

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

May 28, 2020  
Health Care Authority  
Meeting Held Telephonically  
Olympia, Washington  
12:00 p.m. – 3:30 p.m.

**Members Present:**

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

**PEB Board Counsel:**

Michael Tunick, Assistant Attorney General

**Call to Order**

**Sue Birch, Chair**, called the meeting to order at 12:04 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.

The Board met in Executive Session at 12:10 p.m., pursuant to RCW 42.30.110(l), 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 public portion of the meeting resumed at 1:00 p.m.

**Meeting Overview and Follow Up**

**David Iseminger**, Director, Employees and Retirees Benefits Division, provided an overview of today's meeting and a follow up from the April 15, 2020 meeting.

Since the April 15 meeting, due to COVID-19, the Internal Revenue Service (IRS) issued guidance that employers across the nation are allowed to take advantage of

additional flexibility related to medical Flexible Spending Accounts, Dependent Care Assistant Programs, and switching enrollment changes in medical plans mid-year.

There are usually strict requirements about what plan changes can happen mid-year, because most employees are taking payroll deductions out of their paychecks to take advantage of tax savings that can happen in the current tax year. There are regulations that don't allow mid-year switches without specific circumstances. HCA lobbied the IRS for additional flexibility. We were hearing from members that with schools and day care centers closing and medical supplies being gathered up in the months of March and April, in particular, members were very concerned that the contributions they had in FSA and DCAP funds were going to be lost at the end of the year.

There will be a mid-year limited open enrollment event to allow certain types of changes in both the PEBB and SEBB populations around July. We are focused at this point on allowing changes to FSA and DCAP benefits contributions and targeting an opportunity for people currently not covered that are in a waive status to be able to elect coverage or add dependents mid-year. We would like mid-year changes completed before the annual open enrollment this fall.

HCA also worked with our carriers that if a retiree is rehired into work in the PEBB portfolio, and they were previously in PEBB retiree coverage this year, their accumulators won't reboot, such as their deductible and out-of-pocket maximum. This reduces the barrier to any retiree who's interested in being rehired into the workforce for addressing COVID issues. We have not identified anyone that has actually fallen into that scenario, but the carriers have committed to working with us to reduce that barrier.

A third area that's being worked on is testing related to antibody, or serology testing. Regence, on behalf of the Uniform Medical Plan, and all of the carriers have been working on different policies. Some requirements must align with federal law, which is why it's not a benefit design piece that needs Board action because it relates to some federal requirements. Once I have a better understanding of what's needed, I'll provide the Board with more information, but I did want to alert you to the antibody and serology testing for COVID-19 in all the plans.

Delta Dental, with the shutting down of dental services and non-emergent services under the Governor's proclamations in mid-March through mid-May, approached HCA and indicated they will be refunding the equivalent of one month of the admin fee since there was less administrative work during the COVID period because of dental closures. That fee will be returned to HCA and then the state budget.

On April 30 we worked with Limeade, our SmartHealth vendor, to launch a platform for approximately 220,000 Medicaid folks, which is about 15% to 20% of the Medicaid population, to be able to access wellness supports and a variety of other resources during the stressful times we're under. At this point, about 1,700 Medicaid individuals have registered and are participating in SmartHealth, which we continue to promote.

The last two pieces I want to highlight are some of the tangible results from your Special Board Meeting on April 2, 2020, where we brought you three different COVID-related resolutions to help address the developing emergency. The first two resolutions were around deadlines for COBRA extensions and people being able to continue coverage

on a self-pay basis. To date, about 35 individuals have elected to extend their coverage between the PEBB and SEBB Programs because both Boards passed those resolutions providing that opportunity. About 50 chose not to take that opportunity. Approximately 40 to 45 are still evaluating the option with the understanding that if they did elect, it would be retroactive to when their coverage would have terminated, and they would pay the full premium.

The Board, on April 2, 2020, also passed Resolution PEBB 2020-03, allowing individuals hired as first responders, researchers, anyone working in a medical facility, or public health officials, to have benefits begin the first of the month in which they actually work eight hours. For the standard PEBB eligibility, benefits begin the first of the month after eligibility is established. As of May 22, 2020, 187 employees have been hired under that eligibility at the University of Washington and the Department of Health. The UW has the lion's share at 163. I asked their Benefits Administrator to tell me more about those positions and they are all individuals hired into direct patient care at one of the hospitals or part of the COVID testing labs within the School of Medicine.

I want the Board to understand some of the impacts resulting from your actions at the beginning of April. There are 187 people hired during the COVID emergency so far that have benefits eligibility retroactive to the first of the month. And there are 35 individuals who have taken advantage of self-pay extension coverage between you and your sister Board.

