're only 142 days in. The relative change is much more significant at 58.4%, a decrease from 243 days to 101 days.

**Elyette Weinstein:** You cut out when you were discussing how you calculate the average pill usage per day. I couldn't hear everything you said.

**Ryan Pistorosi:** The way we like to standardize drug utilization in pharmacy is to look at a measure known as the day's supply. Someone may use one tablet a day, another person may use three tablets a day. They're the same prescription, they're getting the same kind of benefit. But rather than looking at how many tablets are dispensed, or how many vials, or syringes, we use a calculation that looks at how much drug was used per day so we can standardize. Everyone has 365 days in a year, but they may not be using the same number of tablets or units of drug. This is just a measure for this analysis. If you looked at the number of tablets in a specific drug like Lisinopril, a blood pressure drug, you could compare someone using tablets of Lisinopril to milliliters of insulin, to Albuterol inhaler administrations. This is a way we can standardize across all different drug types into a single measurable unit.

**Elyette Weinstein:** Thank you.

**Ryan Pistorosi:** Slide 7 – When Non-covered Drugs are Requested. The non-covered drugs are the main change with the 2020 PDL. We created a mixed classification for Tier 3 drugs which are now some of the non-covered drugs. When members are requesting the coverage for non-covered drugs, two options can occur. The request could be approved, which happens when it is determined that a member is unable to use the appropriate formulary alternative and the requested non-covered drug is

covered at a Tier 2. These were drugs previously in Tier 3 so the cost share for these members was a 50% cost share on the drug. If it was a specialty drug, it was capped at \$150 per 30-day supply, so the concession made when we were moving forward with this was wanting to help the members, because we realized these drugs are medically necessary and they have exhausted their lower-cost, higher-value alternatives. We wanted to let them have a lower cost share. For some members who are using certain types of diabetes medications or inhalers, they were having to spend \$200 to \$300 a month because it was a 50% cost share. Now they're paying at Tier 2, which is capped at paying \$75 a month. This helped members who were approved for these requests.

For members who were denied, Moda discovered, there were preferred alternatives available to the member and Moda would provide that list to the member so they could discuss it with their prescriber. Different plans have different preferred drugs. It can be confusing. We wanted to help the members and providers to have this information so that they could review to see if any of the drugs on the list were appropriate alternatives. The member could then switch to a PDL alternative or appeal the determination based on special circumstances, which could help expedite it. Or they could obtain the requested medication that was denied using the Washington Prescription Drug Program or if they are a resident of Oregon, the Oregon Prescription Drug Program discount card. The discount card is offered through the Northwest Drug Consortium. There is a specific discount card for the residents of Washington and one for the residents of Oregon. It helps members buy drugs similar to how the Consortium for Washington and Oregon would purchase the drugs, and at the same rate that UMP is purchasing the drugs.

Slide 8 – Exception Requests. This slide compares the number of request statistics for 2019 and 2020. In 2019, 449 Tier 3 exception requests were received. Some were members using a Tier 3 drug and requesting a Tier 2 cost share. The requests listed for 2020 include exception requests starting on October 1 of 2019 and going through June 15, 2020. There have been ten times the number requests, and as such, a higher approval rate. This indicates a number of members in UMP who would be using these Tier 3 drugs and who could have qualified for this reduced cost share, didn't know the process or have the opportunity to apply for the reduced cost savings. Because we put that as a highlight in our member communications for open enrollment, we received a lot of questions from members. We saw a significant increase in the amount of approvals, which helps our members because they are going from Tier 3 cost share down to Tier 2 cost share. Some members went to the alternative drug. Members are not going without their drugs, they're able to see what other alternatives there are.

Slide 9 - 2020 PDL Exception Requests: Top Requested Drugs. The drugs listed have had at least 75 requests and the conditions they treat. These are the brand name versions.

Slide 10 – Customer Service Calls per 1,000 Members (2018 – 2020). This slide is the update from the customer service perspective. The chart shows the member experience around open enrollment. The January, February, and March information is updated to show how the member experience changed. The call volume increased through open enrollment, which isn't surprising. We usually see an increase in calls in January, but not in 2020. It was a delayed increase in calls per 1,000 members. This

may be attributed to members going to the pharmacies with questions or due to COVID-19. To avoid trips to the pharmacy, did members have other options?

Slide 11 – Customer Service Wait Time Average (2018 – 2020). The goal was 30 seconds or less. There was an increase in January. January 2020 is also when the SEBB Program went live for UMP, too. There are approximately 93,000 more members in UMP. There were a lot of calls to the pharmacies which increased the wait time. Moda does offer a call-back service for members who don't want to wait on hold. They are placed in the queue and will receive a call back from the representative when they are next in line.

Slide 12 – Customer Service Abandonment (2018 – 2020). Moda measured the time a call came in and does not get to a customer service representative. The goal is less than three percent. Most months, the goal was met. It was higher in January, which can be attributed to the increase in the number of calls and the SEB Board Program going live, and slightly higher in February and March, but within the goal.

Slide 13 – COVID-19 Impact. Two actions were taken to assist our members in getting through COVID-19. One of the first actions taken was to postpone prior authorizations for maintenance drugs that would have expired in March, April, or May. Those authorizations were extended three months without requiring the member to go into the doctor's office to get labs drawn or other types of criteria for a reauthorization. This extension affected 2,802 members. Second, members are allowed early refills, up to a 90-day supply, to reduce trips to the pharmacies.

Slide 14 – Future Analyses. Current and ongoing analyses are: longitudinal analysis of member experiences, cost and savings analyses, and change in drug use within drug classes.

**Sue Birch:** Ryan, on behalf of the Board I want to thank you because everything we can do to try to get greater value for our members is much appreciated. You've shown us that we're moving in the right direction.

### **SmartHealth**

**Jenny Switzer**, UMP Account Manager, ERB Division. Slide 3 – What is SmartHealth? SmartHealth is Washington State's voluntary and confidential wellness program. HCA contracts with Limeade, who administers the SmartHealth Program. It's an online mobile-friendly wellness program that supports employees and their well-being. It includes customized activities based on self-reported information and participants can earn rewards such as gift cards, their deductible, or HSA incentives.

Slide 4 – Incentive Eligibility. The following group subscribers can qualify for SmartHealth wellness incentives: employees enrolled in a PEBB medical coverage, employees not enrolled in Medicare Part A and B, COBRA subscribers not enrolled in Medicare A and B, and PEBB Continuation Coverage Unpaid Leave Subscribers. Spouses enrolled in PEBB medical coverage and employees that waive PEBB medical coverage have access to SmartHealth and can utilize it to better their well-being but are not eligible for the wellness incentive. Retirees who defer PEBB medical coverage do not have access to SmartHealth.

Slide 6 – Incentive Levels. There are three different incentive levels. Level 1 is completing a well-being assessment, a self-reported assessment of your overall well-being to earn 800 points and get a \$25 Amazon gift card. Level 2 is a member who completes Level 1 and then earns 2,000 total points. They can receive \$125 Wellness incentive applied to the next year's medical deductible or their HSA account. Level 3 employees complete Levels 1 and 2 and earn 4,000 total points and a wellness champion badge on the portal to encourage them to keep going and focus on their personal well-being.

Slide 7 – SmartHealth Incentive Details. The deadline for the \$25 Amazon gift card is December 31 for all members. For the \$125 wellness incentive, the Board voted last year to move the deadline from September 30 to November 30 to give our members more time to complete the levels, if you are in the PEBB Program prior to October 1. For members that enroll after October 1, they just need to complete Level 2 by December 31 to receive the \$125 wellness incentive.

Slide 8 – 2019 Participation. Of 165,839 eligible members, 74,988 members registered in the SmartHealth portal. 2,818 spouses registered and 4,823 retirees registered to participate in the SmartHealth Program.

Slide 9 – Most Viewed Activities in 2019. This slide shows a highlight of some of our most viewed activities in 2019. We had an activity where people could learn about the Moda Diabetes Prevention Program, tracking steps that can be linked to a Fitbit or Garmin activity tracker, and then a video that highlighted SmartHealth stories. In 2019, we featured 398 unique activities for our members.

Slide 10 – Statewide Well-being Assessment. This slide is a quick overview of our statewide well-being assessment. The assessment highlights areas of strengths and opportunities for improvement for our organizations and as a full picture of the PEBB statewide look. They are available to organizations for their individual populations so that they can plan for the next year and know areas they can focus on as the statewide assessment reports. In 2019, our top scoring areas were smoke-free living, drinking moderately, and self-care. In the 2019 areas of opportunity were healthy weight, sleep, and back health. The PEBB Program areas of opportunity are very similar to Limeade's overall customer population.

Slide 11 – Well-being Assessment Trends 2016, 2017, 2018, and 2019. The well-being assessment trends are from people completing the self-reported well-being assessment. This tool is to see how effective our marketing campaigns are to our members, informing them of the assessment, and to track when people are most engaged with this part of the activities.

Slide 12 - \$125 Incentive Trends 2016, 2017, 2018, and 2019. This slide shows the trend for the \$125 incentive. HCA watches this trend graph to see how well our communications are working.

Slide 13 – 2020 WBA Percentage of Completion Same Period Previous Years. This slide shows the percentage of completion for the well-being assessment from 2016 through 2020. In 2018, there was a spike when the \$25 Amazon gift card was new and

heavily promoted by the wellness coordinators in each of the organizations. For 2020, almost 39% of the registered population has completed the well-being assessment.

Slide 14 – 2020 Most Viewed Activities. To date, for 2020, the activities viewed the most are listed. Tracking 5,000 daily steps was viewed the most, then Be Smart with Your Money, COVID-19: Learn the Facts, COVID-19 Resources, Learn About the Diabetes Prevention Program, to name a few.

Slide 15 – COVID-19 Crisis Response Activities. There were 20 activities to address health and wellness issues related to the COVID-19 pandemic, with more added each month.

Slide 16 – User Feedback on COVID-19 Activities. HCA received good feedback from members on the activities related to COVID-19.

**Tim Barclay:** Jenny, I'm wondering if the program has been in place long enough, and if there's data available, that at some point we can move beyond participation as our measure of success and start looking to see if people are really changing to healthier behaviors as a result of the participation in SmartHealth? Is there ever a way we can look and see what we're really achieving in terms of results instead of just participation?

**Jenny Switzer:** That is a topic we discuss all the time. How do we move into making it an intrinsic desire for people to be more engaged in all levels of wellness and well-being? That statewide well-being assessment gives us a picture each year how our members are rating, although it's a self-assessment. We do have a way of seeing how people are self-reporting their improvements, and maybe areas where they've gone backwards. We don't see it on an individual level. I don't have anything specific that I can give you, but we're in those conversations, and the well-being assessment does give us a pretty good picture of where we're seeing improvements.

**Tim Barclay:** I think that's one of the things we want to think about going forward, because as we talked extensively at our last board meeting, given the budget constraints we're faced with, this is one of the things we are spending real money on, both through the direct cost of the program and the incentives that go along with it that I would hope at some point we could start to produce something to support that investment, that it's really making a difference. I appreciate your comments.

### **Supplemental Long-Term Disability (LTD) Benefit Options**

**Jean Bui**, Manager, Portfolio Management & Monitoring Section

**Marcia Peterson**, Manager, Benefits Strategy & Design Section

**Paula Williamson**, Protected Leave and Accommodation Manager, Employee Resources Division.

Slide 2 – Overview. The current Basic Long-Term Disability benefit is inadequate to cover the needs of PEBB Program subscribers. There is a very low likelihood that we will have the ability to improve the basic LTD benefit, both due to receiving no additional funding during the 2019-2021 biennium and with the current state fiscal challenges brought on by the COVID-19 pandemic. Although we offer supplemental employee LTD coverage, only 34% of PEBB Program subscribers have enrolled. This number increased after a special open enrollment event held in 2019.



Slide 3 – Three Types of Group Disability Coverage. How do we increase participation in supplemental coverage? Short-term coverage covers an employee's salary during a short-term disability. The disability would prevent the employee from their ability to work their usual job. This includes pregnancy, accidental injuries, and illness. The short-term disability has been replaced by the Washington State Paid Family and Medical Leave Program.

Long-term disability covers an employee's salary during a longer-term disability. This is a situation in which the employee is unable to perform with reasonable continuity the duties of their job. The third bullet needs a correction and it should read: sickness, injury, or pregnancy after the benefit waiting period, usually 90 days, through the employee's maximum benefit period, which is specific to each claim. The slide deck will be corrected for the next meeting.

Slide 4 - Three Types of Group Disability Coverage (*cont.*). The third type of disability group is Social Security Disability, which results in the inability of the employee to engage in any substantial gainful activity. This is medically determined and could be the result of a physical or mental impairment. The disability is expected to last for at least 12 months or to result in death.

These three types of disability benefits, along with an employee's sick leave and vacation leave, are the income protection for employees facing a disability that makes them unable to work.

Slide 5 – Nationwide Disability Facts. One in four people now age 20 will experience a disability during their career. Only 20% of people have disability insurance. Approximately 50% of adults could not cover their salary for three months. And 40% of adults do not have enough cash on hand to cover a \$400 emergency expense.

Slide 6 – Factors in Whether to Select Disability Insurance. Research shows that the disability product is not well understood, including what is considered a disability. Product descriptions aren't relatable. Later Paula will provide some real-world experience PEBB Program members have had related to disability. Often employees are unlikely to understand the incidence of a disability unless they personally have family or friends who have experienced one. LTD products are often complex and hard to understand, resulting in an employee defaulting to no choice at all, especially if the value is questionable. Or they rely on the employer selection as their default option, assuming that it would be adequate to cover their needs. In the case of the PEBB Program, that would be a maximum of \$240 per month for the basic benefit.

Slide 7 – Current PEBB Program LTD Benefit. This slide compares the current PEBB Program basic and supplemental benefits. The basic benefit covers 60% of the first \$400 of monthly income. It is \$50 up to a maximum of \$240 per month and is 100% employer paid. Supplemental covers up to 60% of the first \$10,000 of monthly income, from \$50 up to a maximum benefit of \$6,000 per month and is 100% employee paid.

**Marcia Peterson:** Slide 8 – Comparison from 1977 to 2020. The basic LTD benefit for PEBB Program members hasn't changed since 1977 when the median household income in the United States at that time was \$13,570. In Washington State in 2018, the median household income was \$74,073, so a huge difference in income during that

time. The basic benefit possibly covered more of a salary than it does today. While household income has increased over 400% during the last 43 years, the basic LTD benefit hasn't changed. And as was noted, only about 34% of PEBB Program subscribers have enrolled in that supplemental benefit. What we end up with is a vast number of employees, when faced with a disability and look to their disability benefit, if they haven't signed up for supplemental, realize their salary of \$240 a month is what they're going to be living on during this time. This is one of the reasons we wanted Paula Williamson to share her experience of dealing with employees in this type of situation.

**Paula Williamson:** Thank you for the opportunity to share this experience. Our long-term disability basic benefit is woefully inadequate, I find in working with staff in my role as the Protected Leave and Reasonable Accommodation Manager at the Health Care Authority. HCA has about 1,400 or so employees. Several times a year we have a staff member who is facing end of work life decisions due to a chronic condition or the sudden onset of a very serious health condition like a cancer, Parkinson's, Alzheimer's, or any of those conditions that we all can name. I'm the one they come to when they are trying to figure out next steps in their lives. When they ask, because they remember something about a long-term disability benefit, can we get that started? I will go into the system and look at their status and determine they only have the basic benefit. When they started with the state years and years ago, just as Jean was saying, people don't anticipate becoming disabled in their work lives. When they first start with the state, they are somewhat overwhelmed with so many decisions as far as getting enrolled into benefits, and PERS, learning a new job, and all the acronyms we have, that long-term disability isn't really on their radar. So, when they come to me, because they're really facing a decision to stop working because they are incapable of working anymore, I get to break the news to them, "Yes, you have the basic long-term disability which will pay you a maximum of \$240 a month." It's a very difficult conversation to have with someone and it breaks my heart every time.

In the private sector, we've seen this approach have a very positive impact on things like 401k plan participation. Anything we can do here at HCA to steer people in the direction of making a decision, whether it's a default decision to be enrolled in an optional buy up with the option to select out would be a beneficial so when they're faced with no longer being able to work, I can look in the system and share with them, yes, after 90 days you have a meaningful benefit of 60% of your salary, up to \$10,000 of that salary, for a total benefit of up to \$6,000 per month. It's something that makes the next step in their life seem doable. So, I encourage you to really think about this as a possible option for us to help our employees throughout their work lives. Thank you.

**Marcia Peterson:** Slide 9 – Options to Improve Disability Coverage for PEBB Program Subscribers. Obviously, we would like to improve disability coverage for PEBB Program subscribers. There are a few options we've looked at. One is looking for a way to request funding for increasing the basic benefit so it would go to a maximum monthly benefit of \$1,500. HCA finance staff estimated the annual cost to the state for the PEBB Program alone at about \$12.8 million to bring it up to that level. To add the SEBB Program, it would be almost double that amount.

We could also increase the percentage who select that supplemental benefit by improving the communication regarding the value, which we are working on for the next

open enrollment. HCA is working with The Standard to improve at least the way that it's communicated so people understand more about the benefit itself.

HCA offered a one-time open enrollment period in March 2019 for the supplemental plan, where we allowed people to sign up without evidence of insurability. Enrollment increased from 28% to 34%. That 34% we learned is pretty average for public sector employees for supplemental benefits. We can also look at an automatic enrollment with an option to opt out.

Slide 10 – Proposing Opt-Out Benefit for LTD Supplemental. HCA is proposing an opt-out benefit for LTD supplemental for all the reasons we've discussed today. We are unlikely to get additional funding in the near future to improve the basic benefit. Improving the communications, try as we might, only gets us so far. We are looking for Board feedback on this option of getting more members comprehensive coverage.

Slide 11 – Automatic Enrollment with Opt-Out. I want to talk about behavioral economics because this is a tool we're talking about using for this opt-out approach. Behavioral economics is a study of how people make decisions and research shows people don't always make the most rational choices that benefit us. We are subject to all kinds of influences when we make choices. An example is if you want people to eat healthy and you run the cafeteria, you put the fruit at eye level when people walk in the door, not the coconut cream pie. The fruit is the first thing they'll choose because that's the first thing they see. It's called giving a nudge, not mandating. It's not saying you can't have coconut cream pie, it's working on that subtle nudge. It makes it easier for people to make "good choices" and harder to make "bad choices."

One way to encourage people to make good choices in a benefit program is to automatically enroll them, but give them that option to opt-out. That has been shown to be successful since people tend to stick with the default option because it's more work to change. It increases the percentage of people who take advantage of those employer benefits that are available to them who normally may not.

Slide 12 – Automatic Enrollment with Opt-Out (*cont.*). We are talking about mirroring the approach the Department of Retirement Systems has used. They utilize this opt-out approach in to increase the percentage of state employees who took advantage of the Deferred Compensation Program, which is a great retirement savings program. Thirty days after a new employee is hired, they receive a letter from the Department of Retirement Services regarding the Deferred Compensation Program enrollment, indicate they are automatically enrolled, and they have 30 days to opt-out of program. This has worked amazingly well. Over the last three years, they've maintained an approximate 90% retention rate. HCA would like to discuss a similar approach for supplemental LTD with the Board.

Slide 13 – Possible Opt-Out Supplemental LTD (Existing Employees). The proposal is to start in January 2022 and have all PEBB Program subscribers not already enrolled in supplemental LTD coverage receive a letter in the fall of 2021 letting them know they're going to be auto enrolled in supplemental LTD. They would have the option to opt-out at any time, depending on the design we're proposing. If they wanted to re-enroll later, they would be subject to evidence of insurability. Their first payroll deduction for this benefit would begin in January 2022.

Slide 14 – Possible Opt-Out Supplemental LTD (New Hires). Newly hired PEBB Program subscribers would be automatically enrolled. They would receive a letter letting them know they have their 31-day new hire period to opt-out, which is very similar to other benefits elections they have in our program. The coverage would be effective the first calendar day of the following month. If they opt-out and want to re-enroll later, they would be subject to evidence of insurability.

We've discussed this proposal with The Standard and they are excited to offer this option. That's as far as we have gone because we want Board feedback before going further.

**Yvonne Tate:** I want to compliment you all. I think it's very important, especially in this space and time, to make sure employees have all the long-term disability insurance possible. \$240 a month is absolutely nothing to live on. I just appreciate that you all recognize that, and you're working hard to try and make things better.

**Tim Barclay:** Are you proposing to eliminate the basic benefit at the same time you do this opt out supplemental?

**Dave Iseminger:** It actually is part of the proposal right now. So just to summarize, it would be retiring the basic benefit, making the structure only a supplemental employee-paid benefit that is opt-out. The one piece that I think might have gotten missed. It's still up in the air, we're still working through this piece, and I would appreciate the Board's insight. There are a couple of options that can be evaluated. It could be opt-out at any point, and it's effective first of the next month, like many other changes that happen for PEBB throughout the year, or it could be opt-out once a year during annual open enrollment. If you were to ask us today, our recommendation would be to opt-out at any point, effective first of the next month.