**Sue Birch:** I want to acknowledge that Dave single-handedly brought the IRS issue forward in our country and has been helping other large purchaser groups be aware of this issue. Dave, truly, without your leadership and action taking that issue forward, I don't believe the IRS would have responded or made that adjustment. So, thank you for moving on that modernization during COVID, and on many of the other things you just referred to. To both you and your team, we really appreciate your leadership.

#### **Agenda Item: UMP Additional Plan Proposal**

**Shawna Lang**, ERB Division UMP Senior Account Manager. Slide 2 – Objectives: Overview of proposed new medical plan, PEBB benefit design comparison, and introduce the resolution to approve.

Slide 3 – Plan Name. The proposed new plan is UMP Select with an 82% Actuarial Value.

Slide 4 – UMP Benefit Design Comparison. As a review of the UMP benefit design, UMP Select deductible is \$750 for single and \$2,250 for family. The out-of-pocket maximum is \$3,500 for single, \$7,000 for family, and 20% coinsurance.

Slide 5 – UMP Select Deductible Insights. A subscriber can reduce their deductible by \$125 by earning the SmartHealth Wellness Incentive. Also, remember under the Collective Bargaining Agreement, many represented employees receive \$250 from the employer contribution to the Medical Flexible Spending Arrangement (FSA).

**Dave Iseminger:** Under the Collective Bargaining Agreement, for a represented employee who makes under \$50,004 annually, as of a certain date evaluated before the beginning of the next plan year, the state puts an employer contribution of \$250 into that

FSA. It is immediately available for those individuals to access and use at the very beginning of the plan year. 2020 is the first year that benefit was operationalized. Approximately 18,000 represented state employees received the \$250 contribution. A little over 16,000 of those individuals are first time utilizers of a medical Flexible Spending Account. Through the first quarter of the year, about 25% of the employees who received that benefit have already exhausted it.

This benefit is not allowed if an individual is enrolled in the CDHP, the IRS qualified High Deductible Health Plan because IRS and Congress have determined individuals can't double dip into both a Health Savings Account and Flexible Spending Account. This benefit is specific to individuals who sign up for a non-CDHP (IRS qualified High Deductible Health Plan).

**Shawna Lang:** Slide 6 – UMP Select Deductible Insights (*cont.*). The \$2,250 family deductible includes the embedded deductible of \$750. Once the \$2,250 family deductible is reached, the plan pays for all covered services, even if some enrolled family members have not met their own deductible. It's an embedded deductible.

Slide 7 – UMP Benefit Design Comparison - compares Classic, CDHP, and UMP Plus. The major differences are the coinsurances of 15% versus 20% for UMP Select. It's the same for everything else on this page.

Slide 8 - UMP Benefit Design Comparison (*cont.*) – shows the major differences again are the 20% coinsurances. The benefit limit for spinal manipulation, acupuncture, massage, physical therapy, occupational therapy, and speech therapy (PT, OT, ST) are the same as Classic, as well.

Slide 9 - UMP Benefit Design Comparison (*cont.*) – shows the pharmacy comparison, which matches UMP Classic. The only difference is the deductible, which is \$250 single and \$750 for a family.

Slide 10 – UMP Select Similarities with UMP Classic. It has the same provider network; the same statewide and national coverage, which is under blue card coverage; same coverage of services, exclusions, and clinical policies; and same treatment limits for chiropractic, acupuncture, massage, PT, OT, ST, and Neurodevelopmental Therapy (NDT).

**Megan Atkinson**, HCA Chief Financial Officer. Joining Megan is Ben Diederich from Milliman and Tanya Deuel, Finance Division. As you consider adding the UMP Select Plan, I want to talk about the financial side, as well. Shawna shared the benefit package and highlighted a lot of the differences. We're going to talk about how the different benefit cost share, the different AV, translates into premiums, and then how that translates into employer and employee split of the premiums with the mechanism we have in place for the state index rates.

Slide 11 – Employer and Employee Premiums. This slide is a refresher. Bid rates for the UMP plans are developed to cover best estimate projected costs. We get these bid rates in advance of actual experience. They're developed to be a best estimate and standardized by the projected risk score. The UMP Select plan has a lower monthly employee premium contribution, but a higher employee cost share. That's what

Shawna shared in some of the prior tables, where the point of service cost share was higher, even though the benefit limits were the same. The terms of the Collective Bargaining Agreement specify that the employer and employee premium share is an 85%/15% weighted average.

Slide 12 – Calculating the State Index Rate. This is the graphic to illustrate how the weighted average index rate works. It's a very simplified example with hypothetical, illustrative numbers. The graph shows three plan offerings: Plan A, B, and C; bid rates varying from \$550 to \$450, and an assumed number of adult units enrolled. Remember the conversion to adult units because we don't count a child as a full 1.0, which played out in our tier factors. If you do the math, with plan A as our example, the \$550 times the 3 adult units is \$1,650. When you add across, the \$1,650 plus the \$500 for the monthly cost in Plan B, plus the \$2,700 monthly cost in Plan C gets you to the total monthly cost of \$4,850. Divide that by 10, which is a total of the adult units. That is the weighted average of \$485 shown in the purple box. Again, per the terms of the Collective Bargaining Agreement, that's multiplied by 85% to determine the employer contribution for the premium split, which is \$412 in this example.