**Tim Barclay:** I guess I would just add that while normally I'm not a fan of taking benefits away from members, I think if you leave the basic benefit in there, it adds more confusion than value. I think you'll have people turning down the supplemental and still relying on the basic, no matter how much you tell them it's almost worthless. I think it's a good thing to change direction at the same time and make it a supplemental only benefit.

**Harry Bossi:** Just a suggestion, and you probably already considered this, but rather for existing hires who would have to opt out, instead work with Standard to have another special open enrollment like there was two years ago. It might make it more palatable because that can turn ugly, unfortunately, especially with the communication campaign. For new hires moving forward, it would be the opt-out. That way existing employees aren't feeling like they're being forced into or out of something. New hires would understand that it is part of the benefits package. Those are my comments, but thank you for looking at other ways to achieve greater coverage for employees. Much appreciated.

**Dave Iseminger:** Harry, I want to give you one piece of context because we've had a variety of conversations with The Standard. This has been a multiyear process. I know we brought you and the SEB Board ideas about trading benefits within the portfolio.

Then there was the request to the Legislature, and now we're here looking for another road to go down, which is where we are on this proposal. When we talked with The Standard about the concepts of open enrollment, I think it's important to know that when we did that one-time special open enrollment in March 2019, we got a 6% increase in net participation. I think it's important to know that the industry standard participation that exists for public sector large employers like ourselves does tend to be around 35%. There is a saturation point that happens when opting in no matter what you do. Our successful efforts of March 2019 got us to that typical place. But I think the type of participation we could get from an opt out approach is double, or even triple participation. It would be significantly higher and offer a lot more protection. We will certainly talk with Standard to see if anything has changed on that front. But I did want to highlight that we have reached a typical average saturation point for participation of a public sector large employer.

**Elyette Weinstein:** I used to work for Department of Retirement Systems as an attorney, and then also the State Actuary working with the State Pension Benefit Board. What we ran into, I forget who discussed this, but there's a cliff argument, and it is that employees that got into PERS2 or TRS2 when they were new and didn't get the benefits that PERS1 or TRS1 got, were screaming, and yelling, and appealing all the time, especially if they had just missed the cliff. It isn't the people who say, "Well, I was new. I guess I can't opt out." No, they're like, "Well, that was an arbitrary date. Prove to me that date is based on anything economic." I'm just saying you're not going to stop people from arguing. I guess the point I'm trying to make is after about ten years with the retirement system, we saw cliff arguments all the time. These are 20 years after a person was into TRS2, and they would be screaming and yelling that they weren't allowed into TRS1. I think people are going to protest if they're to say, come in new, and the people that were already there weren't mandated in and they were. They're going to see it. I mean, they filed charges saying it's discriminatory.

**Sue Birch:** Thank you for those comments. I think at this point, we are going to let this issue ride, because we don't have any decisions to make today.

### **2021 PEB Board Meeting Schedule**

**Dave Iseminger:** The PEB Board meeting schedule for 2021 is included behind TAB 10. We generally have the same weeks at the same point of the year. We always schedule three meetings in July, not knowing exactly how the rate season will go and which of the meetings we'll need. We always meet twice in July. We anticipate next Wednesday's meeting being the last Board Meeting of the season. As part of the Open Public Meetings Act, the meeting schedule will be filed with the Code Advisor's Office. The length of our meetings are determined by the agenda so mark your calendars with these dates.

### **Public Comment**

No public comment.

### **Next Meeting**

July 22, 2020

1:00 p.m. – 3:30 p.m.

## **Preview of July 22, 2020 PEB Board Meeting**

**Dave Iseminger**, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the July 22, 2020 Board Meeting.

**Tim Barclay:** Dave, let's suppose hypothetically that Tanya does not come back with good justification for KP Northwest CDHP rate differential? I noticed that the premium resolution is by carrier and not by specific product. What are our options as a Board if she doesn't come back with a good justification, and they are not willing to lower their premium to be consistent with the others? What are the Board's options to address that situation?

**Dave Iseminger:** Tim, I can think of at least two preliminary pieces. The first is, remember there was the resolution about the rate development process that was passed a meeting or two ago that talked about carriers can't submit anything unless the Board or agency requests it. We could always entertain exercising that right, either using the Board's request, or the agency's request, to ask Kaiser Northwest to present a bid rate option that does not include the high deductible health plan. If we get to a point where next week there's not satisfactory answers, and the Board wants to hold over that resolution for another week, we can get direction from the Board to engage with Kaiser Northwest. We could have a relatively short meeting on July 29 to finish up the rate-setting process with KP Northwest.

I'll remind all Board Members that all our carriers listen in on all of our calls. I suspect there'll be some conversations from KP Northwest as early as tomorrow, given the questions that were raised today so we can try to provide answers. But you could hold over the resolution for a week and give specific direction for the agency to engage with the carrier if that is the direction we all deem is the best option going forward.

**Tim Barclay:** Is there anything we can do for you today to make that process easier if they want to offer a more appropriate rate for that plan?

**Dave Iseminger:** It would be helpful if the Board wanted to give us the direction today that if KP Northwest wanted to adjust only their CDHP rate, you would entertain additional information on that CDHP rate. That would be helpful today. That way if we determine in conversations with KP Northwest that such an adjustment could be made, you would have already indicated on the record your willingness to entertain that. I would encourage you, if you want to go down that path, to be very specific about what you would or wouldn't allow. I don't think you need a formal vote, but I'd like you to have a straw poll if that's the direction you want to go.

**Tim Barclay:** I would certainly support it.

**Yvonne Tate:** I support it.

**Harry Bossi:** I have some concerns about the CDHP, in particular, because of the low enrollment and wondering if it's just a drag. Thank you.

**Sue Birch:** We'll have our next meeting on July 22. I wish for you all to be well, wear your masks, stay safe, and be socially distant.

Meeting Adjourned: 3:41 p.m.

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

**Draft**

July 22, 2020  
Health Care Authority  
Meeting Held Telephonically  
Olympia, Washington  
1:00 p.m. – 3:30 p.m.

**Members Present:**

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

**PEB Board Counsel:**

Michael Tunick, Assistant Attorney General

**Call to Order**

**Sue Birch, Chair**, called the meeting to order at 1:03 p.m. Due to COVID-19 and the Governor's Proclamation 20-28, today we're meeting telephonically only. Sufficient members present to allow a quorum. Board introductions followed.

**Meeting Overview**

**David Iseminger**, Director, Employees and Retirees Benefits Division, provided an overview of today's meeting.

**Approval of April 15, 2020 Meeting Minutes**

Leanne Kunze moved and Elyette Weinstein seconded a motion to approve the April 15, 2020 PEB Board Meeting minutes. Minutes approved as written by unanimous vote.

**Follow Up from July 15, 2020 Meeting**

**David Iseminger**, Director, Employees and Retirees Benefits Division. This is our last Board Meeting of the season. You'll notice you just approved April 15, 2020 meeting minutes, but May, June, and July minutes are yet to be completed. Traditionally, we

post meeting minutes once they are approved by the Board. Due to more interest in both programs about the activities of the Board, as we go forward into this offseason, when Connie and I have finished finalizing and are ready to present minutes to you for approval, we're going to post draft versions online, noting they are drafts and not yet approved by the Board. Although unapproved, it will give people general insights as to what was discussed without waiting until March of the following year.

Slide 3 – July 15, 2020 “Supplemental Long-Term Disability (LTD) Benefit Options” presentation. Replacement Slide 3. At our last meeting, Jean Bui and Marcia Peterson had a presentation about a future change proposal on the long-term disability benefit. There was an error on Slide 3 of their presentation. The corrected Slide 3 is in today's slide deck behind TAB 4. The change was the language on the very last bullet that Jean walked through, but I wanted to correct the record on it.

Your sister Board asked a question that was much easier to answer for them than it is for you, but we will answer it for you as we go further into this LTD conversation next Board season. The SEB Board wanted to see information about premium examples and what people are paying under the current rates. There is only one waiting period in the SEBB Program where there are, I believe, four or five different waiting periods that can be selected in the PEBB Program. It's one formula that's very easy to do in SEBB very quickly and it's in a presentation for tomorrow's SEB Board Meeting. It wasn't as fast to be able to do it here. Since it isn't an urgent topic for this Board and it's really relating to 2022, I didn't feel the need to push that through given the current furloughs to get that into the materials for this meeting. But as we go further into the conversation next year about the LTD benefit in the proposal, we will make sure to highlight and do illustrative calculations of the premiums that people were paying to give people a sense as to what they might be paying, if indeed an opt-out benefit was the way LTD was structured in the future. Wanted to give you a heads up.

### **2021 Premium Resolutions – Non-Medicare**

**Tanya Deuel**, ERB Finance Manager, Financial Services Division and **Megan Atkinson**, Chief Financial Officer, Financial Services Division. Today, we are asking the Board to take action on the 2021 Non-Medicare Premium Resolutions presented at the July 15 meeting.

Slides 2 – Follow-up On KPNW CDHP Premiums. Last week, the Board had concerns regarding the Kaiser NW CDHP premiums. Kaiser was listening to last week's meeting and was very responsive. We met after the Board meeting, to discuss a game plan on how to address the Board's concerns. Kaiser NW believes their risk modeling supported their original proposed rates. However, Kaiser NW did decide they would submit another round of bids and decided to accept some additional financial risk in their CDHP product. This is to help support and offset, for our PEBB Program members, any impacts members are seeing through their personal budgets due to COVID and furloughs, as well to help mitigate any potential membership losses. Kaiser NW wants to maintain a good partnership with the Board. We quickly were able to get another round of rates from Kaiser NW for the CDHP plan only.

Slide 3 – Employee/Employer Premium Contributions. This slide is an updated table of rates, just for Kaiser NW. In bright red letters at the top you'll see noted as presented today, July 22. Kaiser NW CDHP now reflects a \$25 employee premium. The state



index rate did remain the same at \$581 for a total updated composite rate of \$606. Right below that is the table presented last week with the updated rates reflecting each of the employee contributions by tier. You'll see the \$25 single employee contribution is then rippled through each of the tiers, reflecting a zero percent increase, and zero dollars, from Plan Year 2020.

Slide 4 - Employee/Employer Premium Contributions. This is a recap of the rates presented on July 15 reflecting the \$43 premium.

Slide 5 – Non-Medicare Retiree Rates by Tier – July 22. This is the updated Non-Medicare retiree rates by tiers. When Kaiser NW updates their CDHP bid rate, it also has an impact on our Non-Medicare retirees since they pay the full bid rate. Originally their rate was \$637 and is it is \$619.

Slide 6 – Non-Medicare Retiree Rates by Tier – July 15. Slide 5 shows an overall increase of only 1.6%, as opposed to 4.6% on this slide.

Slide 7 – Impact on Other Contributions. HCA was able to change this rate after it was presented publicly because the Board made a request for additional conversations regarding Kaiser NW's CDHP rate. Kaiser NW CDHP is unique in the fact that it does have a smaller membership. Typically, if we were to update a rate for one of our plans, due to the nature of the state index rate, the employer contribution being a weighted average and depending on the enrollment, normally we would have to redo all of the numbers for the entire portfolio, if there was a change in the state index rate. Kaiser NW CDHP enrollment was small enough that there was no impact to the state index rate. That's why we were able to bring these numbers back to the Board so quickly. In the future, if the Board has concerns about a plan or carrier, there is a potential that we may need to take time to rebalance all of the rates again and may not be able to come back quite as quickly.

### **Sue Birch: Vote – Premium Resolution PEBB 2020-14 – Non-Medicare Premium**

**Resolved that**, the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest employee and Non-Medicare retiree premiums as presented at the July 22, 2020 Board Meeting.

Tim Barclay moved, and Tom MacRobert seconded a motion to adopt.

**Tim Barclay:** I want to thank KPNW for looking into this so quickly in response to the concerns from the last Board meeting, and just say thank you. I appreciate their hard work for the program.

Voting to Approve: 7

Voting No: 0

**Sue Birch:** Resolution PEBB 2020-14 passes.

**Sue Birch: Vote – Premium Resolution PEBB 2020-15 – Non-Medicare Premium**

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

Yvonne Tate moved, and Harry Bossi seconded a motion to adopt.

Voting to Approve: 7

Voting No: 0

**Sue Birch:** Resolution PEBB 2020-15 passes.

**Sue Birch: Vote – Premium Resolution PEBB 2020-16 – Non-Medicare Premium**

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

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

Voting to Approve: 7

Voting No: 0

**Sue Birch:** Resolution PEBB 2020-16 passes.

**Medicare Retiree Options**

**David Iseminger**, Director, ERB Division. I'm going to describe the purpose of this presentation and Marcia Peterson will proceed with the discussion. During the last legislative session, there was a budget provision that described some work for the Health Care Authority to do with stakeholders to address retiree topics and issues, particularly when it came to the available options within the Medicare portfolio for Medicare retirees. That budget provision was ultimately vetoed by the Governor on April 30 when the Governor was trying to eliminate different parts of new spending that could be existing within the budget, recognizing there was a fiscal crisis coming. Part of the veto message acknowledged that the Health Care Authority had already done a report in 2018, which Marcia will describe. Because of that recent work, and the fact that the PEB Board has retiree representatives on the Board, it would be prudent to have a discussion at a Board Meeting about this entire concept. This is that presentation, to include a conversation particularly about Medicare retiree issues.

HCA's report was done in 2018 with recommendations and suggestions to move forward with an MA-PD plan proposal. As you know, HCA has done a procurement for MA-PD plans and brought them to the Board. A majority of the Board passed a resolution last board meeting and there will be MA-PD plans in the portfolio come this January. One of the main features of that report has been implemented. That's what makes the timing of this conversation a little strange.

Slide 3 – PEBB Board Discussion. There was a gubernatorial request to include this topic on a PEB Board Meeting agenda. Per the gubernatorial message, we invited the Office of State Actuary and we believe there are one or two representatives listening into the conversation, but they don't intend to participate.

**Marcia Peterson**, Manager, Benefits Strategy and Design Section, ERB Division. Slide 4 – Report on Medicare Plan Options. This process started 2017, or even a bit earlier. During 2017, you may recall UMP Classic experienced large increases in Medicare premiums largely due to the prescription drug increases. If those prices kept going up, it would be unsustainable going forward, both for the members and the state. HCA was already thinking about the portfolio for our retirees and how to expand it. We hadn't thought of proposals yet, but then all of this happened, and we started to focus on whether or not there were other options we could look at for Medicare retirees specifically.

The table on Slide 4 is from this report, which is in the Appendix of your Briefing Books. It's a snapshot from August 2018 showing that the vast majority of our Medicare retirees were in the UMP Classic, Kaiser Washington Classic, Medicare Advantage programs, and a large group in the Premera Medicare Supplement Plan at the time. Is there a way for us to expand the options that are available?

Slide 5 – Summary Report Recommendations. One of the recommendations in the report was for HCA to conduct a procurement for one or more MA-PD plans, Medicare Advantage plus Prescription Drug plans, at least one of which would offer national PPO coverage. These would be offered in addition to the options currently offered to PEBB Medicare retirees. One of the conclusions in the report was that competition between the options will determine if any plan needed to be discontinued in future years, which is just a way of saying there was no recommendation to make any changes to the current offerings shown on the previous slide.

Slide 6 – Medicare Advantage Plus Prescription Drug Plans. HCA looked at a number of options for additional plans, including an employer group waiver plan, and a private Medicare Advantage exchange. This slide is a summary of our recent conversations on this topic.

Slide 7 – 2018 RFI Major Findings. This slide is out of the report and summarizes the major findings from the Request for Information we conducted with major carriers in September 2018. HCA gained considerable insight into the Medicare Advantage Pharmacy Plan offerings. We've talked with the Board that MA-PD plans can offer additional flexibility and benefit design and allow customization for medical and prescription benefit levels similar to UMP Classic Medicare. Members could retain access to their providers anywhere in the country. It provides a single coverage option for all the Medicare benefits. There are talks about CMS being able to expand some of those offerings to more innovative areas, such as offering alternative medicine, gym membership, etc., the things Original Medicare has not offered in the past. It also substantially reduces the employer responsibility for benefit administration issues because we have a carrier working with us on this.

There aren't a lot of disadvantages listed as part of our findings from the RFI, but wanted to note there is a potential 12 to 14 month timeframe around CMS approval or

changes. Another disadvantage is that PEBB Medicare retirees may not take advantage of it.

Slide 8 – Current Proposal. The current proposal was to conduct a procurement for MA-PD. HCA has finalized negotiations with UnitedHealthcare. Two plans were authorized by the Board on July 15 and the premiums were substantially lower than UMP Classic. HCA is also in the process of conducting a survey of retirees to try to understand what their overall priorities are around their health benefits - medical, dental, vision, etc. At our January 2021 retreat, we should be able to present some of that information to you in terms of what people say are their priorities. This information will help guide us for the future if we want to continue to work on expanding the options or making changes to the portfolio of benefits for the Medicare retirees.

**Dave Iseminger:** When I became Acting Director of the PEBB Program, I had the opportunity to discuss with the Board 20% rate increases on UMP Classic. I vividly remember the stakeholder public comment feedback about the impact of a 20% rate increase. That started a three-year journey that culminated last week with the approval of MA-PD plans. That journey began with a question about the sustainability of the Medicare portfolio, and sustainability in two contexts: a. those retirees who are paying that monthly premium and the impact on their personal budgets with fixed incomes that often do not have regular anticipated COLAs, necessarily, year over year; and b. the sustainability of the retiree Medicare explicit subsidy, and how that relates to what is called the Retiree Drug Subsidy, which has essentially over the years been a flat dollar amount that the federal government will send to the state, that in our state goes directly into the General Fund.

What has happened is the amount of money that's being spent in the explicit subsidy, year over year, is far outpacing, and in fact growing, compared to a flat amount that comes from the federal government every year under the Retiree Drug Subsidy. There was this concern that the state is spending more money to chase a small amount of money. Every year they're spending more and more money to chase the same amount of money. As a proxy, the amount of money we get every year into the General Fund from the Retiree Drug Subsidy is about \$20 million. The last time the Medicare explicit subsidy was raised from \$168 to \$183, that \$15 monthly incremental increase, cost more than \$20 million. That was what started this journey. It was twofold. It was the chasing of the RDS amount from the federal government, as well as the kitchen table home budget impact of ever increasing, because of pharmacy drug costs, Medicare rates.

That's culminated in the MA-PD proposal. Now we're at a juncture in the road where we're about to implement that, see the impacts of that, and at the same time assessing, saying, "What's next," because we never rest on our laurels. We begin working on the strategy for the next piece. And that brings us to this retiree survey we're conducting. It's an electronic survey due to COVID. We will push it out to various retiree organizations that we often meet with on a regular basis, and ask some simple questions about, "Here are things we often hear are concerns for retirees." If these concerns are true, what are the highest priority areas of the portfolio to work on, whether it's financial benefit design, administrative aspects like paying your premiums, or enrolling, and the difficulties, or ease of that process.

Slide 9 – Discussion

**Elyette Weinstein:** Is it possible to see the survey before we have our retreat?

**Dave Iseminger:** Yes. I will get it sent out to the Board once we have one of the more official launch emails we're sending to groups.

### **Diabetes Management Program RFI Results**

**Kat Cook,** Benefit Strategy Analyst, Benefits Strategy and Design Section, ERB Division. Slide 2 – Diabetes Background. Diabetes is when the body doesn't regulate blood sugar. There are three types of Diabetes, Type 1, Type 2, and Gestational.

Type 1 is the most severe and affects about 5% of the population. It was originally called juvenile onset diabetes, but it's now Type 1 because in rare instances, adults that didn't have it as juveniles can get it. It is a nonreversible condition and people are usually insulin-dependent for the rest of their lives.

Type 2 affects 90% of people with a diabetes diagnosis, which means their cells do not respond well to the insulin their body creates. This is acquired later in life, but some teens and tweens have been diagnosed with Type 2 diabetes. It's not always insulin dependent. It is controllable, and in some instances, reversible.

The third type is gestational diabetes, which is diabetes acquired during pregnancy. This is temporary and usually resolves after pregnancy but increases the odds of the individual having Type 2 diabetes later in life.

In 2019, the PEBB Program had 26,331 members with diabetes. 2020 numbers won't be available until the end of the calendar year. The bulk of our members with diabetes in the PEBB Program were in the Uniform Medical Plan.

Diabetes also increases the risk for additional high-risk complications. These comorbidities include: high blood pressure, asthma, high cholesterol, arthritis, heart disease, stroke, depression, anxiety, kidney disease, and cancers. Diabetes is the number one cause of nontraumatic lower limb amputations in the US. It's also the seventh leading cause of death in the state of Washington, according to a 2017 study by the Department of Health. But if we look at diabetes as a contributing factor with someone with other comorbidities, it becomes the third leading cause of death, after cancer and heart disease.

There are also health equity concerns with diabetes. It affects people of color at a much higher rate than those who are white. Adults who make less than \$25,000 a year are twice as likely to have diabetes than those who make \$75,000 or more a year. We see this disease affecting the most disadvantaged much more heavily, as we see with a lot of our social determinants of health.