The numbers on Slide 12 could change as enrollment changes. Looking at the Adult Units row, Plan A has three adult units, Plan B has one adult unit, and Plan C has six adult units. If you were to switch enrollment to show six adult units in Plan A, the more expensive plan, and three adult units in Plan C, the less expensive plan, and went through the rest of the math, you would see the index rates fluctuate as enrollment fluctuates. Now I'm walking you through the example of moving enrollment. The index rate also fluctuates as the plan bid rate fluctuates. Essentially, we know our plan bid rates change year over year, and typically, if not always, increase in cost due to inflation.

If we introduce this UMP Select plan, which has a lower AV, and therefore a lower bid rate than our UMP Classic plan, as enrollment occurs in the Select Plan, that will put downward pressure on the index rate. It will also put downward pressure on the total average portfolio plan rate as enrollment moves into a plan with a lower bid rate, or lower premium plan.

Slide 13 – Determining Employee Premiums is a refresher of how the index rate plays out in determining employee premiums. We calculated a \$412 index rate, take the plan bid rate, which for Plan A was \$550, subtract the \$412 index rate and the remainder is the employee contribution. Using that idea as you introduce additional plans in the portfolio, and when those plans gain enrollment, with the UMP Select being an 82% AV plan, it will have a lower bid rate than UMP Classic. As the new plan gains in enrollment, it'll put downward pressure on the index rate that will impact the employee contribution. The weighted average nature of the index rate does not change. The 85%/15% split does not change.

When we introduced the UMP Plus plans, and even back when we introduced the UMP CDHP, this happened to the index rate.

Slide 14 – Determining Employee Premiums by Tier – Sample Illustration. This slide is not impacted by the introduction of a new plan, it's following the story all the way through as we determine employee contributions, where we start with plan bid rates.

We calculate the index rate, employee premiums, and then employee premiums by tier using tier ratios.

Slide 15 – Rate Considerations for UMP Select. When Milliman develops rates for the UMP Select, there are assumptions we will make. As we work through procurement and rate developments this summer, we will need to set premiums before we have enrollment in UMP Select. HCA will assume all memberships into UMP Select will transfer from UMP Classic in the initial year. The plan will have the same average risk score as UMP Classic. The bid rate will be calculated to only reflect the difference in cost share, which means taking into consideration the difference in the employee monthly premium that will help offset the difference to the employee in the cost share and the deductible.

For 2021 UMP Select bid rate, the employee premium will be lower, as the cost sharing is higher. For 2022 Select bid rates, the level of enrollment will inform the risk score of the population. Are they essentially healthier or less healthy than the average? Then we'll be able to have a better refinement of the projection of the plan cost.

**Elyette Weinstein:** Is there something about self-insured employers that makes this particular plan design fit them? I see the resolution refers to self-insured plans. How does that relate to the design and why was it chosen for self-insured plans?

**Megan Atkinson:** With the self-insured plan, we're clarifying that this is another offering from our Uniform Medical suite of plans, all of which are self-insured offerings, as opposed to the Kaiser Permanente offerings.

**Dave Iseminger:** Elyette, the Board's authority has two major areas: benefit design and eligibility. Specifically, for the self-insured plan, claims are with the state and owned by the state. There's a more direct control of the benefit design. You obviously, as a Board, influence the fully insured benefit design. But when we bring things to you for action later in the Board season of fully insured plans, we will only bring you the final rates, which are the embodiment of benefit design along with the rate. Here, where we build the rate after the benefit design because it's the plan that's owned and run by the state, we ask you to separately authorize the benefit design first, so it is more solidified to be able to set the rates. We present benefit design resolutions related to the self-insured plan in a way that is different than the fully insured plans because of where the claims' risk lies at the end of the day.

**Elyette Weinstein:** Thank you. That was helpful.

**Sue Birch:** Can you remind me just how we got here and how this journeyed from the SEBB Program to here?

**Dave Iseminger:** As we started the SEBB Program launch in 2018, we began the benefit design process with the SEB Board working on the self-insured medical plans that would be in that portfolio. We didn't have to do a procurement for that benefit design because it's our own state-run plan and we were simultaneously doing a procurement for a fully insured plan. The SEB Board, under legislation, was directed to consider and leverage various parts of the PEBB Portfolio, so we presented them information about the various self-insured plans that existed in the PEBB Program,

which did not include an 82% AV plan. In the SEBB population, there was additional concern with the way the lower end of eligibility is set, which is 630 hours per school year. That contrasts with PEBB eligibility, which is 80 hours per month for six months. With the wide range of income distributions, particularly as part-time classified staff in the K-12 world were getting a much larger employer contribution under the SEBB Program, there was still concern that a wider range of affordable options for all of the income distributions that existed in the SEBB population was needed. From there, we identified it would be important to add an additional AV options in the SEBB Portfolio, and the UMP Achieve 1 (82% AV) was created. UMP Achieve 1 was authorized by the SEB Board to leverage UMP Plus, UMP Classic, and UMP CDHP, which have different names in the SEBB portfolio.