Slide 3 – Diabetes Costs. The medical costs listed are for Washington State, not PEBB or SEBB Program specific. In the state of Washington, in 2017, medical costs for diabetes were estimated at \$4.9 billion. These costs include prescriptions, acute care, diabetes maintenance or management, and any of the related comorbidities mentioned

earlier. Lost productivity costs for Washington were estimated at \$1.7 billion in 2017. That averages out to \$2,500/per person in lost productivity, and that's due to absenteeism, energy, all sorts of factors. This totals \$6.6 billion of cost in one year.

The estimated lifetime average medical cost for someone with diabetes is between \$55,000 and \$130,000 per person. The graph on Slide 3 shows the cost comparison between someone with diabetes versus someone without diabetes. Someone without diabetes costs just over \$4,500 per year, while someone with diabetes is \$23,761. To take care of the PEBB population for one year at that average rate, it would cost more than \$800 million.

Slide 4 – Diabetes Prevention Programs are key. The PEBB Program has offered a diabetes prevention program via Omada since 2019. These are digital point solutions, which are specific digital services provided by a vendor to fill a health care gap. People with an A1C test in the prediabetic range use these diabetes prevention programs to prevent Type 2 diabetes. Omada is no cost to the member. It's a 16-week education program where people log in, get their educational benefits, and learn what they need to do to manage their disease. They are issued a smart scale because the goal of the prediabetes program is to hit 5% weight loss. Once someone loses 5% of their body weight, their risk for developing Type 2 diabetes goes down by 58%. 36% of PEBB Program Omada participants met or exceeded the target weight loss of 5%. There were 2,945 participants last year and 1,060 participants met the 5% or greater weight loss goal. This year's data won't be available until year end. Given that 58% estimate reduction, approximately 615 people will be less likely to get Type 2 diabetes. The lifetime savings on successful members could range from \$33 million to almost \$80 million.

HCA used SmartHealth for education to give some screening quizzes and direct people to diabetes resources through Omada, if they qualified as prediabetic, or through Kaiser's One Stop Program.

Slide 5 – Diabetes Management Offerings. Diabetes management is different from diabetes prevention. These are people with a diagnosis of diabetes with an A1C rate above 6.4. How do they manage that condition? Kaiser offers Diabetes One Stop which is endorsed by the American Diabetes Association and the Centers for Disease Control. Any Kaiser members with diabetes have access to a digital point solution through Kaiser. The UMP offers traditional case management where a nurse checks in with patients with a diabetes diagnosis on a regular basis, usually every one to three months. We haven't seen high utilization of this in UMP so we might want to look at getting more members' access.

HCA's Washington Wellness Program did trainings in 2018 and 2020 about diabetes management. Wellness educators at different locations and different districts were educated on what to pass along to the members so they would receive good information about how to manage diabetes. It's also several tiles on SmartHealth. If a Kaiser SEBB Program member was on SmartHealth and they went through information that indicated they might be diabetic, they could be referred straight to Kaiser's One Stop Program. All members have traditional diabetes management available, which was how it was

done before the digital point solutions, with care provider, diabetic educators helping them with nutrition, and access to glucometers through their prescription plan.

Slide 6 – Diabetes Management. It takes work on both sides of the patient and the patient's care team to manage diabetes. How that's done varies from patient to patient. On this slide, patient activities are listed first: blood glucose checks, reduction of carbohydrates and sugars, 20 minutes of vigorous physical activity, and medication, which may or may not be insulin. There are also non-insulin medications used to control Type 2 diabetes, like Metformin and Victoza.

The care team will check a diabetic patient's feet for neuropathy, do eye exams to make sure there's no retinal deterioration, nutrition education by a diabetic educator, and also regular tests of both the hemoglobin A1C and for comorbidities, like high blood pressure and cholesterol.

In the past, the patient and the care team was analog. When a patient went to their doctor, they would discuss issues with their diabetes and tweak as necessary. A patient could go months without feedback. With a digital point solution, the monitoring is constant. In some cases, the care team has access to the patient's daily blood glucose checks to get a real time picture to identify and manage trends.

Slide 7 – Digital Diabetes Management Programs (DMPs). This slide shows what programs offer and their benefits. According to a Mercer study, 94% of consumers are willing to try at least one digital tool to help manage their health. These programs offer blood glucose tracking, food logging, coaching, education elements, activity tracking, and medication tracking for individuals with Type 1 diabetes or Type 2 diabetes that is out of control.

The benefits of a digital diabetes management program are: lower A1C, instant feedback, gamification and nudges, documentation, possible reversal, cost reduction, and accountability without fear of judgment.

Slide 8 – RFI Summary. HCA issued a Request for Information (RFI) for diabetes management programs on May 1. There were eleven respondents: Betr Health, Cappa, Cecelia, LexisNexis, Livongo, Omada, One Drop, Pops, Solera, Vida, Virta, and WellDoc.

Three of the respondents were eliminated from the final report because they were considered out of scope. One was a diabetes prevention program only, one was a data assessment only looking at risk scoring our members for diabetes using social determinants of health, and one was a marketplace solution. They offered a wide array of diabetes management and weight loss programs we could buy, but their per member/per month price was almost 300% higher than the average per member/per month (PM/PM) of our in-scope respondents. If HCA wanted to offer a marketplace solution, we could offer more than one of the in-scope respondents and save money. That's where we are now.

The RFI questions focused on user experience, clinical development of the program, clinical results of the program, the PM/PM price, and technical specifications.

Slide 9 – Two Types of Self-Directed DMPs. HCA determined there were two types of self-directed diabetes management programs. The first type we called high engagement, which offered in depth education elements that helped to bring people on board and learn what they needed to do to manage their disease. Some offered the possibility of reversing Type 2 diabetes. The more the application offers, the more it costs. The high engagement vendors are Betr Health, Cecelia, Livongo, Omada, Vida, and Verta. These are daily maintenance applications. Engagement was easy and these had a lower cost. Another difference is a low engagement program that will probably be used for the rest of their life, whereas the high engagements were focused on the education elements. They had specific curriculum lengths, six weeks, six months, two years, etc., and it differed from program to program. The American Diabetes Association recommends matching individuals with programs that best work for them. There's no one digital point solution that will work for all of our members.

Slide 10 – High Engagement Products. High engagement products had a cost range of \$65 to \$200 per member/per month. It's a wide range of costs for what you get. Two products had an additional cost of a one-time implementation fee. A high engagement product requires a more serious time and lifestyle commitment from the member. In the highest engagement product, the member received a meal plan and shopping list. These programs typically ended after one to two years. The average net savings, based on their marketing materials, was about \$23.25 per member/per month. The average return of investment (ROI) self-disclosed by the vendors was 1.3% to 1%.

Slide 11 – Low Engagement Products. For low engagement products, the per member/per month cost range is between \$40 and \$60. These products are more effective for a casual user. The program has no end date, which also makes this a better product for someone with Type 1 diabetes, or gestational diabetes because Type 1 diabetes is not reversible. The average net savings on the low engagement products, based on these companies own marketing materials, was almost \$80 per member/per month. Their self-disclosed average ROI was about 2% to 1%.

Slide 12 – Next Steps. The RFI gave us information for a future Request for Proposal (RFP) if we decide to proceed. Given the current COVID budget situation, an RFP is not a financial possibility until plan year 2022 at the earliest. If the decision is to move forward at a later date, everything is set up to launch an RFP.

HCA will leverage SmartHealth for additional diabetes education and tools to get people understanding their options. HCA will support and promote plans with existing diabetes management programs. Regence has also costed out offering Omada or Livongo to UMP members. While we're not in a position to do that now, it could be something we talk about in the 2021 Board season. HCA can publicize Kaiser's and Premera's diabetes management programs through our wellness programs, SmartHealth, and other wellness support.

**Tim Barclay:** Costs are per enrollee right? These are people who actually take the time and effort to enroll in the program, right?

**Kat Cook:** One of the high-touch programs offered a per diabetic/per month rate and we pay for every diabetic estimated in PEBB. But what I did, to make it an apples-to-



apples comparison, I took the number of diabetics in PEBB and compared that to the usual participation rates. I tweaked the number to get it to be apples-to-apples. With all but one of these, we pay per user.

**Tim Barclay:** I just want to ask because, for example, I have a daughter who has Type 1 diabetes, who, quite honestly, would have no need for any kind of a program like this. She knows how to take care of herself. I think it's good to have it available for people who really need it, enroll in it, and engage in it. That to me, strikes me as money well spent. Thank you.

**Harry Bossi:** In the RFIs, was there a discussion or information relative to lab results? Would they have to be shared in order for the vendor, the manager if you will, to understand what the A1C level is, or some other things that are going on? Wouldn't that need to be incorporated somehow?

**Kat Cook:** That's usually handled with the digital point solutions for diabetes. The user will self-disclose their A1C tests through the application. Did that address your question?

**Harry Bossi:** Yes, and sometimes people make mistakes for whatever reason. They don't want to share the information. It seems to me, although I know they are more laborious, cumbersome, that somehow actual lab results could be shared through a user agreement. That might be more effective. But that's a long way down the road.

### **2020 Overview Medical Flexible Spending Arrangement and Dependent Care Assistance Program (FSA & DCAP)**

**Marty Thies,** Account Manager, ERB Division. Slide 2 – Overview. Today we'll review the Medical Flexible Spending Arrangement and Dependent Care Assistance Program benefits available to PEBB Program members and provide a quick overview of 2020 PEBB enrollments.

Slide 3 – Authority and Benefits. By statute, HCA is tasked with offering and implementing a salary reduction plan, making it possible for employees to reduce their salary through payroll deduction so they can participate in tax advantaged benefits. For PEBB Program members, two such benefits are available. First, the Medical Health Care FSA, whereby employees can deduct from their paychecks up to \$2,700 for 2020, which can be used for eligible out-of-pocket medical costs. The IRS often adds about a \$50 COLA to this maximum election each fall. Second, the Dependent Care Assistance Program, which works the same way, but comes with a \$5,000 annual maximum election, and can be used for eligible dependent care expenses. The \$5,000 maximum is statutory and has not changed for this benefit for many years.

Slide 4 – How A Medical FSA Works. Employees must sign up for an FSA during open enrollment. Each open enrollment, they must enroll for the subsequent plan year. They must elect the amount they want deducted for the plan year, which is divided by the number of annual paychecks. On the first day of the plan year, January 1, the total amount of the annual election is available for use, which means an employee can spend the entire annual election amount immediately. Claims can be by debit card swipe or purchase claims submitted to the FSA administrator for reimbursement directly to the

member. Any unclaimed funds at the end of the claiming period are forfeited to the plan sponsor.

Slide 5 – Grace Period and Carry Over. In the past, employees have been dissuaded from participating because of the risk of forfeiting their funds. The IRS addressed that disincentive in 2005, and again in 2013, by implementing two design elements that reduce the risk of forfeiture. In 2005, the grace period was introduced, which allows up to another two and a half months into the next plan year to incur out-of-pocket costs and until March 31 to claim funds leftover from the previous year's FSA. Anything unspent after the grace period concludes is forfeited. In 2013, the carryover was implemented, whereby unspent funds at the end of the plan year up to \$500 can be carried over and used during the entirety of the next plan year. The PEBB FSA has the grace period. A plan can adopt the grace period, the carryover, or neither. They just can't adopt both.

Slide 6 – Dependent Care Assistance Program (DCAP). DCAP functions the same way, except it covers eligible dependent care expenses. This could be adults or children up to \$5,000 per year. The total annual election is not available the first day of the plan year, unlike the FSA. You can only get reimbursements of eligible expenses up to the amount that's been contributed to date. Although a grace period is allowable for DCAP, the HCA benefit does not have a grace period, such that employees must "use it or lose it" by December 31.

Slide 7 – Pros and Cons. For millions of people across the country who participate, the advantages outweigh the disadvantages of these arrangements. An employee could forfeit funds they don't claim. Reducing taxable earnings can have a downward impact on the Social Security benefit one receives in retirement. But advantages can be significant for many families. As an example, if an employee in a 12% tax bracket, and that's extremely conservative, opts for both the FSA and DCAP benefits at the maximum election, they would save over \$900 in income tax. And because they don't pay the FICA tax on their total election, they save another \$590, for a total one-year tax savings of over \$1,500. State agencies also save because they don't pay their share of the FICA tax on deferred earnings.

Slide 8 – FSA/DCAP Logistics. There are four stakeholders involved in the ongoing financial flows associated with these tax advantaged accounts: the employee; the administrator, which is Navia Benefit Solutions; the Health Care Authority; and the employers, our public agencies, and higher education. First, an employee signs up for these accounts during open enrollment. The agency they work for sets up the payroll deductions for the subsequent year. Deferrals, as they are drawn out of the pay, go to the appropriate account maintained by the Health Care Authority. Using their out-of-pocket expenses, employees claim against what they have elected or deducted. Navia then reimburses the employee for their claims, and bills the Health Care Authority, which reimburses Navia. The Health Care Authority pays Navia a per participant/per month fee to cover administration. And this is an amount that is partially offset by annual forfeitures.

Slide 9 – 2020 PEBB Enrollment: FSA. There were about 15,500 FSA accounts opened and more than \$25 million in deferrals, payroll deductions, for this year, with an average deferral per participant of over \$1,600. At that very conservative 12% tax rate,

the FSA saved PEBB employees over \$3 million in income taxes, and another \$2 million in FICA taxes, for a total of \$5 million in employee tax savings.

Slide 10 – 2020 PEBB Enrollment: DCAP. We enrolled over 2,800 accounts with \$12 million deferred, an average of nearly \$4,300 per deferral, for another \$2.4 million in tax savings.

Slide 11 – Savings: 2020 Tax Advantaged Accounts. Total savings to the state and its employees through both programs: \$7.4 million in total tax savings for PEBB employees and \$2.9 million in agency FICA savings, for a total savings of almost \$10.3 million.

Slide 12 – Collective Bargaining Agreement (CBA). An additional benefit for some PEBB Program members this plan year and next is that our FSA contract is also serving represented PEBB Program members who are eligible for a \$250 FSA contribution, negotiated last year through the Collective Bargaining Agreement. To be eligible, the PEBB Program subscriber must be an active represented employee on November 1 of last year, for this year's contribution. They must earn at a rate of pay lower than \$50,005 annually. They must be eligible for the employer contribution for medical benefits and be a subscriber on a PEBB medical plan. Or having waived coverage, they must be a dependent on someone else's PEBB medical plan. These funds, once awarded, are available to employees through Plan Year 2020 grace period, which ends next March.

Slide 13 – Collective Bargaining Agreement (*cont.*). We've made a real effort to let recipients know about this benefit. This slide lists the communications, when and to whom they were sent.

Slide 14 - Collective Bargaining Agreement (*cont.*). This was the HCA's first year facilitating this benefit. Over 18,000 employees received the \$250. Only 1,250 opened their own account. Another 17,000 accounts, 93% of the total, were accounts that were created, because the recipients didn't participate on their own. The total amount deposited on behalf of eligible PEBB Program subscribers was more than \$4.5 million. With the CBA recipients in the PEBB population, PEBB currently has more than 32,000 medical FSA accounts.

Slide 15 - Collective Bargaining Agreement (*cont.*). So far, recipients are accessing the funds available to them through this benefit, but at a slower rate than we'd like to see. The chart on this slide shows the usage for the 17,000 accounts that held only the \$250 on January 1. We're assuming those who are contributing to their own FSA through payroll deduction will be more consistently conscious that they have an FSA account and that they need to spend it. The blue line shows the accounts that haven't been touched. As more people access the accounts, the line drops! The green line is the number of these accounts that have been spent entirely. They are at zero balance. As of July 1, only about 37% of these 17,000 accounts have been tapped. 63% have not. And about 9% of these accounts have already been drained to zero.

Slide 16 – COVID-19 and FSA/DCAP. There have been several COVID-related developments pertaining to HCA's tax advantaged accounts. First, on March 23, 2020, the HCA submitted a letter to the IRS requesting the incurred expense deadline be extended from March 15, right when Coronavirus was cresting the first time, to May 31,

2020, which would provide additional time to accrue and claim expenses through the FSA. HCA also requested the IRS that participants would be able to change annual election amounts, for both FSA and DCAP accounts, over a period of 90 days due to the variety of family hardships and community closures resulting from the pandemic.

Second, within its authority as plan sponsor, the HCA implemented a claiming deadline extension for both of these tax advantaged accounts, initially moving it out to May 15, 2020. In addition, the US Department of Labor has issued its own claiming extension for FSA accounts until 60 days after the declaration that the national emergency is ended, which at this time is indeterminate.

Third, pertaining to dependent care, the Coronavirus has created situations for many thousands of families that impacted their need for childcare, as well as the cost and availability of childcare. Our current WAC outlines what constitutes a qualifying event, which allows the participant to change their annual DCAP election up or down. HCA has issued a reminder to Payroll and Benefits Administrators at the agencies, and Navia issued a similar targeted reminder to all 2020 DCAP accounts holders, so they are aware of their option to adjust their election if their daycare costs have changed.

Finally, as authorized by IRS Notice 2020-29, allowing what they call “temporary leniency” regarding FSA rules, HCA has launched a limited open enrollment period, during which members can adjust 2020 annual elections up or down, or enroll for a tax advantaged account for the rest of 2020. This takes place the month of July, which we’re past the middle of it. Also, members can continue to submit 2019 expenses for DCAP through August 31, 2020 and they can incur additional costs against their unspent 2019 FSA funds through that same date, August 31, 2020.

HCA received initial data from the limited open enrollment on July 15. For Medical Flexible Spending Arrangements, there’s been a net increase in total elections since the limited open enrollment period began on July 1, 2020 by about \$23,000. That’s about seven one hundredths of 1% of all 2020 elections. There hasn’t been a huge net change. But interestingly, net state agency elections increased by \$50,000, while net higher education elections dropped by about \$30,000. I’m not sure what that means at this point, but I thought it was notable.

In the DCAP book of business, the total net elections for both employer groups dropped \$34,000 for employees of state agencies and \$114,000 for higher education. This represents a 1.3% drop in annual elections in the DCAP book of business. I think that is an indication that people have been hit with their daycare arrangements and it’s reflected in these changes.

Slide 17 – Status: Moving Forward. Navia Benefits Solutions, based in Renton, has been our vendor since the 2014 plan year. HCA is currently conducting a Request for Information (RFI) to gather industry information on rates, how administrators engage with plan sponsors, marketing opportunities, implementation strategies and timeframes. To proceed from that RFI, we will need an affirmative from OFM where we have filed an exception request to continue with a possible RFP. If an RFP does follow, it may include an HSA benefit, which are currently subcontracted through our medical plans. We may want to contract directly for these HSA services, which are typically offered by the same vendors that offer FSA and Dependent Care FSA services.

**John Comerford:** Can you get DCAP with one dependent, a spouse or do you have to have children?

**Marty Thies:** You don't necessarily have to have children. It also applies to eldercare.

**Dave Iseminger:** Another key piece about the DCAP benefit is, in order to use the funds, you have to be using it for care that helps facilitate your ability to work, search for work, or studies to advance your career. There are parameters in which you're eligible to use the funds. You can't, for example, pay a spouse to stay home and take care of your children. That doesn't fit within the requirements of the program. There are work-related requirements this benefit is tied to.

**John Comerford:** So you couldn't use it to pay for a Medicare supplement, if you did not have PEBB coverage.

**Dave Iseminger:** That's correct, John. We will follow up with more detail afterwards, but I think that's correct.

### **PEBB My Account Enhancements**

**Jerry Britcher**, Chief Information Officer, Enterprise Technology Services Division. Slide 2 – Background. Currently, the PEBB Program primarily uses paper for initial enrollment, which includes things like social security number, date of birth, sensitive type of information. HCA wants to get away from paper forms, which are hand keyed into our Pay1 System, an old mainframe system. It adds complexity, especially for new Benefits Administrators who work within the various business areas. We plan to leverage our experience gained in building the SEBB My Account environment implemented last October.

Slide 3 – Current PEBB Functionality. Without making any enhancements, members are currently able to make changes to their medical and dental coverage during open enrollment. They're also able to attest to spouse or state registered domestic partners. They can remove medical or dental for dependents, and they can waive coverage for themselves. Those transactions must be made within the PEBB open enrollment period.

Slide 4 – Current PEBB Functionality (*cont.*). On a year-round basis, including the open enrollment period, but outside of that, they can view medical and dental coverage information. They can view their employer-paid basic life and basic accidental death and dismemberment insurance, long-term disability insurance, download their Statement of Insurance, view their premium surcharges, and make changes to their attestations for tobacco use.

Slide 5 – Project Goals. The goals of this project are to: reduce the current paper and manual process for PEBB Benefits Administrators and implement an online web interface, add new functionality to improve the employees' and Benefits Administrators' experience in interacting with PEBB, and incorporate broad time windows to allow for adequate testing.

We realize there are people who prefer using paper, so we will not eliminate the paper forms, but we hope to greatly reduce their use by making it easier to submit their documents electronically.

Slide 6 – New PEBB My Account Functionality for Employees. It's intended to build on the capability to provide enhanced employee functionality, in particular in the areas of initial plan elections and initiating common special enrollments, which include marriages, divorces, births, etc. The new application will be mobile friendly and adapt itself to whatever device the end user is using. It basically auto adjusts to those dimensions of the device you are using. The employee will also be able to add and remove dependents, and to submit dependent verification documents online.

Slide 7 – Timeline. This slide shows the current timeline. The goal is for testing and modifications to wrap up in April 2021, at which point, the training materials will be developed to begin training in May 2021 for the Benefits Administrators. The goal for launching the enhancements is Fall 2021 for PEBB Open Enrollment.

**Dave Iseminger:** I'm personally excited about this project. I've been asking the team to give me daily updates about how the limited open enrollment is going for the PEBB and SEBB Programs now. I have extraordinarily real time, robust, data about what is happening in SEBB My Account. The number of subscribers who are moving from waived status into enrolled status, the number of dependents that are added. But on the PEBB Program, because it's paper based that has to be keyed, and state employees are furloughing limiting them from actually being able to get into a mainframe to type it in, I'm not going to know the PEBB data until sometime in late August. I think it is important to have the self-service option for initial elections going forward. I'm extraordinarily excited that the Legislature gave us some funding to do some of this modernization, leveraging the work we just did for SEBB My Account.

**Jerry Britcher:** One other piece of context is our population that enrolled for the SEBB open enrollment last year is roughly equal in size to the population for PEBB. That was their initial experience with SEBB for all 147,000 subscribers who enrolled. We have the experience.

**Sue Birch:** I want to thank Jerry, Dave, and the whole team that's been involved, because we have absolutely made strides in getting us into the modern world with this process. I do want to preface the Board though, that there is just an enormous amount of IT development work happening statewide, because of contact tracing and testing, and use of electronic health records. We have to continue to keep advancing to have data flow more seamlessly. For example, as the long-term care trust comes up, it's going to be really important that we have interfaces, and understand from a master person index, just more and more about our clients and how data flows. The team has been open and willing to work on modernization. So thanks, Jerry and Dave, for getting us into the modern world.

**Jerry Britcher:** Thank you.

**Tom MacRobert:** Jerry, I'm just wondering, if we're now in the fall of 2021, am I going to be able to examine different plans sitting in front of my computer and I'm not going to have to do anything else? I'll be able to get a comprehensive view of the different

Kaiser plans, the different UnitedHealthcare plans, the different Uniform plans? Am I understanding that correctly?

**Jerry Britcher:** You are.

**Dave Iseminger:** But Tom, actually it's even better than that. You don't even have to be at your desktop because you can also access the information via tablets, smartphones, and other devices.

**Jerry Britcher:** That is correct. This is device independent. But yes, that functionality will be electronically available to you.

**Tom MacRobert:** I want to say, in that respect, that I commend you for that. That will be an awesome feature to have.

**Dave Iseminger:** Thank you, Tom. We learned in SEBB that many people were extraordinarily happy that they didn't have to sit at a desktop, that they could be at a bus depot, for example, if they were classified staff between shifts, and use their own smartphones to be able to look at benefits. Some school districts, for the SEBB open enrollment, made virtual computer labs with iPads at bus stations, depots, and other places where staff were not able to access desktops on a regular basis, and it became a very important and useful tool that we got a lot of kudos for making available. So very glad that Jerry's team was able to make it usable on multiple devices and you could be anywhere and use devices to access this tool. So, I'm very excited about bringing that to PEBB, too.

### **Public Comment**

None

### **Next Meeting**

January 27, 2021

9:00 a.m. – 4:00 p.m.

**Dave Iseminger:** Thank you Board Members. It's been a strange year with the emergency meetings in April, the virtual setting we're in, the Skype format we're using. In the offseason we'll look for a better platform to conduct our meetings in the event we're still meeting virtually. Thank you again for your hard work.

Meeting Adjourned: 2:45 p.m.

**DRAFT**

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

January 27, 2021  
Health Care Authority  
Virtual Zoom Meeting  
9:00 a.m. – 3:30 p.m.

**Members Present via Phone**

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

**SEB Board Counsel**

Katy Hatfield

**Presentation details can be found in the Briefing Book on the PEB Board webpage at: [PEB Board meetings and materials webpage.](#)**

**Call to Order**

**Sue Birch**, Chair, called the meeting to order at 9:04 a.m. Sufficient members were present to allow a quorum.

Chair Birch indicated attendance for both the Board and the public, for the 2021 Board season, will be attended via Zoom only, unless Governor's Proclamation 20-28 is modified. Board introductions followed.

New Board Member, Scott Nicholson, was introduced. Scott is the Deputy Assistant Director of State Human Resources, which provides human resources policy support to Washington State agencies and 65,000 employees in areas such as workforce strategies, classification, compensation, diversity/inclusion, civil service rules, and labor relations. Prior to his current role, Scott performed similar work for a school district, which gives him unique insights for the PEBB and SEBB Programs. Scott replaces Tim Barclay who stepped down from the Board at the end of his most recent term.



## **Meeting Overview**

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

## **COVID-19 Agency Response**

**Jean Bui**, Portfolio Management and Monitoring Section Manager, and **Tanya Deuel**, ERB Finance Manager, brought the Board up-to-date on the agency response to COVID-19.

The PEB Board passed two resolutions regarding COVID-19. They were: Resolution 2020-07 COVID-19 Continuation Coverage Eligibility and Resolution 2020-08 COVID-19 and Enrollment Timelines.

Carrier and agency actions were shared.

HCA provided a limited enrollment during July 2020 to allow members to modify certain benefits that require payroll deductions. A total of 1,098 subscribers took advantage of this option.

## **Achieving Health Equity for PEBB Program Members**

**Dr. Emily Transue**, Medical Director for ERB Programs, and **Mia Nafziger**, Senior Health Policy Manager, discussed health equity and what we can do to lessen inequities and disparities.

The presenters walked us through an example of two patients with similar diagnoses which had the same provider recommendations for both. Even with this scenario, the likelihood of clinical outcomes may be very different due to: race, which may be heavily influenced by a variety of social and societal factors not traditionally considered medical, like income, education, housing, language, etc.

Health equity means everyone has a fair and just opportunity to be as healthy as possible and health disparities are differences that exist among specific population groups in the attainment of full health potential.

Social determinants of health are conditions in which people are born, grow, live, work, and age. These include: safe housing, transportation, and neighborhoods; racism, discrimination, and violence; education, job opportunities, and income; access to nutritious foods and physical activity opportunities; clean vs polluted air and water; and language and literacy skills. All of these social determinants of health shape health outcomes.

## **Social Determinants of Health Roundtable**

**Dr. Emily Transue** facilitated a discussion on social determinants of health.

Roundtable participants:

- Diane Oakes, Chief Mission Officer, WA Dental Service & Delta Dental of WA
- Kim Wicklund, Director Community Health, Kaiser Permanente WA (KPWA)
- John Kendrick, Service Area Director, Continuum of Care, Kaiser Permanente Northwest (KPNW)

- Keith Bachman, MD, FACP, KPNW
- Rachel Andrew, MS, LMFT, CCM, Director of Clinical Programs, Premera Blue Cross
- Naim Munir, MD, Vice President, Medical Management & Population Health, Premera Blue Cross
- Charles Levine, Vice President, Provider Network Management, Premera Blue Cross
- Kimberly Hadeed, RS-BSSN, CCM, Regence BlueShield, Case Management Supervisor, BlueCare Path Team

Health equity, diversity, and inclusion are priority concerns for our panel members and their organizations. They all take these topics very seriously. Some common themes and goals were shared:

1. Engage providers in areas where collaboration is possible
2. How well do providers include diversity and equity in their businesses
3. Offer patients the opportunity to select what type of doctor they want to go to
4. Work to expand data and data analytics
5. Community involvement to determine social and economic factors and to work on solutions
6. Work to achieve diversity at every level from providers through administration
7. Big need for dental care (disadvantaged people have greater dental issues)
8. Invest in: core foundation, own responsibility, internal policies & cultural disparities
9. Provide training to ensure cultural competence for providers
10. Divert funding to areas in need
11. Take programs to the elementary school for children that don't have health care
12. Be aware of the biases. What is the best intervention and when should it occur? Such as food insecurities, transportation, access, etc. Break down these barriers.
13. Get the community and providers at the same table.
14. Listen/engage with members, providers, PEBB, SEBB. Active listening and measuring cultural competencies.
15. Funding needs to be consistent with our words

There is no one answer on how these themes/goals are accomplished. Lack of data is a big concern. Providers can't or are unwilling to share their data due to PPI. When surveying patients, they are reluctant to respond and are wary about why you want to know. How this information is collected is important to protect its validity. To date, the best way to gather this information is when directly in contact with the patient. Whatever is being done now, there is a lot more to do.

**Charles Levine:** Many of the goals are the same for all. Continue to focus together. Bring providers to the same table. Drive toward getting data more broadly. Work on ability to share medical records and help between providers and agencies. Do a better job of working with the providers.

**Yvonne Tate:** Suggest inquiring, as part of our contract management, about diversity of staff and what training they provide their staff on diversity. This is important at all levels.

All panel members agreed there is a lot more work to be done. Their suggestions for achieving their top priorities:

**Diane:** Operational Efficiencies

- Create resources
- Go digital
- Make simpler
- Rural providers

**Drew:** Reduce some of the burdens

- Automation
- Support rural communities
- Look at different ways to better engage

**Naim:** Engage with providers and delegate that they manage their areas

- Physician care

**Charles:** Getting helpful data

- Remove hurdles
- Ability to connect medical records (automate)

**Sue Birch:** Vast opportunity for public/private partnerships

- State ensure interoperability
- State to work more with federal partners

**2020 Retiree's Survey**

**Ellen Wolfhagen**, Senior Account Manager, discussed the results of a survey conducted last summer asking how to improve their experience as a PEBB Program member.

**Working Lunch: 2021 Open Enrollment Summary**

**Renee Bourbeau**, ERB Benefits Accounts Section Manager, provided a summary of 2021 open enrollment. Benefits Accounts went to great lengths to ensure a successful open enrollment. Provided staff training, contracted with a vendor to provide technical support for PEBB Program subscribers to maneuver through their first open enrollment, conducted seven webinars to 1,400 Benefits Administrators, provided a Virtual Benefits Fair tool, and provided access to ALEX.

Future customer service strategies include faster response time from staff to Benefits Administrators and adding additional staff to assist in monitoring daily FUZE and trends.

**Governor's Proposed Budget Update - PEBB**

**Tanya Deuel**, ERB Finance Manager, Financial Services Division, shared highlights from the Governor's proposed budget. Proposed PEBB funding rate for Fiscal Year 2022 is \$988 and for Fiscal Year 2023 it's \$1,018 per eligible employee per month. Both amounts are adequate to maintain the current level of benefits.

The Medicare explicit subsidy is unchanged from the current maximum of \$183 per month.

For the Collective Bargaining Agreement, the Employer contribution remains at 85% of the tiered weighted average. While the wellness deductible incentive remains \$125, the \$25 gift card is eliminated.

### **2021 Legislative Session**

**Cade Walker**, Executive Special Assistant, ERB Division, provided an update of the current legislative session. We are currently analyzing 22 bills, either as lead or support.

HCA has one agency request legislation, SB5322, which clarifies the prohibiting of dual enrollment between the SEBB and PEBB Programs.

HCA submitted written testimony in support of HB 1052 – Group Insurance Contracts. This bill aligns with insurance codes and allows HCA to hold our carriers accountable for service to PEBB and SEBB Program members.

Other bills introduced have to do with Paid Family and Medical Leave, Pharmacy, Eligibility, Provider/health care services, expanded durable medical equipment, and the Open Public Meetings Act.

### **PEBB/SEBB Consolidation Report**

**Sara Whitley**, Fiscal Information and Data Analyst, Financial Services Division, discussed the report submitted to the Legislature in November 2020. This report was legislatively mandated requiring a report of the potential fiscal impacts and administrative efficiencies of consolidating the PEBB and SEBB Programs.

The document lists both potentially minor impacts and potentially significant impacts. Minor fiscal impacts could be: alignment of plan offerings, tier factors, and vision benefit. Significant fiscal impacts could be consolidating non-Medicare risk pool and alignment of employee/employer contribution structure.

Potential minor administrative efficiencies could include: alignment of accounting processes and contract/carrier management. Significant administrative efficiencies could include: consolidation of the Boards, enrollment and eligibility processes, and communication vehicles.

These lists are not exhaustive, but a starting point. The report indicates the full consolidation could not occur before January 1, 2025. All of the pieces would need to align.

### **Leveraging SEBB Program Medical Contracts for PEBB Program**

**Lauren Johnston**, SEBB Procurement Manager, discussed opportunities for leveraging the SEBB Program contracts for use in the PEBB Program.

**Sue Birch**: As we send out a Request for Renewal (RFR) to our current contractors, we need to include the topic of social and moral determinant of care.

## **Life & Long-Term Disability Insurance Update**

**Kimberly Gazard**, ERB Contract Manager, provided an update on Life and LTD insurance, including an anticipated proposal on a new LTD benefit design.

HCA had a life insurance beneficiary campaign for ten days starting on July 30, 2020. The goal was to ensure subscribers had listed their beneficiaries to make it easier when they needed to collect their life insurance. 64,293 subscribers took action and updated their beneficiaries. There are still 195,343 insurance documents without a beneficiary designation, including basic life, basic AD&D, supplemental life, and supplemental AD&D.

HCA is planning to look at new strategies in Quarter 1 2021 to increase beneficiary designation.

Long-Term Disability continues to be an area HCA would like to see improvement. Not much has changed since 1977. SEBB LTD mirrors the PEBB LTD plan. While household income has increased 445% during the last 43 years, the Basic LTD benefit has not. The majority of PEBB Program subscribers receive a monthly LTD benefit of \$240 per month when they experience a disability.

HCA is proposing an opt-out design for new hires and existing PEBB Program subscribers. Subscribers could opt-out at any time. Subscribers would be automatically enrolled in coverage equal to 60% of their salary (up to \$16,667 of monthly salary) with no evidence of insurability required.

A subscriber could opt-out, or reduce coverage to 50% of their salary, at any time, effective the first of the next month. To later access or request an increase coverage, evidence of insurability would be required.

If a subscriber opts-out of coverage, they are still eligible for the \$240 per month benefit.

The proposed Opt-out Supplemental LTD plan option would start January 1, 2022.

The additional employee-paid LTD Plan offering include a 50% buy down option with a 90-day benefit waiting period, in addition to the 60% LTD plan.

This presentation is an introduction to the proposal. HCA will bring proposed resolutions to the Board in March for your initial thoughts on the plan. Board action on the policy is scheduled for April 2021.

## **Public Comment**

None.

## **Next Meeting**

March 17, 2021

12:00 p.m. – 5:00 p.m.

Meeting adjourned at 3:15 p.m.

**TAB 4**



# Long-Term Disability Insurance

Kimberly Gazard, Contract Manager  
Employees and Retirees Benefits (ERB) Division  
April 14, 2021

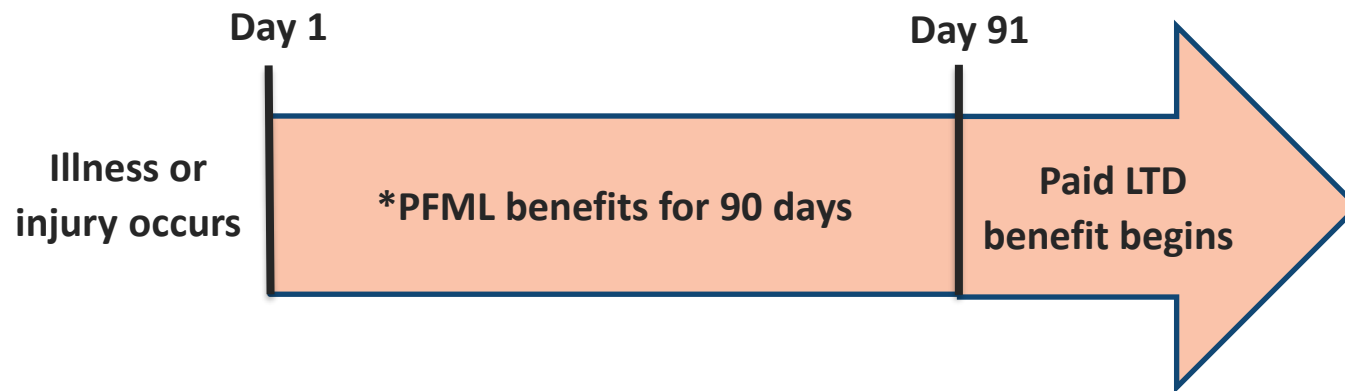
# Overview

- Long-Term Disability (LTD) Insurance
  - Modifications to policy resolutions based on SEBB stakeholder feedback
  - Opt-Out policy resolutions



# Benefit Waiting Period PFML\* Example

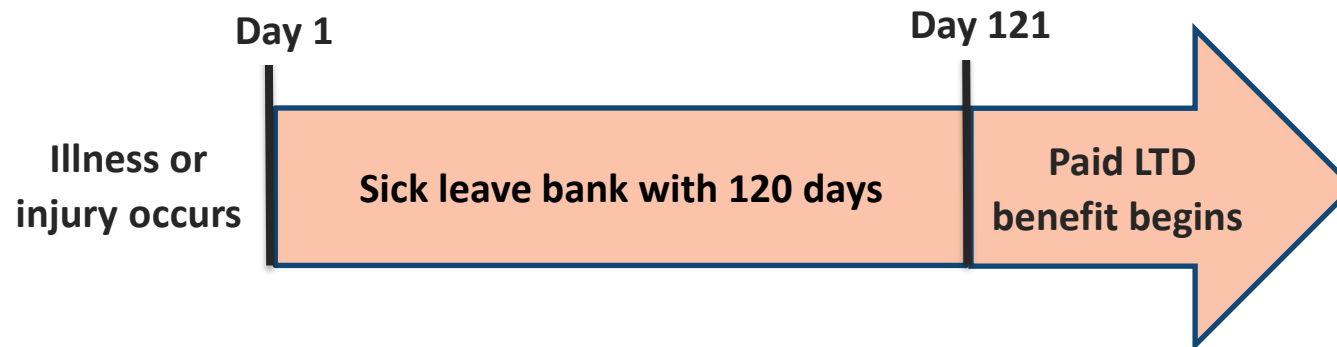
- Employee is receiving PFML benefits for 90 days and has 30 days in their sick leave bank.
  - Because the PFML waiting period is greater than the sick leave waiting period, the LTD benefit begins paying on day 91.



\*PFML = Washington Paid Family & Medical Leave Law

# Benefit Waiting Period Sick Leave Example

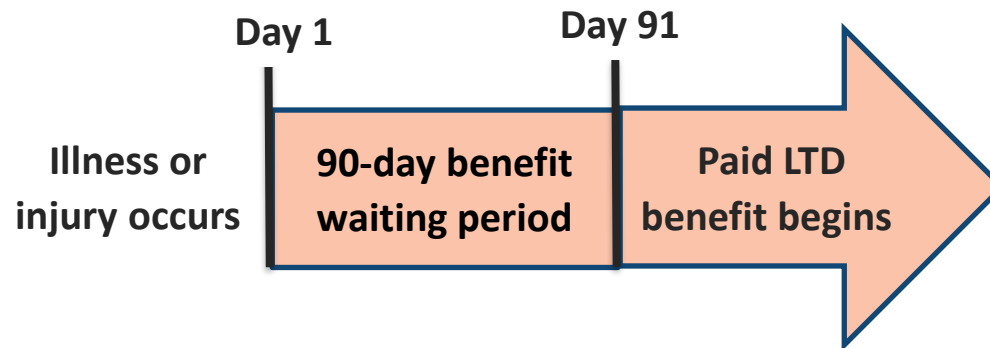
- Employee is receiving PFML benefits for 90 days and has 120 days in their sick leave bank.
  - Because the sick leave waiting period is greater than the PFML waiting period, the LTD benefit begins paying on day 121.



\*PFML = Washington Paid Family & Medical Leave Law

# Benefit Waiting Period 90-days Example

- Employee is not receiving PFML benefits and does not have sick leave.



\*PFML = Washington Paid Family & Medical Leave Law

# Resolution PEBB 2021-10

## Employee-Paid Long-Term Disability (LTD)

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

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

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

# LTD Policy Definitions

- “Paid Time Off Plan” means an arrangement that provides paid time off benefits under a single type of leave for all purposes
- “Fractionated Period Of Paid Time Off” means 50% paid time off for which you are eligible under a PTO Plan

# Resolution PEBB 2021-11

## Employee-Paid Long-Term Disability (LTD)

### Enrollment Procedures

#### **Resolved that,**

- All employees who are eligible for the employer contribution towards PEBB benefits as of December 31, 2021 and not already enrolled in supplemental LTD insurance or did not make an election (reducing or declining coverage) during an enrollment period established by the Health Care Authority in 2021, will be auto-enrolled in employee-paid LTD insurance at the 60% coverage level with an effective date of January 1, 2022 without Evidence of Insurability (EOI).
- An employee who becomes eligible for the employer contribution towards PEBB benefits on or after January 1, 2022 must make an election (reducing or declining coverage) during the benefit election period. If the employee fails to timely elect coverage, the employee will be defaulted into coverage according to Resolution PEBB 2021-12 without EOI. The effective date of coverage will be according to the policy established in May 1995.