I've highlighted in SEB Board updates numerous times over the last two years that advancements were being made to the SEBB portfolio; and after the SEBB Program launched, we would begin to present to you what we learned from the SEBB Program population that would work for the PEBB Program population. This is the first concrete piece. There are many other pieces we will bring to the Board over the next couple of years, or from an administrative standpoint, to implement. For example, we're working on IT developments, of which we'll keep the Board apprised. When it comes to other things we've learned about eligibility or benefit design, we will continue to tee up conversations about additional opportunities and decisions.

One opportunity we will likely be talking about next Board season is the potential for additional fully insured plans for the portfolio. There are two additional carrier options in the SEBB Program and a variety of additional plans. Some of the carriers are interested in introducing other plans with deductibles that exist in the SEBB portfolio that don't exist in the PEBB portfolio because of a need, demand, and enrollment that materialized in the SEBB portfolio. The genesis here was looking at the income distribution of staff in the K-12 world, making sure there were affordable options, and then having a similarly large situated employer population for state employees.

**Elyette Weinstein:** Thank you.

**Tom MacRobert:** Where it says Rate Considerations for UMP Select, it says rate development assumes all membership will transfer from UMP Classic. Are we saying that if you are enrolled in the Kaiser Permanente plan you would not be eligible to make that transfer?

**Megan Atkinson:** No. I thought about that as I was reading that bullet. In order to set rates for the initial year where there is no enrollment in the new plan, we need to make assumptions about the population for the entirety of the portfolio. For the initial rate setting, we're assuming some percentage of current enrollees in UMP Classic will switch to the UMP Select product. That's just a simplifying assumption for rate setting. In reality, if you adopt this resolution and we offer this plan, when open enrollment hits later this year, any PEBB Program member can choose UMP Select. It will be open enrollment to everyone eligible for the PEBB Program.

**Dave Iseminger:** Employees and non-Medicare retirees only, not Medicare retirees.

**Megan Atkinson:** It's just an assumption for rate setting. It's not about enrollment limitations. Does that help?

**Tom MacRobert:** Correct. Yes.

**Leanne Kunze:** I also was wondering about that assumption, and I appreciate your clarification, Megan, but I still have a question. What informs that assumption? It seems like there would be more likelihood there would also be CDHP folks that would move onto Select, which would have an impact. I'm wondering what the reality was when a similar plan was added to the SEBB portfolio.

**Megan Atkinson:** When we offered it for the SEBB portfolio, it was the initial year of the program. We went from zero enrollment in SEBB Program overall, because it was our initial launch year to enrollment in all plans. Part of the assumption is going back and looking at how enrollment went into the CDHP and the Plus plans when offered. It's one of those simplifying assumptions we make so we can move forward with rate development. It's not intended to be a crystal ball representation of what reality will be.

**Ben Diederich, Milliman:** I will add, to some degree because we risk adjust the projected cost for the program, it doesn't necessarily matter what the switching assumption is going to be because every bid rate for each individual plan is developed to represent the entirety of the portfolio. When we estimate the bid rate, it doesn't matter what the switching is going to be as much as it matters what the benefit relativity is between the two plan options.

**Leanne Kunze:** And my follow up question to that, it would appear it has the greatest impact on the employees' portion should they remain on UMP Plus with an assumption like this, correct? On the rate setting?

**Dave Iseminger:** Leanne, can you say that question one more time? We got puzzled when you said UMP Plus.

**Leanne Kunze:** Yes. Going back and looking at how the index works and how it is spread across, those in a Collective Bargaining Agreement having that 85%/15% split, how would that impact the amount of the employee portion? We get it's still 85%/15%, but the likelihood of that amount increasing for the employee, dollar for dollar, if they remained in UMP Plus versus moving. Wouldn't there be an impact as a result?

**Dave Iseminger:** Just to clarify, I think you are meaning to say UMP Classic instead of UMP Plus. UMP Classic being the core and where most people are enrolled. Do you agree that I think we're answering your question in the context of UMP Classic?

**Leanne Kunze:** Actually, no. I'm looking at the people who have chosen UMP Plus, and for whatever reason, they are just going to hold on, "I'm going to be UMP Plus period." Wouldn't their premium likely go up as the Select plan comes in, with an assumption that all Classic moves to Select?

**Ben Diederich:** As the Select plan gets introduced, because it has a lower bid rate, as more and more people select that option, the index rate will be decreasing, and that will



increase the contribution on all plans, as if we were to take the counter case of UMP Select not being introduced.

**Megan Atkinson:** I will also make a clarifying statement, Leanne, because we are not going to be assuming that all of the Classic population switches over to UMP Select. We are going to be assuming a fraction of the population switches over to UMP Select. That's the assumption we will use to help us set the index rate.

**Dave Iseminger:** That assumption is based on the historical introduction of both UMP Plus about five years ago and UMP CDHP about nine or ten years ago. Both of those came in when they were originally introduced around 5%.

**Megan Atkinson:** Yes, we're assuming a fraction of the UMP Classic population will switch over to this new plan, and that allows us to have the enrollment in that plan for purposes of calculating the index rate.

**Dave Iseminger:** The other thing I'd like to add for additional context is, when we look at the enrollment trends that happened in UMP Classic, UMP CDHP, and UMP Plus, what typically happens is Classic remains pretty stable. The uptick in enrollment in a new plan is newly eligible PEBB Program members interacting with the portfolio for the first time. After that initial switch happens, most of the uptick in enrollment in the new plan is based on new enrollment into the PEBB Program population, not additional switching year over year.

**Sue Birch:** Slide 16 - Resolution for vote.

#### **Resolution PEBB 2020-06 - Self-Insured Plan Offering.**

**Resolved that,** beginning January 1, 2021, the PEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks, and the same clinical policies as the Uniform Medical Plan Classic. The cost shares (deductibles, out-of-pocket maximums, coinsurance for services, etc.) will be the same as the UMP Classic, except for the following:

- Annual Deductible (medical): \$750/\$2,250 (single/family)
- Annual Deductible (drug): \$250/\$750 (single/family)
- Out-of-Pocket Maximum (medical): \$3,500/\$7,000 (single/family)
- Coinsurances: 20%/80% (member/plan)

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

[As a non-voting member, there was a question as to whether John Comerford could make a motion. During a review after the Board meeting, it was identified that per PEBB Board By-Laws, the non-voting member has the same privileges of all Board Members, except for the actual vote.]

**Diane Sosne:** Good afternoon. I don't know the number of people on the call, but I wanted to do a shout out to Yvonne Tate who I worked with years and years ago at Group Health, I believe.

**Yvonne Tate:** Yes.

**Diane Sosne:** I'm a registered nurse and President of SEIU Healthcare 1199 NW. We represent 32,000 nurses, doctors, professional, technical, and service health care workers in Washington State and Montana. I, myself, am a nurse. We are part of SEIU International Union. It's a two million member union in the US, Canada, and Puerto Rico, the largest health care union in the United States. Both our local and Washington State represents a lot of state employees who are covered by PEBB, as well as public employees, and state employees in other states. So, I appreciate this opportunity and the lively discussion about this new plan.

I have several points I want to make for the Board's consideration and deliberations. We believe that basically, and we think this is shared in this state, the main goal of health insurance is to keep people healthy, prevent disease, that we should have more of an emphasis on a wellness system than a sick system. But we do obviously need value-based purchasing to keep people healthy and have excellent care for chronic disease.

There has been discussion about how you control costs, and if you think about the fact that - and I think this statistic is still applicable - roughly 80% of health care costs are attributed to 20% of the covered insured population. That probably varies a little bit, but generally. Now with COVID, I think there may be some new assumptions. There was talk about some assumption other presenters made, that we have a new world now, that when this plan was designed, it was not COVID. Now I think we have to think about a COVID world, and not just in terms of whether people get sick and get COVID, but what COVID has done to the economy in Washington State, employment, etc.

I had also sent some correspondence. Shane Hopkins, our Executive Vice President, and I sent the Board some correspondence with a white paper. I want to make a correction on that which is we refer to a \$750 deductible as a high-deductible plan, but we know that it is not technically the definition in the Affordable Care Act, and that it doesn't come with an HSA or an HRA.

And then there was the point, I think Dave or maybe somebody else on staff made, about the trade-off between, as an employee, you either pay more in deductible and less in out of pocket, visits and copays, coinsurance, or vice versa. The comment was made that this would help offset costs. Well, it only helps offset costs. I looked at the \$38 premium for the employee versus \$138. If the insured, let's just take an individual now, takes that hundred dollar difference a month savings that they're not putting into their premium and puts it into some type of dedicated health care savings account so that, at the point they have to pay for care, they have the money to pay for their deductible, up to \$750. And when they do visits, they have the extra 5% to pay for the office visit, as well as the extra money to pay on medications.