# Resolution PEBB 2021-11

## Employee-Paid Long-Term Disability Enrollment Procedures (*cont.*)

- After January 1, 2022, an employee at any time may elect to reduce employee-paid LTD to the 50% coverage plan without EOI or fully decline employee-paid LTD. The effective date of the change in coverage will be the first day of the month following the date the employer receives the required election.
- An employee who seeks to increase coverage from the 50% coverage plan to the 60% coverage plan, or access previously declined employee-paid LTD, will be subject to evidence of insurability. The effective date of the change in coverage will be the day of the month the contracted vendor approves the required form.
- Any employee who declines employee-paid LTD insurance will remain enrolled in employer-paid LTD insurance.

## Resolution PEBB 2021-12 Amending Resolution PEBB 2020-04 Relating to Default Enrollments

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



# Resolution PEBB 2021-12 Amending Resolution PEBB 2020-04 Relating to Default Enrollments

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

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

# Resolution PEBB 2021-13

## Employer-Paid Long-Term Disability Insurance

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

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

# Questions?

Kimberly Gazard, Contract Manager  
Employees and Retirees Benefits (ERB) Division

[kimberly.gazard@hca.wa.gov](mailto:kimberly.gazard@hca.wa.gov)

# Appendix

# Resolutions Revised Since the March 17, 2021 Board Meeting

## Proposed Resolution PEBB 2021-10 Employee-Paid Long-Term Disability (LTD) (Revised After Stakeholder Review)

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

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

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

# Proposed Resolution PEBB 2021-11

## Employee-Paid Long-Term Disability (LTD)

### Enrollment Procedures

(Revised After Stakeholder Review)

- All employees who are eligible for the employer contribution towards PEBB benefits as of December 31, 2021, and not already enrolled in supplemental LTD insurance, or did not make an election (reducing or declining coverage) during an enrollment period established by the Health Care Authority in 2021, will be auto-enrolled in employee-paid LTD insurance at the 60% coverage level with an effective date of January 1, 2022 without Evidence of Insurability (EOI).
- An employee who becomes eligible for the employer contribution towards PEBB benefits on or after January 1, 2022 must make an election (reducing or declining coverage) during the benefit election period. If the employee fails to timely elect coverage, the employee will be defaulted into coverage according to Resolution PEBB 2021-12 without EOI. The effective date of coverage will be according to the policy established in May 1995.

# Proposed Resolution PEBB 2021-11 Employee-Paid Long-Term Disability Enrollment Procedures (*cont.*) (Revised After Stakeholder Review)

- After January 1, 2022, an employee at any time may elect to reduce employee-paid LTD to the 50% coverage plan without EOI or fully decline employee-paid LTD. The effective date of the change in coverage will be the first day of the month following the date the employer receives the required election.
- An employee who seeks to increase coverage from the 50% coverage plan to the 60% coverage plan, or access previously declined employee-paid LTD, will be subject to evidence of insurability. The effective date of the change in coverage will be the day of the month the contracted vendor approves the required form.
- Any employee who declines employee-paid LTD insurance will remain enrolled in employer-paid LTD insurance.



# Proposed Resolution PEBB 2021-13

## Employer-Paid Long-Term Disability Insurance

(Revised After Stakeholder Review)

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

- Benefit Waiting Period (the longer of): ~~—Later of~~
  - 90 days;
  - the entire period of sick leave (excluding shared leave) for which the employee is you are eligible under the employer's sick leave,;
  - The Fractionated Period of Paid Time Off (PTO) for which the employee is eligible, if your Employer has a PTO plan, as those terms are defined in the policy;
  - The entire period of or other non-vacation salaried continuation leave plan (excluding vacation leave) for which the employee is eligible; or
  - The end of Washington Paid Family and Medical Leave Law for which the employee is receiving benefits
- No Choice Sick Leave
- Choice Pension
- Maximum Monthly Benefit \$240 400 (60% of \$400 667)

# March 4, 2021 Board Materials



# Long-Term Disability Insurance

Kimberly Gazard, Contract Manager  
Employees and Retirees Benefits (ERB) Division  
March 17, 2021

# Overview

- Long-Term Disability (LTD) Insurance
  - Benefit overview
  - Implementation timeline
    - New employees
    - Existing employees
  - Opt-Out design communication strategies
  - Proposed employee-paid LTD rates
  - Similar situated employer with Opt-Out design
  - Opt-Out policy resolution

# Proposed Employee-Paid LTD Benefit

## 60% Default Plan

Covers 60% of the first \$16,667 of monthly income

Up to a maximum benefit of \$10,000/month

Minimum monthly benefit of \$100 or 10% of the LTD benefit before deductible income (whichever is greater)

Benefit Waiting Period (whichever is greater): 90 days, period of sick leave, and/or period of Washington Paid Family & Medical Leave

Opt-Out at any time with cancellation effective the first day of the following month

## 50% Buy Down Plan

Covers 50% of the first \$16,667 of monthly income

Up to a maximum benefit of \$8,333/month

Minimum monthly benefit of \$100 or 10% of the LTD benefit before deductible income (whichever is greater)

Benefit Waiting Period (whichever is greater): 90 days, period of sick leave, and/or period of Washington Paid Family & Medical Leave

Opt-Out at any time with cancellation effective the first day of the following month

# Comparing Current to Proposed

## Current 60% Employee–Paid Plan

Covers 60% of the first \$10,000 of monthly income

Up to a maximum benefit of \$6,000/month

Minimum monthly benefit of \$50

Benefit Waiting Period (whichever is greater): 90/120/180/240/300/360 days, period of sick leave, and/or period of Washington PFML

Opt-Out at any time with cancellation effective the first day of the following month

## Proposed 60% Employee–Paid Plan

Covers 60% of the first \$16,667 of monthly income

Up to a maximum benefit of \$10,000/month

Minimum monthly benefit of \$100 or 10% of the LTD benefit before deductible income (whichever is greater)

Benefit Waiting Period (whichever is greater): 90 days, period of sick leave, and/or period of Washington Paid Family & Medical Leave

Opt-Out at any time with cancellation effective the first day of the following month

# Employer-Paid LTD Benefit

Covers 60% of the first \$400 monthly insured income

Up to a maximum benefit of \$240/month

Minimum monthly benefit of \$100 or 10% of the LTD benefit before deductible income (whichever is greater)

Benefit Waiting Period (whichever is greater): 90 days, period of sick leave, and/or period of Washington Paid Family & Medical leave

# Implementation Timeline

	2021				2022
	Q1 JAN-MAR	Q2 APR-JUN	Q3 JUL-SEP	Q4 OCT-DEC	January 1st
<b>Policies &amp; Certificates</b>			Update 2022 policy and certificate with final Opt-Out LTD language	Issue electronic and print member certificates to include Opt-Out LTD language	<b>GO LIVE for PEBB Opt-Out LTD plan design</b>
<b>OIC Filing</b>	Language supporting the Opt-Out LTD plan design should be filed with the WA OIC as soon as possible. Language needs to be approved by the WA OIC prior to Opt-Out effective date and before communication the Opt-Out design change				
<b>Employee Communications &amp; Marketing Support</b>	Draft key messages to support Opt-Out and vet with HCA for approval	Draft and finalize 2022 employee communication and marketing pieces using key messages for Opt-Out		Roll out updated and new employee communications pieces to support Opt-Out	
<b>Benefits Administration Support - HCA</b>	Identify all HCA and Standard plan administration materials that need to be updated to support Opt-Out plan design: LTD Administration manual, HCA intranet language and links to materials. Other customized training and education pieces. Update accordingly.				



# Proposed Opt-Out Employee-Paid LTD Starting January 1, 2022

- New hires

- PEBB Program subscribers **would be automatically enrolled** (90-day benefit waiting period & 60% plan)
- New hires would receive a letter letting them know they have their 31-day new hire period to Opt-Out
  - Coverage would generally be effective the first calendar day of the following month (similar to all other benefits election)
- Subscribers can Opt-Out at any time but would be subject to evidence of insurability (EOI) if they choose to re-enroll (or increase from 50% coverage). The cancellation/termination would be effective the first day of the month following the termination date.

# Proposed Opt-Out Employee-Paid LTD Starting January 1, 2022 (*cont.*)

- Existing subscribers
  - All PEBB Program subscribers ***not already enrolled*** in employee-paid LTD
  - Subscriber would receive a letter in fall 2021 letting them know they are being auto-enrolled in employee-paid LTD (90-day benefit waiting period & 60% plan)
  - Evidence of Insurability (EOI) will not be required for the Opt-Out transition
    - The Standard has agreed to allow prior EOI declines under the Opt-Out design
  - First payroll deduction for January 2022
  - Subscribers can Opt-Out at any time but would be subject to EOI if they choose to re-enroll (or increase from 50% coverage). The cancellation/termination would be effective the first day of the month following the termination date.

# Opt-Out Communication Strategy

- The ERB Outreach & Training Unit team will provide training to the employer benefits office staff and forwardable email messages for communication to employees
- Ongoing information will be provided through our newsletters and GovDelivery emails
- Targeted letter mailed to PEBB Program subscribers who are not currently enrolled in employee-paid LTD insurance
  - This letter will also be emailed to PEBB Program members who have subscribed to the PEBB GovDelivery
- The PEBB Program will provide an FAQ and Fact Sheet
- HCA webpage(s) will be updated with information about the Opt-Out transition

# Proposed Preliminary Employee-Paid LTD Rates

	Benefit Waiting Period (BWP)	Current Rates	60% Default / 50% Buy Down		Rate Difference Compared to Current	
			60% Default Plan All 90-Day BWP	50% Buy Down Plan All 90-Day BWP	60% Plan	50% Plan
Basic LTD (PMPM)	90	\$2.10	\$2.10	\$2.10		
Supplemental: TRS, PERS, or Other	90	0.60 %	0.47 %	0.28 %	-22%	-53%
	120	0.36 %				
	180	0.28 %				
	240	0.27 %				
	300	0.25 %				
	360	0.24 %				
Supplemental: Higher Education	90	0.72 %	0.59 %	0.35 %	-18%	-51%
	120	0.42 %				
	180	0.32 %				
	240	0.30 %				
	300	0.28 %				
	360	0.27 %				

PMPM = Per Member Per Month

\*Note: Rates & Plan Design are subject to WA State Office of the Insurance Commissioner approval

# Similar Situated Employer with Opt-Out Design

- Standard has an employer with 110,000 lives that has a similar opt-out plan design
  - They have a default 60% employee-paid benefit, and they can choose a cheaper 50% option or drop coverage entirely
  - Prior to implementing the auto-enroll, they had 45% participation in the LTD with 35% in the 60% plan and 10% in the 50% Plan
  - After implementing the auto-enroll, 22% opted out of coverage entirely

# Employee-Paid LTD Premium & Benefits

## 60% LTD Plan

(90-day benefit waiting period)

Calculating an employee's insured monthly pre-disability earnings

Example 1:

<b>Monthly Earnings</b>	<b>\$2,583</b>
(\$31,000 ÷ 12 months)	
<b>Rate (0.0047)</b>	<b>x 0.0047</b>
<b>Monthly Premium Due</b>	<b>\$12.14</b>

***Maximum monthly benefit when submitting a claim: \$1,550\****

## 50% LTD Plan

(90-day benefit waiting period)

Calculating an employee's insured monthly pre-disability earnings

Example 2:

<b>Monthly Earnings</b>	<b>\$2,583</b>
(\$31,000 ÷ 12 months)	
<b>Rate (0.0028)</b>	<b>x 0.0028</b>
<b>Monthly Premium Due</b>	<b>\$7.23</b>

***Maximum monthly benefit when submitting a claim: \$1,291.50\****

*\*amount before reduction by Deductible Income*

## Employee-Paid LTD Premium & Benefits (*cont.*)

<b>60% LTD Plan</b> (90-day benefit waiting period)	<b>50% LTD Plan</b> (90-day benefit waiting period)																
Calculating an employee's insured monthly pre-disability earnings	Calculating an employee's insured monthly pre-disability earnings																
Example 3:	Example 4:																
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"><b>Monthly Earnings</b></td> <td style="text-align: right;"><b>\$4,250</b></td> </tr> <tr> <td colspan="2">(\$51,000 ÷ 12 months)</td> </tr> <tr> <td><u>Rate (0.0047)</u></td> <td style="text-align: right;"><u>x 0.0047</u></td> </tr> <tr> <td><b>Monthly Premium Due</b></td> <td style="text-align: right;"><b>\$19.97</b></td> </tr> </table>	<b>Monthly Earnings</b>	<b>\$4,250</b>	(\$51,000 ÷ 12 months)		<u>Rate (0.0047)</u>	<u>x 0.0047</u>	<b>Monthly Premium Due</b>	<b>\$19.97</b>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"><b>Monthly Earnings</b></td> <td style="text-align: right;"><b>\$4,250</b></td> </tr> <tr> <td colspan="2">(\$51,000 ÷ 12 months)</td> </tr> <tr> <td><u>Rate (0.0028)</u></td> <td style="text-align: right;"><u>x 0.0028</u></td> </tr> <tr> <td><b>Monthly Premium Due</b></td> <td style="text-align: right;"><b>\$11.90</b></td> </tr> </table>	<b>Monthly Earnings</b>	<b>\$4,250</b>	(\$51,000 ÷ 12 months)		<u>Rate (0.0028)</u>	<u>x 0.0028</u>	<b>Monthly Premium Due</b>	<b>\$11.90</b>
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<b>Monthly Premium Due</b>	<b>\$11.90</b>																
<b><i>Maximum monthly benefit when submitting a claim: \$2,550*</i></b>	<b><i>Maximum monthly benefit when submitting a claim: \$2,125*</i></b>																

\*amount before reduction by Deductible Income

# Employee-Paid LTD Premium & Benefits (*cont.*)

<b>60% LTD Plan</b> (90-day benefit waiting period)	<b>50% LTD Plan</b> (90-day benefit waiting period)																				
Calculating an employee's insured monthly pre-disability earnings	Calculating an employee's insured monthly pre-disability earnings																				
Example 5:	Example 6:																				
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"><b>Monthly Earnings</b></td> <td style="text-align: right;"><b>\$6,750</b></td> </tr> <tr> <td colspan="2">(\$81,000 ÷ 12 months)</td> </tr> <tr> <td><b>Rate (0.0047)</b></td> <td style="text-align: right;"><b>x 0.0047</b></td> </tr> <tr> <td colspan="2"><hr style="border: 0.5px solid black;"/></td> </tr> <tr> <td><b>Monthly Premium Due</b></td> <td style="text-align: right;"><b>\$31.72</b></td> </tr> </table>	<b>Monthly Earnings</b>	<b>\$6,750</b>	(\$81,000 ÷ 12 months)		<b>Rate (0.0047)</b>	<b>x 0.0047</b>	<hr style="border: 0.5px solid black;"/>		<b>Monthly Premium Due</b>	<b>\$31.72</b>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;"><b>Monthly Earnings</b></td> <td style="text-align: right;"><b>\$6,750</b></td> </tr> <tr> <td colspan="2">(\$81,000 ÷ 12 months)</td> </tr> <tr> <td><b>Rate (0.0028)</b></td> <td style="text-align: right;"><b>x 0.0028</b></td> </tr> <tr> <td colspan="2"><hr style="border: 0.5px solid black;"/></td> </tr> <tr> <td><b>Monthly Premium Due</b></td> <td style="text-align: right;"><b>\$18.90</b></td> </tr> </table>	<b>Monthly Earnings</b>	<b>\$6,750</b>	(\$81,000 ÷ 12 months)		<b>Rate (0.0028)</b>	<b>x 0.0028</b>	<hr style="border: 0.5px solid black;"/>		<b>Monthly Premium Due</b>	<b>\$18.90</b>
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<hr style="border: 0.5px solid black;"/>																					
<b>Monthly Premium Due</b>	<b>\$18.90</b>																				
<b><i>Maximum monthly benefit when submitting a claim: \$4,050*</i></b>	<b><i>Maximum monthly benefit when submitting a claim: \$3,375*</i></b>																				

*\*amount before reduction by Deductible Income*



# Proposed Resolution PEBB 2021-10 Employee-Paid Long-Term Disability (LTD)

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

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

- The following Benefit Waiting Period (the longer of): 90 days; the period of sick leave (excluding shared leave) for which the employee is eligible under the employer's sick leave, paid time off (PTO), or other salaried continuation plan; or the end of Washington Paid Family and Medical Leave Law for which the employee is receiving benefits
- No Choice Sick Leave
- Choice Pension
- A Maximum Monthly Benefit of \$10,000 for the 60% coverage and \$8,333 for the 50% coverage

# Proposed Resolution PEBB 2021-11 Employee-Paid Long-Term Disability (LTD) Enrollment Procedures

- All employees who are eligible for the employer contribution towards PEBB benefits as of December 31, 2021, and not already enrolled in supplemental LTD insurance, or did not make an election (reducing or declining coverage) during an enrollment period established by the Health Care Authority in 2021, will be auto-enrolled in employee-paid LTD insurance at the 60% coverage level with an effective date of January 1, 2022.
- An employee who becomes eligible for the employer contribution towards PEBB benefits on or after January 1, 2022 must make an election (reducing or declining coverage) during the benefit election period. If the employee fails to timely elect coverage, the employee will be defaulted into coverage according to Resolution PEBB 2021-12. The effective date of coverage will be according to the policy established in May 1995.

## Proposed Resolution PEBB 2021-11 Employee-Paid Long-Term Disability Enrollment Procedures (*cont.*)

- After January 1, 2022, an employee at any time may elect to reduce employee-paid LTD to the 50% coverage plan or fully decline employee-paid LTD. The effective date of the change in coverage will be the first day of the month following the date the employer receives the required election.
- An employee who seeks to increase coverage from the 50% coverage plan to the 60% coverage plan, or access previously declined employee-paid LTD, will be subject to evidence of insurability. The effective date of the change in coverage will be the day of the month the contracted vendor approves the required form.
- Any employee who declines employee-paid LTD insurance will remain enrolled in employer-paid LTD insurance.

# Proposed Resolution PEBB 2021-11

## Example #1

Ashley is an existing employee on PEBB benefits making \$31,000 annually who did not previously enroll in supplemental LTD in the PEBB Program. During the fall 2021 enrollment period set by HCA, Ashley does not convey an election to Opt-Out or decline employee-paid LTD insurance under the new LTD Opt-Out enrollment process.

What LTD benefits does she have effective January 1, 2022?

**Ashley is automatically enrolled in employee-paid LTD insurance at the 60% coverage level and employer-paid LTD insurance**

# Proposed Resolution PEBB 2021-11

## Example #1 (*cont.*)

On January 31, 2022, Ashley looks at her pay stub and sees a deduction of \$12.14 for LTD insurance. She calls her employer and asks about the deduction. After learning more information, on January 31, 2022, she submits an election request to Opt-Out entirely from employee-paid LTD insurance.

What is the effective date of the requested change in employee-paid LTD insurance? **February 1, 2022**

Will she receive a refund of the \$12.14 premium for January 2022 coverage? **No, the change in coverage is prospective**

# Proposed Resolution PEBB 2021-11

## Example #2

Shawn is a newly hired employee on January 15, 2022 and determined to be eligible for the employer contribution for benefits that same day. For employee-paid LTD insurance, Shawn submits an election on February 12 to enroll at the 50% coverage level.

What is the last day he could submit a timely election? **February 15, 2022**

When will all his PEBB benefits, including employee-paid LTD benefits, start? **February 1, 2022**

Will the employer have any LTD premium to return to him? **It depends on the employer's payroll timelines, but the same processes could be used that already exist for premiums associated with the PEBB medical plan default enrollment**

## Proposed Resolution PEBB 2021-12 Amending Resolution PEBB 2020-04 Relating to Default Enrollments

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

## Proposed Resolution PEBB 2021-12 Amending PEBB 2020-04 Relating to Default Enrollments

The default election for an eligible employee who fails to timely elect coverage will now be as follows:

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



## Proposed Resolution PEBB 2021-13 Employer-Paid Long-Term Disability Insurance

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

- Waiting Period – Later of 90 days; the period of sick leave (excluding shared leave) for which you are eligible under the employer's sick leave, paid time off (PTO), or other salaried continuation plan (excluding vacation leave); or end of Washington Paid Family and Medical Leave Law
- No Choice Sick Leave
- Choice Pension
- Maximum Monthly Benefit \$400 (60% of \$667)

## Next Steps

- Incorporate Board feedback in the proposed policies
- Submit feedback by March 29, 2021
- Bring recommended policy resolutions to the Board to take action on at the April 14, 2021 Board Meeting

# Questions?

Kimberly Gazard, Contract Manager  
Employees and Retirees Benefits (ERB) Division

[kimberly.gazard@hca.wa.gov](mailto:kimberly.gazard@hca.wa.gov)

# Appendix

# Resolution PEBB 2020-04

## Default Enrollment for An Eligible Employee Who Fails to Make A Timely Election

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

- Enrollment in employee-only medical coverage;
- Enrollment in employee-only dental coverage;
- Enrollment in basic life insurance;
- Enrollment in basic AD&D; and
- Enrollment in basic long-term disability insurance.