When we think about, as a health care union, health care employees, and taking care of the public, we want to have no barriers for chronic conditions like heart disease,

diabetes, pulmonary disease, asthma, those types of things. We don't want any kind of barrier for someone to then either get the diagnosis in the first place or have good treatment in the second place. It's sort of like the view of, is this a better financial deal for people? It's really in the pocket of the beholder.

2018 data show pre-COVID, 4 in 10 adults couldn't cover a \$400 emergency. The New York Times had an article in April, since COVID, it's even worse. Many people are living paycheck to paycheck due to the cost of housing, childcare, student debt, medical costs. And even though we're talking about a state employee population that is employed, we look at the high rate of unemployment in the state. You have to look at the entire family income. We have many state employees who have spouses or partners that are unemployed. So I think all of this raises a concern about will people who are choosing their insurance plan pick the option of, "I need the money now. So I have asthma, I have diabetes, I have whatever, but I need the money in my paycheck now, so I'm going to go for the \$38 a month premium" - versus -- they should be going in to manage their chronic disease, or have it diagnosed. We know there is a very high percentage of people walking around with diabetes and don't know it. Will there be that barrier and they'll put it off? I think even with education and saying you need to think about this, it really runs the risk of putting people, state employees who choose this option, and haven't done best practice around putting the \$100 they're saving into an account to pay for the deductible, at risk of a barrier to seeking care.

So I understand that at this late date, and also because the SEBB plan is so new, there isn't data to look at how this has affected roughly 30,000 people. Dave, I think you mentioned that 18,000 of the PEBB population, employees, took advantage of the \$250 money to help offset costs. That's a fraction of state employees. And there's a lot of questions about do people put off important care?

I appreciate the opportunity to raise these questions because I think with COVID and what we need to be doing as a state and a country around health care, we should not be promulgating policy and benefit plan designs that, in fact, can make health care outcomes worse. I raise this for consideration. I realize you're very far down the road in your process. I'm glad to answer any questions, but I think there are some significant issues that I have not heard discussed. Again, I think the arguments, the presentation, very well done. But it did not take into effect a number of the points I'm raising.

**Sue Birch:** Thank you, Diane, for those comments.

**Tim Barclay:** I would like to have a little discussion with the Board about this new plan. In fact, I'd like to advocate that the Board not approve it and not add it to the portfolio at this time. What I'd like to do is lay out a little bit of my rationale. My point is, I don't think we're adding real value for members here. And I think in fact, we could be deceiving them into making a bad choice.

Rather than comparing UMP Classic to UMP Select, I'd like to compare the CDHP to Select. On Slide 4, note CDHP is a better health plan. Just at a high level, we know it has an 88% actuarial value versus UMP Select, which we know has an 82% actuarial value. On the face of it, to begin with, we know CDHP is a better benefit package for members with a cheaper premium. If we look at the details, we can see why.

Take an individual, for example. We know they get \$700 contributed to their HSA account, which offsets the single member deductible of \$1,400, essentially creating a net single member deductible of \$700, which is better than the \$750 in the Select Plan. Similarly, for a family you get a \$1,400 dollar contribution to offset the \$2,800 family deductible, leaving a net \$1,400 dollars, which is better than the \$2,250.

In terms of out-of-pocket maximum, doing the same math, you'll find the out-of-pocket maximums are the same between the two plans and the coinsurance is better in the CDHP than in the Select Plan. If you go through and do the analysis, looking at sample claims at various levels, from a few hundred dollars to thousands of dollars, what you'll find is that consistently people fare better under the CDHP than they do the UMP Select. Simply put the CDHP has a better health plan.

There are cash flow timing issues. The CDHP doesn't put the \$700 in your account January 1. However, I would argue that people who are expecting expenses in January, aren't going to sign up for the CDHP for the first time. If you don't use your CDHP \$700 HSA, or your \$1,400 HSA, it's not like a medical Flexible Spending Account (FSA) because you don't lose it. It carries forward into the next year. People who have maintained enrollment in the CDHP oftentimes build a balance and become better off over time.

In my mind, the UMP Select option is worse than an option that's very comparable that we have on the table now with a higher premium. I fear people who select this plan will be picking it because they don't understand the nature of the CDHP. I think we'd be far better off educating the membership and encouraging CDHP enrollment, which to me is a great value. I also think it's consistent with trying to get people to own their health care dollars, they're responsible with how they spend, it gives them the money upfront. It's not a huge barrier to seeking basic coverage because you get the contribution to your HSA. In my mind, it's just a better option than UMP Select. When I look at the portfolio, I question what value we're adding by putting in UMP Select. It just doesn't make sense to me.

With that, I would urge the Board not to add this benefit plan, not to add a reduced AV, not to pass cost shifting onto members, which is what it does, not to reduce the index rate, which is what it does. I will be voting no on the proposal.

**Sue Birch:** Thank you, Tim, for those comments. Dave, Megan, or Ben, could I ask for clarification on how the CDHP equals the 88% AV?

**Megan Atkinson:** What Tim is addressing, on Slide 4 you can see UMP Classic, the CDHP, and UMP Plus showing their actuarial value estimates. Again, actuarial value is a way of quantifying the percent of the costs shared between the employer and the employee. A higher AV means that more is borne by the employer. A lower AV means more is borne by the employee. The CDHP has such a high actuarial value, which is not typical of a CDHP, because in the PEBB portfolio the CDHP comes with an employer contribution to the HSA. If we didn't have the employer contribution Tim was addressing earlier, the \$700 for the single, then the AV for the CDHP would be about 82%, which puts it in line with the actuarial value of UMP Select.

For clarification, HSA contributions accumulate with no expiration on those funds. Tim, I think that's the point you're making, which is a critical difference in terms of thinking about the actuarial value.

**Dave Iseminger:** I would just add that the employer contribution under the HSA plan is something that has never changed in the PEBB Program since the introduction of the CDHP plan in the portfolio in 2012. The comparable plan set up in the SEBB Program is the same plan design as the UMP CDHP in the PEBB Program, but the employer contribution in the SEBB portfolio is \$350, half of the PEBB Program contribution. There are a variety of analyses that go into place setting the employer contribution. Although the \$700 amount in the PEBB Program has not historically changed, it's always a possibility. It is not controlled by the Collective Bargaining Agreement, but a creature of when the plan was born. I do have concerns, as we go forward with state budget discussions, that there are going to be many things that have been on the table across state government that historically have never been evaluated or considered. I think it's prudent for us to also keep that in mind, that \$700 is not a firm number that's required by the IRS or the Collective Bargaining Agreement. It can be changed and directly impacts the AV, as Megan described. If there was no contribution, the plan would be roughly 82% AV.

**Tim Barclay:** Dave, could we clarify though? You're not suggesting that it could be changed for the next plan year?

**Dave Iseminger:** Correct.

**Tim Barclay:** You're not suggesting that people could sign up for it and all of a sudden be blindsided by a change? We're locked into this for next year.

**Sue Birch:** For 2021?

**Tim Barclay:** Correct.

**Sue Birch:** We're not locked in beyond that, because we have a very rough state budget process occurring before us because of COVID. I hear Dave saying that while it's currently in the budget, if the climate continues, and me being an executive, along with my team, that has to cut nearly \$500 million by next Monday. This isn't something we would recommend, but if the Legislature were to go rogue and look at things to cut, I think Dave's point is this is a creature of the past it may roll to a different construct.

**Dave Iseminger:** I would add, Tim, it's hard for me to say that there are no circumstances in which the HSA could change for 2021 because there's been discussion that there may or may not be a special session of the Legislature. Once rates are set by this Board in July, there are 60 days between now and when all kinds of creative things can happen. And all sorts of things have happened in the last 60 days nobody would have anticipated. I wouldn't say it's completely 100% locked in for 2021. It's an extraordinary series of events that would need to lead to a change in that HSA contribution for 2021. It's unlikely, but possible.

**Sue Birch:** It's not something HCA is recommending, but we have been told there are no sacred cows, everything will be examined.

**Harry Bossi:** I really appreciate Tim's insights and I've come to agree with everything he said. The bottom line, my main concern is I think this is adding a plan that doesn't add value to a portfolio that has great options for every level of income that employees have. It has options. I think this adoption would add confusion without bringing value. There's really, as Tim pointed out, little difference between it, ultimately, with the cost factors in the CDHP, whereas the CDHP is a much better value.

Another point that wasn't brought out was with the HSA connected to the CDHP, the employees also had the ability to contribute their own, if they're in a position where they have money, so it helps them down the line to save towards retirement or some other factor. At any rate, I think Leanne also made a point of concern that was borne out in the presentation that this would potentially drive down the index rate, which I think then hurts far more people than those that might be helped by adoption of this additional plan. I'm sorry to ramble, but I think I will be voting no, as well. Thank you.

**Elyette Weinstein:** I do appreciate all the possibilities presented by the staff. They're very knowledgeable and prepared. However, Tim has presented to us, in addition to the staff, what the facts are today, and that's what we're voting on. There are many possibilities. The Collective Bargaining Agreement on the Health Services Account contribution could be renegotiated upwards. We just don't know what could happen. Frankly, we could have an income tax. Anything is possible, but personally I always find I need to vote on what the facts are, the actual facts before me, and not get caught up in what I think may happen because I'm always wrong. Thanks.