# August 1995 Election Period

## Move that:

~~“new employees have 31 days to return enrollment forms with their plan selections. If a plan selection is not made or a waiver form is not returned, the employee will be defaulted into the UMP and the UDP which may automatically initiate a payroll deduction.”~~

*\* The strikethrough policy was superseded by Resolution PEBB 2020-04*

May 1995

## Effective date of coverage for employees eligible for the employer contribution

**I move that we accept the recommendations to change the dates of employee coverage to:**

“the first day of the month following the date of hire, unless the first day of employment is the first working day of the month, and to the last day of the month in which employment is terminated”

**TAB 5**





# Policy Resolutions

Stella Ng, Policy and Rules Coordinator  
Policy, Rules, and Compliance Section  
Employees and Retirees Benefits Division  
April 14, 2021

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

# PEB Board Policy Resolutions

- |              |  |
|--------------|--|
| PEBB 2021-01 | Removing the Retiree 2-Year Dental Enrollment Requirement  |
| PEBB 2021-14 | Authorizing A Gap of 31 Days or Less Between Periods of Enrollment in Qualified Coverages During the Deferral Period |
| PEBB 2021-15 | Rescinding PEBB Policy Resolution #4 SmartHealth (as adopted on July 12, 2017)                                       |

# PEB Board Policy Resolutions (*cont.*)

PEBB 2021-02

Employees May Waive Enrollment in  
Medical

PEBB 2021-03

PEBB Benefit Enrollment Requirements  
When SEBB Benefits Are Waived

PEBB 2021-04

Resolving Dual Enrollment When An  
Employees Only Medical Enrollment  
Is In SEBB

PEBB 2021-05

Resolving Dual Enrollment Involving  
Dual Subscriber Eligibility

# PEB Board Policy Resolutions (*cont.*)

- |              |   |
|--------------|---|
| PEBB 2021-06 | Resolving Dual Enrollment Involving A PEBB Dependent With Multiple Medical Enrollments        |
| PEBB 2021-07 | Resolving Dual Enrollment Involving A Member With Multiple Medical Enrollments As A Dependent |
| PEBB 2021-08 | PEBB Benefit Automatic Enrollments When SEBB Benefits Are Auto-Disenrolled                    |
| PEBB 2021-09 | Enrollment Requirements When An Employee Loses Dependent Coverage In SEBB Benefits            |

## RCW 41.05.065 (1) and (2)

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

## RCW 41.05.065(4)

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

# Resolution PEBB 2021-01 Removing the Retiree 2-year Dental Enrollment Requirement

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

## Resolution PEBB 2021-14 Authorizing A Gap of 31 Days or Less Between Periods of Enrollment in Qualified Coverages During the Deferral Period

**Resolved that**, effective January 1, 2022, an eligible retiree or survivor who deferred enrollment while enrolled in qualified coverage may later enroll themselves and their dependent in a PEBB health plan by submitting the required form and evidence of continuous enrollment in one or more qualifying coverages, except that a gap of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualified coverage, and between each period of enrollment in qualified coverages, during the deferral period.



# Retiree or survivor requesting to enroll in a PEBB health plan after deferment

## Example #2

(Revised)

**Example:** George deferred PEBB retiree insurance coverage effective May 1, 2017 and is requesting to enroll in a PEBB retiree health plan effective August 1, 2021.

In August 2021, George submits the required enrollment forms and evidence of continuous enrollment in one employer-based group medical coverage from May 1, 2017 through May 31, 2020 and another employer-based group medical coverage from July 1, 2020 through July 31, 2021.

- Are there any gaps in enrollment greater than 31 days between periods of enrollment in qualified coverages during the deferral period? **No, the evidence provided shows a single gap of thirty-one days or less (30 days) throughout the deferral period (June 1, 2020 through June 30, 2020).**

Resolution PEBB 2021-15  
Rescinding PEBB Policy Resolution #4  
SmartHealth (as adopted on July 12, 2017)

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

# PEBB Policy Resolution #4 SmartHealth (as approved on July 12, 2017)

## Proposed to Rescind Effective January 1, 2022

Resolved, that effective January 1, 2018, all SmartHealth eligible subscribers will receive a separate PEBB wellness incentive after completing their SmartHealth well-being assessment on or before December 31 of the current plan year. This separate PEBB wellness incentive may be earned only once per plan year.

# Dual Enrollment Policy Resolutions

# Language Used Throughout This Presentation

- Auto-enroll: The employee or dependent will be automatically enrolled by HCA into dental and/or vision.
- Auto-disenroll: The employee or dependent will be automatically disenrolled by HCA from medical, dental, and/or vision.
- Employee: All employees of state agencies, higher education institutions, employer groups, tribal governments, and other entities described in RCW 41.05.011(6)(a).
- School employee: All employees of school districts and charter schools, represented employees of educational service districts, and (beginning January 1, 2024) all employees of educational service districts.

# Guidelines/Principles For Resolving Dual Enrollment

1. Look at where the employee and/or their dependent(s) get their medical.
2. Determine whether they are enrolled as an employee or as a dependent.
3. If they are enrolled as an employee in both programs or as a dependent in both programs, determine the length of time they have been receiving benefits in each program.
4. If necessary, auto-enroll the employee and/or their dependent(s) in dental (and if in SEBB benefits, in vision).
5. Respect the default requirements for each program.
6. Avoid creating a gap in any coverage.

## Resolution PEBB 2021-02

# Employees May Waive Enrollment in Medical

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

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

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

## Waiver of Coverage (as approved in May 1995)

**Proposed to Rescind Effective January 1, 2022**

**I move that we accept the recommendations to:**

“allow waiver of coverage for employees and dependents with evidence of other coverage; and allow re-enrollment in the PEBB plans at any time during the plan year with evidence of loss of other coverage, and during “open enrollment” without proof of other coverage.”



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

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

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

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

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

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

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

# Resolution PEBB 2021-06

## Resolving Dual Enrollment Involving A PEBB Dependent With Multiple Medical Enrollments

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

## Resolution PEBB 2021-07

### Resolving Dual Enrollment Involving A Member With Multiple Medical Enrollments As A Dependent

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

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

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

## Resolution PEBB 2021-08

# PEBB Benefit Automatic Enrollments When SEBB Benefits Are Auto-Disenrolled

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

# Resolution PEBB 2021-09

## Enrollment Requirements When An Employee Loses Dependent Coverage In SEBB Benefits

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

## Next Steps

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



# Questions?

Stella Ng, Policy and Rules Coordinator  
Policy, Rules, and Compliance Section  
Employees and Retirees Benefits Division  
[Stella.Ng@hca.wa.gov](mailto:Stella.Ng@hca.wa.gov)

Emily Duchaine, Regulatory Analyst  
Policy, Rules, and Compliance Section  
Employees and Retirees Benefits Division  
[Emily.Duchaine@hca.wa.gov](mailto:Emily.Duchaine@hca.wa.gov)

# Appendix

# Resolution Edited Since the March 17, 2021 Board Meeting

# Proposed Resolution PEBB 2021-06 Resolving Dual Enrollment Involving A PEBB Dependent With Multiple Medical Enrollments (Revised Proposed Resolution PEBB 2021-06)

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

# Original March 17, 2021 Board Materials

# Proposed Resolution PEBB 2021-01 Removing the Retiree 2-year Dental Enrollment Requirement (As presented on March 17, 2021)

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

## Proposed Resolution PEBB 2021-14 Authorizing A Gap of 31 Days or Less Between Periods of Enrollment in Qualified Coverages During the Deferral Period (As presented on March 17, 2021)

Effective January 1, 2022, an eligible retiree or survivor who deferred enrollment while enrolled in qualified coverage may later enroll themselves and their dependent in a PEBB health plan by submitting the required form and evidence of continuous enrollment in one or more qualifying coverages, except that a gap of 31 days or less is allowed between the date PEBB retiree insurance coverage is deferred and the start date of a qualified coverage, and between each period of enrollment in qualified coverages, during the deferral period.

## Retiree or survivor requesting to enroll in a PEBB health plan after deferment Example #1 (As presented on March 17, 2021)

**Example:** Joan deferred PEBB retiree insurance coverage effective July 1, 2018 and is requesting to enroll in a PEBB retiree health plan effective September 1, 2021.

In August 2021, Joan submits the required enrollment forms and evidence of continuous enrollment in other employer-based group medical coverage from July 1, 2018 through August 31, 2021.

- Are there any gaps in enrollment greater than 31 days between periods of enrollment in qualified coverages during the deferral period? **No, the evidence provided shows proof of uninterrupted coverage during the deferral period.**



## Retiree or survivor requesting to enroll in a PEBB health plan after deferment

### Example #2

(As presented on March 17, 2021)

**Example:** George deferred PEBB retiree insurance coverage effective May 1, 2017 and is requesting to enroll in a PEBB retiree health plan effective August 1, 2021.

In August 2021, George submits the required enrollment forms and evidence of continuous enrollment in one employer-based group medical coverage from May 1, 2017 through May 31, 2020 and another employer-based group medical coverage from July 1, 2020 through July 31, 2021.

- Are there any gaps in enrollment greater than 31 days between periods of enrollment in qualified coverages during the deferral period? **No, the evidence provided shows a single gap of thirty-one days or less (30 days) throughout the deferral period (May 1, 2017 through July 31, 2021) between the date the coverage was deferred (May 1, 2017) and the start date of a qualifying coverage (July 1, 2020).**

## Retiree or survivor requesting to enroll in a PEBB health plan after deferment

### Example #3

(As presented on March 17, 2021)

**Example:** Kathy deferred PEBB retiree insurance coverage effective May 1, 2017 and is requesting to enroll in a PEBB retiree health plan effective August 1, 2021.

In August 2021, Kathy submits the required enrollment forms and evidence of continuous enrollment in one employer-based group medical coverage from May 1, 2017 through June 30, 2020 and another employer-based group medical coverage from August 3, 2020 through July 31, 2021.

- Are there any gaps in enrollment greater than 31 days between periods of enrollment in qualified coverages during the deferral period? **Yes, the evidence provided shows a gap of more than thirty-one days (33 days) throughout the deferral period (May 1, 2017 through July 31, 2021)**

## Retiree or survivor requesting to enroll in a PEBB health plan after deferment

### Example #4

(As presented on March 17, 2021)

**Example:** Cindy deferred PEBB retiree insurance coverage effective June 1, 2016 and is requesting to enroll in a PEBB retiree healthplan effective October 1, 2021.

In October 2021, Cindy submits the required enrollment forms and evidence of continuous enrollment in one employer-based group medical coverage from June 16, 2016 through December 31, 2020 and federal retiree medical plan from January 16, 2021 through September 30, 2021.

- Are there any gaps in enrollment greater than 31 days between periods of enrollment in qualified coverages during the deferral period? **No, the evidence provided shows a gap of 15 days between the date PEBB retiree insurance coverage is deferred and the start date of the employer-based group medical coverage, and another gap of 15 days between the employer-based group medical coverage and federal retiree medical plan.**

Proposed Resolution PEBB 2021-15  
Rescinding PEBB Policy Resolution #4 SmartHealth  
(as adopted on July 12, 2017)  
(As presented on March 17, 2021)

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

## PEBB Policy Resolution #4 SmartHealth (as approved on July 12, 2017)

**Proposed to Rescind Effective January 1, 2022**  
(As presented on March 17, 2021)

Resolved, that effective January 1, 2018, all SmartHealth eligible subscribers will receive a separate PEBB wellness incentive after completing their SmartHealth well-being assessment on or before December 31 of the current plan year. This separate PEBB wellness incentive may be earned only once per plan year.

# Proposed Dual Enrollment Policy Resolutions

## RCW 41.05.742 Single enrollment requirement.

Beginning with the 2022 plan year, individuals are limited to a single enrollment in medical, dental, and vision plans among school employees' benefits board and public employees' benefits board plans. However, individuals may be enrolled in both public employees' benefits board and school employees' benefits board plans as long as those enrollments are across different types of plans, such as medical, dental, and vision. The school employees' benefits board and the public employees' benefits board shall adopt policies to reflect this single enrollment requirement.

# SB 5322: Refining the Dual Enrollment Prohibition

SB 5322: Prohibiting dual enrollment between school employees' benefits board and public employees' benefits board programs:

Beginning with the 2022 plan year, individuals are limited to a single enrollment in medical, dental, and vision plans ~~((among))~~ in either the school employees' benefits board ((and)) or the public employees' benefits board ((plans. However, individuals may be enrolled in both public employees' benefits board and school employees' benefits board plans as long as those enrollments are across different types of plans, such as medical, dental, and vision)). The school employees' benefits board and the public employees' benefits board shall adopt policies to reflect this single enrollment requirement.



## RCW 41.05.065(8)

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

## RCW 41.05.050(1)

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

# Resolving the Issue of Dual Enrollment in PEBB and SEBB Benefits

- Challenges and Limitations
- Language used throughout this presentation
- Examples of dual enrollment in PEBB and SEBB
- What employees can do to resolve dual enrollment
- Guidelines and principles for resolving dual enrollment on behalf of the employee
- Recommended policy resolutions

## Challenges and Limitations in Implementing the Requirements of Resolving Dual Enrollments

- Member engagement
- HCA staff time and effort
- Limitations with current technology
- Training and outreach needs
- Limitations on board power
- Federal requirements and IRS rules

# Language Used Throughout This Presentation

- Auto-enroll: The employee or dependent will be automatically enrolled by HCA into dental and/or vision.
- Auto-disenroll: The employee or dependent will be automatically disenrolled by HCA from medical, dental, and/or vision.
- Employee: All employees of state agencies, higher education institutions, employer groups, tribal governments, and other entities described in RCW 41.05.011(6)(a).
- School employee: All employees of school districts and charter schools, represented employees of educational service districts, and (beginning January 1, 2024) all employees of educational service districts.

# Examples of Current Dual Enrollment in the PEBB and SEBB Programs

- An employee is enrolled in PEBB dental but not PEBB medical. They are enrolled in SEBB medical as a dependent.
- An employee is also a teacher at Tumwater High School. They are enrolled in both PEBB medical and SEBB medical.
- An employee is also a custodian at Roosevelt Elementary. They waived medical in both PEBB and SEBB because their spouse works for Boeing and they are enrolled in their spouse's medical. They are enrolled in PEBB dental, SEBB dental, and SEBB vision.
- An employee and a school employee have a child who is enrolled as a dependent in both PEBB medical and SEBB medical.

# Examples of future dual enrollment in the PEBB and SEBB Programs

- An employee's spouse is enrolled as a dependent in the employee's PEBB medical coverage. The spouse gets a job at Capital High School. They waive SEBB medical coverage, but they remain enrolled in SEBB dental and SEBB vision.
- An employee has a child who is already enrolled as a dependent in SEBB medical, SEBB dental, and SEBB vision. The employee becomes eligible for the employer contribution toward PEBB benefits. They enroll themselves and their child in PEBB medical and PEBB dental.
- An employee's spouse is enrolled in PEBB medical as a dependent. The spouse gets a job with Olympia High School and is now a SEBB benefits eligible school employee. They enroll in SEBB medical.

# How Will Employees Know What to Do?

- During fall 2021:
  - Inform the members in our newsletters, enrollment guides, plan change forms, website, GovDelivery, etc.
  - Send out a separate notice to members informing them that they can resolve their current dual enrollment during OE.
- Employees who gain initial eligibility or who have a special open enrollment event and could potentially dual enroll:
  - Information will be included in guides and forms provided to the employee.
  - Customer Service; Outreach and Training efforts.



# What Can Employees Do to Resolve Current Dual Enrollment?

During the open enrollment period in fall 2021 for plan year 2022, employees who are currently dual enrolled can choose either the PEBB Program or SEBB Program for their medical, dental, and vision plans for themselves and for all their covered dependents.

## What Can Employees Do to Avoid Dual Enrollment?

Employees who become newly eligible for the employer contribution toward PEBB benefits, or who experience a special open enrollment, and who are already enrolled in SEBB benefits, can choose to enroll in PEBB benefits or they can waive their enrollment in PEBB Program and maintain their enrollment in the SEBB Program. They must make their decision within thirty-one days of gaining or regaining eligibility, or within sixty days when there is a special open enrollment.

# What If the Employee Does Not Act to Resolve Dual Enrollment on Their Own?

The PEBB Program will need to act on behalf of the employee by auto-enrolling them into one program and auto-disenrolling them from the other program.

This will be determined according to certain guidelines and principles.

# Guidelines/Principles For Resolving Dual Enrollment

1. Look at where the employee and/or their dependent(s) get their medical.
2. Determine whether they are enrolled as an employee or as a dependent.
3. If they are enrolled as an employee in both programs or as a dependent in both programs, determine the length of time they have been receiving benefits in each program.
4. If necessary, auto-enroll the employee and/or their dependent(s) in dental (and if in SEBB benefits, in vision).
5. Respect the default requirements for each program.
6. Avoid creating a gap in any coverage.

# Proposed Resolution PEBB 2021-02 Employees May Waive Enrollment in Medical (As presented on March 17, 2021)

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

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

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

## Waiver of Coverage (as approved in May 1995)

**Proposed to Rescind Effective January 1, 2022**

**I move that we accept the recommendations to:**

“allow waiver of coverage for employees and dependents with evidence of other coverage; and allow re-enrollment in the PEBB plans at any time during the plan year with evidence of loss of other coverage, and during “open enrollment” without proof of other coverage.”

# Proposed Resolution PEBB 2021-03 PEBB Benefit Enrollment Requirements When SEBB Benefits Are Waived (As presented on March 17, 2021)

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

## Proposed Resolution PEBB 2021-04 Resolving Dual Enrollment When An Employee's Only Medical Enrollment Is In SEBB (As presented on March 17, 2021)

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



# Proposed Resolution PEBB 2021-04

## Example #1

**Example:** Bob is an employee who works at the Department of Ecology. His spouse Jane is a teacher at Olympia High School. Bob is currently enrolled in SEBB medical as a dependent on Jane's account. He is not enrolled in PEBB medical because he affirmatively waived, but he is enrolled in PEBB dental.

Neither Bob (the employee) nor Jane (the school employee) takes any action in response to attempts from HCA asking them to choose which plan Bob stays in.

- How does HCA resolve the employee's dual enrollment? **Bob, the employee, will remain in SEBB as a dependent because that is where he is enrolled in medical. He will be auto-disenrolled from his PEBB dental plan.**

# Proposed Resolution PEBB 2021-05 Resolving Dual Enrollment Involving Dual Subscriber Eligibility (As presented on March 17, 2021)

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

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

# Proposed Resolution PEBB 2021-05

## Example #1

**Example:** Mary is a custodian at the University of Washington and at Ballard High School.

Mary has worked for Ballard High School since 2001. She enrolled in SEBB medical, dental, and vision starting with the 2020 plan year. She started working at the University of Washington in November 2020 and enrolled in PEBB benefits as an employee at that time, so she is currently enrolled in both PEBB medical as an employee and SEBB medical as a school employee.

# Proposed Resolution PEBB 2021-05

## Example #1 (*cont.*)

Mary does not act in response to attempts from HCA asking her to affirmatively choose enrollment in either PEBB or SEBB benefits.

- How does HCA resolve the employee's dual enrollment?  
Mary will remain in her elected SEBB benefits because that is where she has been enrolled the longest. She will be auto-disenrolled from her PEBB medical and dental plans.

# Proposed Resolution PEBB 2021-05

## Example #2

**Example:** Paolo is a facilities manager with the Department of Transportation, and he also teaches at Timberline High School.

Paolo waived medical in both programs because his wife works for Boeing and he is enrolled in medical under her plan. Because he is eligible for both PEBB as an employee and SEBB as a school employee, he is enrolled in PEBB dental, SEBB dental, and SEBB vision. He has worked for DOT since 2015 and became eligible for SEBB benefits in 2020.

# Proposed Resolution PEBB 2021-05

## Example #2 (*cont.*)

Paolo does not act in response to attempts from HCA asking him to affirmatively choose enrollment in either the PEBB or SEBB plan.

- How does HCA resolve the employee's dual enrollment?  
Even though Paolo has been enrolled in PEBB dental longer than he has been enrolled in SEBB dental and SEBB vision, he will be kept in SEBB so that he doesn't lose his SEBB vision coverage. He will be auto-disenrolled from PEBB dental.

# Proposed Resolution PEBB 2021-06 Resolving Dual Enrollment Involving A PEBB Dependent With Multiple Medical Enrollments (As presented on March 17, 2021)

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

# Proposed Resolution PEBB 2021-06

## Example #1

**Example:** Julie is a bus driver for Salish Middle School. Her spouse Linda is an employee with the Washington State Department of Health.

Julie is currently enrolled in PEBB dental under Linda as a dependent and is also enrolled in SEBB medical as a school employee. Neither Julie nor Linda act in response to attempts from HCA asking them to affirmatively choose enrollment for Julie in either PEBB or SEBB.



## Proposed Resolution PEBB 2021-06 Example #1 (*cont.*)

- How does HCA resolve the employee's dependent's dual enrollment? Julie will remain in SEBB benefits because SEBB is where she is enrolled in medical as a school employee. She will be auto-disenrolled from her spouse Linda's PEBB dental plan.

# Proposed Resolution PEBB 2021-06

## Example #2

**Example:** Maria is a receptionist at Salish Middle School. Her spouse Charles is an employee with the Department of Commerce.

Maria is currently enrolled in PEBB medical under Charles as a dependent, and she is also enrolled in SEBB medical as a school employee. Neither Maria nor Charles act in response to attempts from HCA asking them to affirmatively choose enrollment for Maria in either PEBB or SEBB benefits.

## Proposed Resolution PEBB 2021-06 Example #2 (*cont.*)

- How does HCA resolve the employee's dual enrollment? Even though Maria is enrolled in medical in both programs, she will remain in SEBB because she is only enrolled in PEBB medical as a dependent, and she is enrolled in SEBB medical as a school employee. She will be auto-disenrolled from her spouse Charles's PEBB medical, as well as any PEBB dental plan in which she is enrolled.

## Proposed Resolution PEBB 2021-07 Resolving Dual Enrollment Involving A Member With Multiple Medical Enrollments As A Dependent (As presented on March 17, 2021)

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

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

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

# Proposed Resolution PEBB 2021-07

## Example #1

**Example:** Carl works for the Office of Financial Management. His wife Melanie works for Roosevelt Elementary School and is a school employee. They have one child, Cooper, who is currently enrolled on both their plans.

Cooper is enrolled as a dependent in both PEBB medical and SEBB medical. He's been a dependent in SEBB medical longer than he has been enrolled as a dependent in PEBB medical.

## Proposed Resolution PEBB 2021-07 Example #1 (*cont.*)

- How does HCA resolve the dependent's dual enrollment? Even though Cooper is enrolled in medical in both programs, he will remain in SEBB medical because he has been enrolled in SEBB benefits longer than he has been enrolled in PEBB benefits. He will be auto-disenrolled from PEBB medical and any PEBB dental plan he is enrolled in, as well.

# Proposed Resolution PEBB 2021-07

## Example #1 (*cont.*)

- What if one parent/legal guardian responds to HCA's notice to resolve the dependent's dual enrollment and the other parent/legal guardian does not? The PEBB Program will perform the action requested by the parent/legal guardian who responded. If both parents/legal guardians give conflicting responses, the PEBB Program will work with the parents/legal guardians to determine which plan the dependent child will remain in and which one they will be removed from.

# Proposed Resolution PEBB 2021-07

## Example #2

**Example:** Frank works for the Secretary of State. His wife Debra works for Capital High School and is a school employee. They have one child, Ella, who is currently enrolled on both their plans.

Ella is not enrolled in either PEBB medical or SEBB medical. However, she's enrolled in PEBB dental, SEBB dental, and SEBB vision as a dependent. She has been enrolled as a dependent in PEBB dental longer than she has been enrolled as a dependent in SEBB dental and SEBB vision.



## Proposed Resolution PEBB 2021-07 Example #2 (*cont.*)

- How does HCA resolve the dependent's dual enrollment? Even though Ella has been enrolled in PEBB dental longer than she has been enrolled in SEBB dental and SEBB vision, she will be kept in SEBB benefits so that she doesn't lose her vision coverage. She will be auto-disenrolled from PEBB dental.

# Proposed Resolution PEBB 2021-08 PEBB Benefit Automatic Enrollments When SEBB Benefits Are Auto-Disenrolled (As presented on March 17, 2021)

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

# Proposed Resolution PEBB 2021-08

## Example #1

**Example:** Steve works for Tumwater High School and is a school employee. His spouse Bruce works for HCA.

Steve is currently enrolled in PEBB medical under Bruce as a dependent. He is also enrolled in SEBB dental and SEBB vision as a school employee. He is not enrolled in SEBB medical because he affirmatively waived SEBB medical when he became eligible for SEBB benefits.

## Proposed Resolution PEBB 2021-08 Example #1 (*cont.*)

- How does HCA resolve the dependent's dual enrollment when he is also enrolled in SEBB dental and SEBB vision as a school employee? Steve would remain in PEBB benefits because that is where he is enrolled in medical. He would be auto-disenrolled from SEBB dental and SEBB vision. If he wasn't already enrolled in PEBB dental, he will also be automatically enrolled in PEBB dental.

# Proposed Resolution PEBB 2021-09 Enrollment Requirements When An Employee Loses Dependent Coverage In SEBB Benefits (As presented on March 17, 2021)

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

# Guidelines/Principles Recap

1. Medical prioritized over non-medical
2. Subscriber status prioritized over dependent status
3. Longevity of enrollment
  - Exceptions: SEBB Vision and NMSN/court order
4. If necessary, the employee and/or their dependent(s) will be auto-enrolled or auto-disenrolled into dental and/or vision
5. We will respect the default requirements for each program
6. No gaps in coverage

## Next Steps

- Incorporate Board feedback in the proposed policies
- Submit feedback by March 29, 2021
- Bring recommended proposed policy resolutions to the Board to take action on at the April 14, 2021 Board Meeting

# Questions?

Stella Ng, Senior Policy Analyst  
Policy, Rules, and Compliance Section  
Employees and Retirees Benefits Division  
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Emily Duchaine, Regulatory Analyst  
Policy, Rules, and Compliance Section  
Employees and Retirees Benefits Division  
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**TAB 6**



# 2021-23 Biennial Budget Update

Tanya Deuel  
ERB Finance Manager  
Financial Services Division  
April 14, 2021

# Proposed Funding Rates

Per employee per month

Adequate to maintain current level  
of benefits

No significant concerns with funding  
rates and underlying assumptions

# PEBB Funding Rate

Governor's  
Proposed

**FY22**

**\$988**

**FY23**

**\$1,018**

Senate's  
Proposed

**FY22**

**\$936**

**FY23**

**\$1,091**

House's  
Proposed

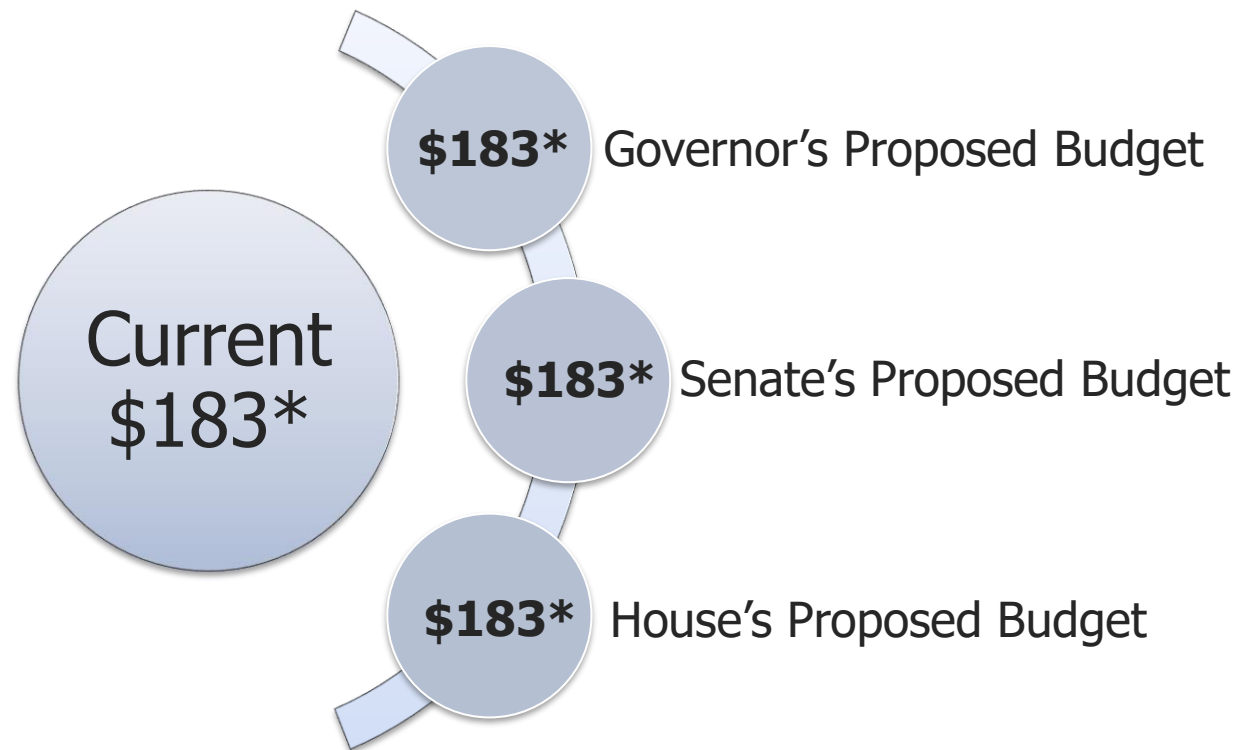
**FY22**

**\$936**

**FY23**

**\$1,091**

# Medicare Explicit Subsidy



\* \$183 or 50% of the premium, whichever is less

# Proposed Budget Similarities

(Governor's, Senate's, and House's Proposed Budgets)

\$5.8 M

**TPA Spending Authority** - Increased spending authority to align with the increased self-insured medical and dental enrollment.

\$285 k

**Scheduling Tool Replacement** – Funds to replace the staff scheduling tool for the customer service center.

\$102 k

**Benefit Administrator Customer Support** — 0.5 FTE O&T staffing increase to support the agencies.

NA

**Board Authority** – Increases to benefits not allowed unless costs are offset by other benefit changes; Cannot make eligibility changes to reestablish retiree eligibility for PEBB benefits.

# Collective Bargaining Agreement

- Employer/Employee split remained at 85%/15%
  - *“The employer will contribute an amount equal to eighty-five percent (85%) of the total weighted average of the projected medical premium for each bargaining unit employee eligible for insurance each month...”*
- \$25 CBA Wellness Gift Card Eliminated
  - Enrolled subscribers who complete the Well-being Assessment will no longer receive a twenty-five dollar (\$25) gift card.

# Proposed Budget Differences

## PEBB My Account

Funding to support enhancements and a more robust maintenance and operation of PEBB My Account.

### Governor's Budget

\$1.2 M

### Senate's Budget

\$853,000

### House's Budget

\$1.2 M

## Retiree Enrollment Window

The HCA must submit a report to the Legislature by January 1, 2022 estimating the fiscal impacts of providing a one-time enrollment window for retirees.

### Governor's Budget

NA

### Senate's Budget

Report Required

### House's Budget

NA



# Questions?

Tanya Deuel, ERB Finance Manager

Financial Services Division

[Tanya.Deuel@hca.wa.gov](mailto:Tanya.Deuel@hca.wa.gov)

**TAB 7**



# 2021 Legislative Session

Cade Walker, Executive Special Assistant  
Employees & Retirees Benefits (ERB) Division  
April 14, 2021

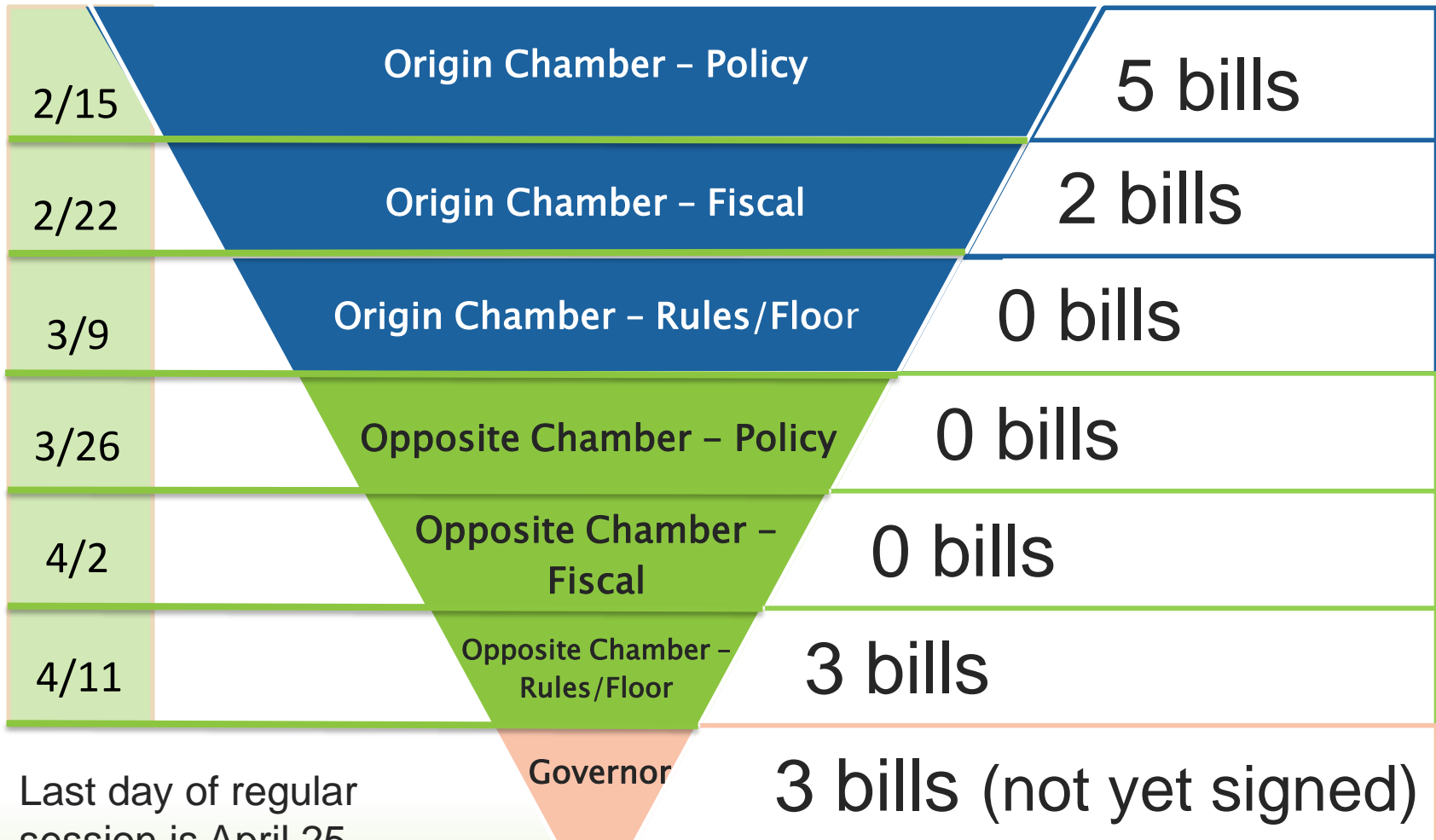
## 2021 Bills Analyzed by ERB Division

	ERB Lead	ERB Support	
High Priority	14	38	40
Low Priority	17	75	91
	31	113	143

Hearings (High Priority Only)	74
-------------------------------	----

Data as of 4/8/21

# 2020 Legislative Session – ERB High Lead Bills



# Upcoming Session – Agency Request Legislation

- SB 5322: Prohibiting dual enrollment between SEBB and PEBB Programs
  - Sponsored by Sen. Robinson
  - Clarification to 2020 ESSB 6189 (4).
  - Would require an eligible member to enroll in the health benefits (medical/dental/vision) in a single program.
  - Currently, the legislation prohibits dual enrollment but it is unclear whether an eligible member could enroll in different health benefits across the two programs.

**PASSED LEGISLATURE  
SIGNED BY GOV!**

# HB 1052 – Group Insurance Contracts

- HCA submitted written testimony in support
- Aligns the insurance code with long-standing HCA statutory requirements that state agencies engage in performance-based contracting
- Performance standards (or performance guarantees) allow HCA to hold carriers accountable for service to PEBB/SEBB Program members
- Examples:
  - Health care claim processing timeliness/accuracy
  - Customer service metrics

# Topical Areas of Introduced Legislation

- Paid Family & Medical Leave
  - HB 1073 (moving back to House due to amendments)
  - SB 5097 (moving back to Senate due to amendments)
- Pharmacy
  - ~~SB 5020 – Rx drug price increases~~
  - ~~SB 5075 – Access to pharmacy services~~
  - ~~SB 5076 – Mail order Rx services~~
  - SB 5195 – Opioid overdose medication (House Floor)
- Eligibility
  - ~~HB 1040 – Health care coverage for retired or disabled school employees~~



# Topical Areas of Introduced Legislation (*cont.*)

- Provider/health care services
  - SB 5018 – Acupuncture and Eastern medicine (Passed Leg.)
  - ~~SB 5088 – Naturopath scope of practice~~
  - ~~SB 5222 – ARNP reimbursement rates~~
  - HB 1196/~~SB 5326~~ – Audio-only telemedicine (Senate Floor)
  - 2SSB 5313 – Health insurance discrimination (Senate Concur)
- Expanded Durable Medical Equipment (DME)
  - ~~HB 1047 – Hearing instruments for children~~
- Open Public Meetings Act
  - HB 1056 – Public meetings/emergencies (Senate Rules)

# Questions?

Cade Walker, Executive Special Assistant  
Employees and Retirees Benefits Division

[cade.walker@hca.wa.gov](mailto:cade.walker@hca.wa.gov)



**TAB 8**



# 2021 Annual Rule Making

Stella Ng, Policy and Rules Coordinator  
Policy, Rules, and Compliance Section  
Employees and Retirees Benefits Division  
April 14, 2021

# Rule Making Timeline

- |              |  |
|--------------|--|
| May 2021     | File proposed amendments (CR-102) and distribute new rules for public comments |
| June 2021    | Conduct public hearing and adopt final rules (CR-103)                          |
| January 2022 | Adopted rules will be effective January 1, 2022                                |

# Focus of Rule Making

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

# Administration and Benefits Management

- Add Medicare Part D late enrollment penalty payment be made to the contracted vendor
- Clarify when a faculty's PEBB medical and dental will begin upon regaining eligibility
- Restructure deferral rule for readability

## Administration and Benefits Management (*cont.*)

- Describing acceptable delivery methods for filing an appeal
- Clarifying that a survivor of a retiree who has deferred enrollment may enroll or continue to defer enrollment in PEBB retiree insurance coverage upon the death of a retiree



# Regulatory Alignment

- Implement legislation related to SB 5322
- Clarifying the special enrollment event that is available when an enrollee enrolls in Medicare or loses eligibility for Medicare applies to dependent as well as the subscriber
- Clarifying that certain special open enrollment opportunities only apply if the dependent is a tax dependent

# Questions?

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

[Stella.Ng@hca.wa.gov](mailto:Stella.Ng@hca.wa.gov)

**TAB 9**



# American Rescue Plan Act of 2021 Premium Assistance For COBRA Continuation Coverage

Emily Duchaine, Regulatory Analyst  
Policy, Rules, and Compliance Section  
Employees and Retirees Benefits Division  
April 14, 2021

# Overview of the American Rescue Plan Act of 2021

The Act includes temporary provisions that affect health care coverage:

- 100% COBRA premium subsidy
- Dependent Care Assistance Program increase to \$10,500 for 2021
- Medicaid financing and eligibility rules
- Health insurance marketplace subsidies

# COBRA Subsidy Eligibility

Available to *Assistance Eligible Individuals* (AEI) defined as employees and their dependents who:

- Lose (or already lost) health coverage due to involuntary termination or reduction in hours (voluntary or involuntary); and
- Are federally eligible for COBRA

## COBRA Subsidy Eligibility (*cont.*)

Available to *Assistance Eligible Individuals* (AEI) defined as employees and their dependents who:

- Elected COBRA or elects COBRA on or after April 1, 2021, and before the subsidy ends on September 30, 2021; or
- Became eligible for COBRA prior to April 1, 2021, and their period of COBRA coverage includes any month between April and September 2021

# Temporary 100% COBRA Subsidy Timeline

- COBRA premiums will be subsidized from April 1, 2021 – September 30, 2021
  - Applies to medical and dental premiums
- The subsidy ends earlier than September 30 if the individual becomes eligible for Medicare or other group health coverage



# Resolutions PEBB 2020-01 and PEBB 2020-02

- Resolutions PEBB 2020-01 and PEBB 2020-02 remain in effect. Resolutions extended:
  - Maximum period of continuation coverage
    - We don't believe the subsidy extends to these months of coverage
  - Enrollment timelines for continuation coverage subscribers
    - We don't believe these extended enrollment timelines are going to affect eligibility for the subsidy

# Implementation

- HCA will notify AEIs of subsidy availability and the extended election period by May 30, 2021
- HCA will notify AEIs of subsidy expiration
- HCA plans to seek reimbursement for the subsidy directly from the federal government

# Implementation (*cont.*)

Identify AElS with help from employing agencies:

- For existing members, we will need employing agencies to help verify whether the loss of coverage was due to an involuntary reduction in hours or termination
- HCA staff will provide guidance to agencies

# Implementation (*cont.*)

## Communications:

- Waiting on federal model notices before significant work on notices begins
- Information is being made available on the PEBB Continuation Coverage (COBRA) website
- Training for staff that will determine eligibility will occur

# Questions?

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

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# Appendix

# PEBB 2020-01 and PEBB 2020-02 Resolutions

## COVID-19 Continuation Coverage Eligibility (Policy resolution 2020-01):

Beginning February 29, 2020, the date that Governor Inslee declared a state of emergency in Proclamation 20-05, the maximum period of continuation coverage is extended until two months after the date the Governor terminates the state of emergency.

## COVID-19 and Enrollment Timelines (Policy resolution 2020-01):

Beginning February 29, 2020, the date that Governor Inslee declared a state of emergency in Proclamation 20-05, any enrollment timelines established for continuation coverage and retiree subscribers will be extended to 30 days past the date the Governor terminates the state of emergency.

The Health Care Authority is authorized, during the state of emergency as described above, to extend this deadline further and extend any other enrollment deadlines as needed to meet the needs of the state and PEBB Program subscribers.

**TAB 10**





# Behavioral Health Overview

Lauren Johnston  
SEBB Procurement Manager  
Employees & Retirees Benefits Division  
April 14, 2021

Emily Transue, MD  
HCA Medical Director  
Clinical Quality & Care  
Transformation Division

# Objectives

- Overview of behavioral health coverage
- Network adequacy
- Benefits under review
- Relevant legislation
- Information and resources

# PEBB Plan Behavioral Health Coverage

Plan	Primary Care	MH/BH Specialist*	Emergent/Urgent Care	Residential Treatment Facilities
KPNW	✓	✓	✓	✓
KPWA	✓	✓	✓	✓
UMP	✓	✓	✓	✓
UnitedHealth -care	✓	✓	✓	✓†

- Includes Applied Behavioral Analysis for children and adolescents

† Only when the facility is covered by Medicare

## PEBB Plan Behavioral Health Coverage (*cont.*)

Plan	Virtual Care Vendors	Telemedicine w/ existing providers	Nurse Contact Lines	Other Programs
KPNW	✓	✓	✓	✓
KPWA	✓	✓	✓	✓
UMP	✓	✓	✓	✓
UnitedHealth -care	✓	✓	✓	✓

# Network Adequacy

## *How do our carriers assess network adequacy?*

- Product filing through Office of the Insurance Commissioner when GeoNetwork Reports are submitted
- Majority of plans go through the National Committee on Quality Assurance (NCQA) review and are accredited
- Access and capacity measured through member contact and outbound surveys
- Identify areas of high-volume services utilized

## Network Adequacy (*cont.*)

### *How do our carriers address specific areas of need?*

- Work on expanding network to improve access, decrease wait times, and improve ease of accessing care for the need(s) identified
- Constantly recruiting new providers, retaining existing providers, creating strategic provider partnerships, and ensuring network incorporates national providers
- Adding telehealth/virtual care providers
- Patient partners in mental health that help determine opportunities and identified pain points in programming or processes

# Similar Programs Offered Across Multiple Plans

## *Online and phone applications:*

- ***myStrength (KPNW and KPWA)***: Cognitive behavioral therapy application. A diverse clinical app to meets individual needs of each person
- ***Calm (KPNW and KPWA)***: App for meditation, mental resilience, and sleep
- ***Find your words (KPNW and KPWA)***: Online resource to help provide tools and the words to talk about depression with others
- ***Ginger (KPNW and KPWA)***: Virtual therapy option; KPWA is already implemented, KPNW anticipated for 6/1/2021 start
- ***Savnello (UnitedHealthcare)***: Top-rated self-help app that uses clinically validated techniques

***Behavioral health case management (all carriers)***: Licensed specialists who provide members with assistance such as coordination of care and care plan management, understanding, and navigating benefits and care options.

## Similar Programs Offered Across Multiple Plans (*cont.*)

### *Provider concierge services:*

- ***Quartet\* (UMP)***: Concierge service that matches members to mental health care providers based on geography, insurance, clinical needs, and when possible, personal preferences. Members can self-refer or be referred through their primary care or specialty care.
- ***Magellan Healthcare (KPWA)***: Helps members find in-network providers and works to schedule the member's first appointment.

\*UMP members must reside and receive care in Washington State.



# Plan Specific Programs

- ***Peer support specialists (KPNW)***: Provide support to other members through their lived experience and success in their recovery process from mental health and/or Substance Use Disorder (SUD)
- ***TEEN – IOP (KPNW)***: Intensive outpatient program for teens
- ***TAYA – IOP (KPNW)***: IOP for older teens to young adults (age 18-24); on hold until summer 2021
- ***AbleTo (UnitedHealthcare)***: Leading 8-week programs designed to treat a range of medical/behavioral comorbidities

# Future Areas of Focus

## KPNW:

- ***Recovery Pathways Program:*** Currently in pilot stage. Focuses on patient engagement for those with co-occurring disorders (mental health and addiction medicine). Expansion will continue if goes as planned.
- ***Spravato (ketamine) treatment program:*** Novel antidepressant previously used as a general anesthetic, recently approved for treatment-resistant depression. Program currently in planning phases with intent to implement in 2021.

## KPWA:

- ***Mental health and wellness:*** Focus on recruitment and retention to address gaps in representation. Partnering with University of Washington MHA students on their Capstone project.

## Future Areas of Focus (*cont.*)

UMP (under consideration):

- ***Omada Mind\****: Whole person care with dedicated support for anxiety, depression, and stress via Omada for Behavioral Health program
- ***myStrength***: Cognitive behavioral therapy application; a diverse clinical app to meet individual needs of each person

UnitedHealthcare:

- Several programs currently in proprietary and confidential stages

\*Current pilot program and only available to the 1,200 members who signed up in Fall of 2020.

# Legislation Passed in 2019

HB 1099 (“Brennen’s Law”): Requires carriers to provide network adequacy to consumers

- Carriers must provide a provider directory which notates what providers are closed to new patients
- Whether a health carrier classifies MH and SUD treatment as primary care or specialty care
- Average wait times to access treatment services
- Information on steps a member can take if they are unable to access covered services
- Any instances where the OIC has taken disciplinary action against the carrier
- ERB has included information on Brennen’s Law in the SEBB and PEBB enrollment guides and on the HCA website

# Legislation Passed in 2020

ESHB 2642 (removing barriers to substance use disorder treatment)

Requires SEBB and PEBB fully insured carriers and the UMP to:

- Provide coverage for no less than 2 days excluding weekends and holidays, in a behavioral health agency that provides inpatient and residential SUD treatment prior to conducting utilization review; and
- Provide coverage for no less than 3 days in a behavioral health agency that provides withdrawal management services prior to conducting utilization review
- Coordinate care between facilities to ensure seamless transfer as soon as possible to an appropriate and available facility or level of care. The health plan shall pay the agency for the cost of care at the current facility until the seamless transfer to the new facility or level of care is complete.

# Mental Health Parity

- Federal law generally prohibits group health plans from imposing less favorable benefit limitations on mental health and substance use benefits than on medical or surgical benefits
  - Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008
  - Multiple modifications over time, including 2016
- All PEBB plans are required to meet this requirement, and continue to actively assess and make changes as interpretation of the requirement evolves

# Information on How to Access Services

- Members can find more information at:  
<https://www.hca.wa.gov/employee-retiree-benefits/school-employees/behavioral-health-services-plan> (included in appendix)
- Or by calling their health plan

# SmartHealth Resources

- Each carrier has a tile up for mental health
- “Mental Health Tips” tile currently up and runs through the end of November
- A new tile, “May is Mental Health Month” will be live from May 1 – May 31
- Eligible members should login (or register for their account) and see what information is available through SmartHealth
- Eligible subscribers can earn points towards their wellness incentive



# Questions?

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# Appendix

# Kaiser Permanente Northwest (KPNW) plans

Resources and access to mental health/SUD treatment	Find providers	Obstacles and ways to mitigate them	Questions to help guide the conversation with customer service
<p><b>Convenient ways to get care:</b> <a href="http://kp.org/getcare">kp.org/getcare</a></p> <p><b>Understanding mental health:</b> <a href="http://kp.org/mentalhealth">kp.org/mentalhealth</a></p> <p><b>Addiction treatment services:</b> <a href="http://kp.org/addiction/nw">kp.org/addiction/nw</a></p> <p><b>Wellness resources:</b> <a href="http://kp.org/selfcare">kp.org/selfcare</a></p> <p><b>Talking with kids about mental health:</b> <a href="http://findyourwords.org/kids-mental-health/">findyourwords.org/kids-mental-health/</a></p> <p><b>How to get mental health services:</b> <a href="http://healthy.kaiserpermanente.org/oregon-washington/doctors-locations/how-to-find-care/behavioral-health">healthy.kaiserpermanente.org/oregon-washington/doctors-locations/how-to-find-care/behavioral-health</a></p>	<p><b>Find doctors and locations:</b> <a href="http://healthy.kaiserpermanente.org/oregon-washington/doctors-locations#/search-form">healthy.kaiserpermanente.org/oregon-washington/doctors-locations#/search-form</a></p> <p><b>How to get mental health services:</b> <a href="http://healthy.kaiserpermanente.org/oregon-washington/doctors-locations/how-to-find-care/behavioral-health">healthy.kaiserpermanente.org/oregon-washington/doctors-locations/how-to-find-care/behavioral-health</a></p>	<p><b>What if my need is urgent? Mental health &amp; SUD:</b> We have urgent appointments available, as well as a 24-hour crisis line for support and emergent needs.</p> <p><b>What if I want/need medication? Mental health:</b> If you have never been on medications for depression/anxiety, start first with your Primary Care doctor who can help and prescribe medications. If they feel you need more specialty medication help, they can refer you to a psychiatrist.</p> <p><b>SUD:</b> We provide medications for substance use disorders through our Addiction Medicine Medical Team. They can be accessed via the call center and they have same/next day access.</p> <p><b>Do you have enough providers? Mental health &amp; SUD:</b> Yes, we have both internal providers and external providers we contract with in all KPNW service areas.</p> <p>If you have questions, concerns, or would like to file a complaint, you can call <a href="#">Member Services</a> or complete an <a href="#">online form</a> and email it to Member Services. You must use the secure member sign-in to submit a question or a concern via the online forms.</p>	<ul style="list-style-type: none"> <li>• Is this for an adult or a child?</li> <li>• Do you prefer virtual or in person visits?</li> <li>• What are your provider preferences (gender, language, geography, etc.)</li> <li>• What are the first steps you need to take?</li> <li>• What types of providers are available?</li> <li>• Do you want a provider with experience working with the LGBTQ community or someone of your background?</li> </ul> <p><b>Phone: 1-800-813-2000 TRS: 711</b></p> <p>If you are concerned about access to services or are having difficulty finding a provider, please contact us at <b>1-855-632-8280</b> during regular business hours or <b>1-800-813-2000</b> if after hours.</p>

# Kaiser Permanente of Washington (KPWA) Plans

Resources and access to mental health/SUD treatment	Find providers	Obstacles and ways to mitigate them	Questions to help guide the conversation with customer service
<p><b>Get care:</b> <a href="http://wa.kaiserpermanente.org/html/public/specialties/mental-health/mental-health-wellness">wa.kaiserpermanente.org/html/public/specialties/mental-health/mental-health-wellness</a></p> <p><b>Important information:</b> <a href="http://wa.kaiserpermanente.org/html/public/specialties/mental-health/information">wa.kaiserpermanente.org/html/public/specialties/mental-health/information</a></p> <p><b>Substance use disorder:</b> <a href="http://wa.kaiserpermanente.org/kbase/topi.c.jhtml?docId=ug4831">wa.kaiserpermanente.org/kbase/topi.c.jhtml?docId=ug4831</a></p> <p><b>Substance use and mental health problems:</b> <a href="http://wa.kaiserpermanente.org/kbase/topi.c.jhtml?docId=ug4809">wa.kaiserpermanente.org/kbase/topi.c.jhtml?docId=ug4809</a></p> <p><b>Substance use disorders in older adults:</b> <a href="http://wa.kaiserpermanente.org/kbase/topi.c.jhtml?docId=ug4806">wa.kaiserpermanente.org/kbase/topi.c.jhtml?docId=ug4806</a></p> <p><i>(more links on next page)</i></p>	<p><b>Find a doctor:</b> <a href="http://wa.kaiserpermanente.org/html/public/fad">wa.kaiserpermanente.org/html/public/fad</a></p>	<p><b>What if my need is urgent? (Mental health &amp; SUD)</b> Call <b>1-888-287-2680</b>, Monday through Friday, 8 a.m. to 5 p.m. We match members with a mental health specialist in requested area or help find addiction treatment. If the member can't wait for an appointment, we can connect them to a therapist over the phone.</p> <p>For help after hours, <b>1-800-297-6877</b> so we can evaluate your symptoms, provide next steps, or contact an on-call psychiatrist.</p> <p><b>What if I want/need medication? Mental health:</b> If you have never been on medications for depression/anxiety, start first with your Primary Care doctor who can help and prescribe medications. If they feel you need more specialty medication assistance, they can refer you to a psychiatrist.</p> <p><b>SUD:</b> We provide medications for substance use disorders through our Addiction Medicine Medical Team. They can be accessed via the call center and they have same/next day access.</p> <p><b>Do you have enough providers? (Mental health &amp; SUD)</b> Yes, we have both internal providers and external providers we contract with in all KPWA service areas.</p> <p>If you have questions, concerns, or would like to file a complaint, you can call <a href="#">Member Services</a> or file an appeal via fax, email or online at <a href="http://wa.kaiserpermanente.org/html/public/customer-service/appeal">wa.kaiserpermanente.org/html/public/customer-service/appeal</a>.</p>	<ul style="list-style-type: none"> <li>• Is this for an adult or a child?</li> <li>• Do you prefer virtual or in person visits?</li> <li>• What are your provider preferences (gender, language, geography, etc.)</li> <li>• What are the first steps you need to take?</li> <li>• What types of providers are available?</li> <li>• Do you want a provider with experience working with the LGBTQ community or someone of your background?</li> </ul> <p><b>Phone:</b></p> <ul style="list-style-type: none"> <li>• <b>1-888-901-4636</b> (M-F, 8 a.m.–8 p.m.)</li> <li>• <b>1-888-287-2680</b> (M-F, 8 a.m.–5 p.m.)</li> <li>• <b>1-800-297-6877</b> (After hours)</li> </ul> <p><b>TTY: 1-800-833-6388</b> <b>TRS: 711</b></p>

# Kaiser Permanente of Washington (KPWA) Plans (*cont.*)

## Resources and access to mental health/SUD treatment

**Teen substance use disorder – Choosing a treatment program:**

[wa.kaiserpermanente.org/kbase/topic.jhtml?docId=uq2564](http://wa.kaiserpermanente.org/kbase/topic.jhtml?docId=uq2564)

**Substance use disorders in older adults:**

[wa.kaiserpermanente.org/kbase/topic.jhtml?docId=ug4806](http://wa.kaiserpermanente.org/kbase/topic.jhtml?docId=ug4806)

**Teen substance use – Making a contract with your teen:**

[wa.kaiserpermanente.org/kbase/topic.jhtml?docId=tk2206](http://wa.kaiserpermanente.org/kbase/topic.jhtml?docId=tk2206)

**Substance use disorder – dealing with teen substance use:**

[wa.kaiserpermanente.org/kbase/topic.jhtml?docId=tj2888](http://wa.kaiserpermanente.org/kbase/topic.jhtml?docId=tj2888)

**Social work services:**

[wa.kaiserpermanente.org/html/public/services/social-services](http://wa.kaiserpermanente.org/html/public/services/social-services)

# Uniform Medical Plan (UMP) Plans

Resources and access to mental health/SUD treatment	Find providers	Obstacles and ways to mitigate them	Questions to help guide the conversation with customer service
<p><b>Case management:</b> If you are looking to get help with a mental health or substance misuse challenge, the first step is to contact the customer service number and inquire about case management. <b>Phone:</b> 1-888-849-3681 <b>TRS:</b> 711 <b>Business hours:</b> Monday through Friday 5 a.m. to 8 p.m. and Saturday 8 a.m. to 4:30 p.m. (Pacific)</p> <p><b>Member resources:</b> <a href="https://regence.com/member/resources/washington-behavioral-health">regence.com/member/resources/washington-behavioral-health</a></p> <p><b>Quartet:</b> Quartet matches members to mental healthcare providers (MHPs) based on the member's geography, insurance, clinical care needs, and, when possible, personal preferences. Traditionally, members are referred through primary care or specialty care settings to Quartet, and then matched to an MHP. Quartet is expanding services to allow members to self-refer without the need of a PCP or specialty provider referral. UMP members can sign up, and get matched to a provider, through visiting the Quartet website at <a href="https://qrt.care/regenceUMP">qrt.care/regenceUMP</a>.</p>	<p><b>Find a doctor:</b> <a href="https://ump.regence.com/pebb/finding-doctors">ump.regence.com/pebb/finding-doctors</a></p> <p><b>Doctor on Demand:</b> UMP Classic and UMP CDHP plans include telemedicine powered by Doctor On Demand. You can talk to any of Doctor On Demand's board-certified physicians, licensed counselors and psychiatrists any time by video chat using your computer or the app, 24 hours a day, 7 days a week, 365 days a year.</p> <p>Register with Doctor On Demand now so that when you actually need care, you're ready. You can activate Doctor On Demand <a href="#">through your Regence account</a> or by downloading the app for iOS, Android, or Windows.</p>	<p><b>For any issues regarding finding a provider, please call UMP Customer Service so we may assist you.</b></p> <p><b>Phone:</b> 1-888-849-3681 <b>TRS:</b> 711 <b>Business hours:</b> Monday through Friday 5 a.m. to 8 p.m. and Saturday 8 a.m. to 4:30 p.m. (Pacific)</p> <p><b>All of Regence's customer service representatives have been certified in mental health first aid training to better assist members with sensitive information.</b></p>	<ul style="list-style-type: none"> <li>• Is this for an adult or a child?</li> <li>• Do you prefer virtual or in person visits?</li> <li>• What are your provider preferences (gender, language, geography, etc.)</li> <li>• What are the first steps you need to take?</li> <li>• What types of providers are available?</li> <li>• Do you want a provider with experience working with the LGBTQ community or someone of your background?</li> </ul> <p><b>Phone:</b> 1-888-849-3681 <b>TRS:</b> 711 <b>Business hours:</b> Monday through Friday 5 a.m. to 8 p.m. and Saturday 8 a.m. to 4:30 p.m. (Pacific)</p>

# Uniform Medical Plan (UMP) Plans (*cont.*)

Who to contact if you need more information or do not think you are receiving the help you need	Prescription drug website	Prescription drug benefit obstacles and ways to mitigate them
<p>If after using the resources and information provided, you have not been able to access care or receive the help you are looking for, Regence Customer Service will engage their Behavioral Health Care Management team and transition you to a clinician who can better support you. Customer Service will also have the support of <a href="#">Quartet</a>, including the ability to warm transfer you to the Quartet team.</p>	<p><a href="http://ump.regence.com/pebb/benefits/prescriptions">ump.regence.com/pebb/benefits/prescriptions</a></p>	<p><b>Finding a network pharmacy and their business hours:</b>            Visit <a href="http://ump.regence.com/sebb/benefits/prescriptions_or">ump.regence.com/sebb/benefits/prescriptions_or</a>            call Washington State Rx Services at <b>888- 361-1611 (TRS: 711)</b>.</p>

# UnitedHealthcare Plans

Resources and access to mental health/SUD treatment	Find providers	Obstacles and ways to mitigate them	Questions to help guide the conversation with customer service
<p><b>Get care:</b>  <a href="https://www.liveandworkwell.com/content/en/public/topics/suds.html">https://www.liveandworkwell.com/content/en/public/topics/suds.html</a></p>	<p><b>Find a doctor:</b>  <a href="https://provider.liveandworkwell.com/content/laww/providersearch/en/home.html?siteId=10275&amp;lang=11">https://provider.liveandworkwell.com/content/laww/providersearch/en/home.html?siteId=10275&amp;lang=11</a></p>	<p><b>What if my need is urgent? (Mental health &amp; SUD)</b>            Substance Use Helpline <b>1-855-780-5955</b>. We are available 24/7 to answer your questions. These may include your personal health, care for a family member, coverage, cost of care, and more. We are committed to making it as easy as possible for you to access the services you or your loved one may need. Simply call us anytime, day or night and we'll be here.</p> <p><a href="https://www.liveandworkwell.com/en/public/custom/recovery.html">https://www.liveandworkwell.com/en/public/custom/recovery.html</a></p>	<ul style="list-style-type: none"> <li>• Is this for an adult or a child?</li> <li>• Do you prefer virtual or in person visits?</li> <li>• What are your provider preferences (gender, language, geography, etc.)</li> <li>• What are the first steps you need to take?</li> <li>• What types of providers are available?</li> <li>• Do you want a provider with experience working with the LBGTQ community or someone of your background?</li> </ul> <p><b>Phone:</b></p> <ul style="list-style-type: none"> <li>• <b>1-800-453-8440</b></li> <li>• <b>TTY: 711</b></li> </ul>