**Leanne Kunze:** So this may be extremely rare, as my other hat is as a labor leader, and I very much want to say thank you and appreciate Sister Sosne's remarks earlier today and look forward to some plan design options on how we could possibly consider improvements in the future regarding health outcome. And in contemplating my vote, I have to say, it's not an easy one, especially knowing my position and beliefs in what I believe our national health care system is lacking. But I also want to recognize in our state health care system, I see significant commitment and understanding of wanting to have plan designs that have a focus of good quality health outcome, as there's recognition in the bigger picture of how that impacts our state budget, and how it impacts the community who makes the state what it is.

And I just want to correct, because when I raised questions about the assumptions, I also don't want it to be assumed what my intent was with that question. I actually believe that it appears, how I'm understanding it, that it would actually create a stabilizing pressure on the state index rate while we're in the fight of our lives, and in an economic downturn that probably none of us have ever experienced before. With the impacts of the pandemic on our state budget, in addition to health outcomes, I'm very concerned that delays in this decision would actually exacerbate the budget gap, and risk way more draconian cuts in the future. I trust the recommendations of the HCA staff in adding this choice, and also in recognition that, while it may not be a large percentage of the members that I represent in my other role, I recognize that all across the state there are several areas where employees have no choice. I think adding this choice, and having the access to the Collective Bargaining Agreement for those who are making lower wages, does create an option and choice for those who we would be concerned would be making those decisions based on financial need.

I believe this actually is a wise move as a Board to support this motion. As odd as that may sound, where people may make an assumption that I'd be voting one way or another based on what I believe our health care system should look like, I believe that this is the right thing to do for the impact that it would have on the state budget and overall health outcomes in the long term. So, I will be voting yes.

**Tom MacRobert:** I want to make sure before I ask my question, it is my assumption that the main reason we are proposing to add UMP Select is because we have people who do not make as much in income and cannot afford some of the other available plans? For them, this is going to become a more affordable plan? Is that a correct assumption on my part?

**Dave Iseminger:** I would say the reasons are truly multifaceted. I don't think it's fair to say that it boils down to one specific piece, as you've highlighted. As time has gone by, the reasons for evaluating UMP Select and possibly supporting this proposal have changed. One or two months ago, none of us would have been mentioning the state budget impact and the wide-ranging cuts state agencies are looking at for not just the next biennium, but the next fiscal year, which starts in roughly 30 days.

State agencies have been directed to identify budget cuts of 15% for the whole state, which is equivalent to cutting the PEBB and SEBB Programs three times for a single year of permanent cuts. That's the level and there is no part of state government that is going to be unaffected by these budget constraints. That was not the crucible in which this was brought forward, but it's also a reality that we know today is an important consideration.

Again, when I previewed different parts of moving and evaluating SEBB Program options that came up into the PEBB portfolio, a fiscal crisis of multi-billion dollars after a global pandemic was nowhere on anyone's radar. It is also a reality of our current circumstances and part of the calculus now, even if it wasn't at the time.

**Megan Atkinson:** I would say it came about because it was a plan offering we identified we needed to have for the SEBB Program launch last year to have plan offerings that appealed to a wide range and variation of K-12 employees. What we saw after open enrollment this past fall in the SEBB Program was a considerable amount of population going into the plan. Given those things, it fills an AV hole in the PEBB portfolio. Those were the motivators for bringing it forward. But to Dave's point, looking at hundreds of millions of dollars in budget reductions at the Health Care Authority and its programs, it does have cost containment levers as well.

**Tom MacRobert:** I want to thank Tim because he's presented some information that, quite frankly, I would have never considered. I think that's going to be an important factor in determining my vote.

**Tim Barclay:** I think it's important to remember that CDHP is a better plan for members. It's a cheaper plan for members. If we educate members about the real value of the CDHP, we show what really happens to people in their claim costs under the CDHP relative to Classic. If we could actually move people from Classic to CDHP through an educational process, that would have more benefit to the state in cost savings than getting people to take UMP Select. I believe the bid rate is lower for the

CDHP than it is the UMP Select. While I appreciate people's concerns about the budget, I would still argue that the CDHP is a better plan of attack. I think it's a better plan. I think it's a cheaper plan. I think it's better for the member. I think it's better for the state. And I think it's better health care policy, in terms of its benefit structure, than a straight higher deductible plan. So, I still would argue, in spite of everything everybody said, that the education of people, and the movement of people to CDHP, is the much better plan of attack for the agency than introducing UMP Select.

**Sue Birch:** Thank you, Tim, for those comments. Are there other Board Members that would like to comment?

**Yvonne Tate:** Well, my question to staff was going to be what education plan they had anticipated for communicating the UMP Select Program so members could fully understand it.

**Megan Atkinson:** I want to talk about a couple of things. It's not an either/or, so I think the issue around helping people understand the CDHP and educate them about understanding deductible, understanding with a monthly premium share, understanding the maximum out of pocket. That's also an area where people aren't as financially literate about purchasing their health care as we would hope. I think there are opportunities for improved financial literacy on health care. I include myself in that bucket of not always thinking through my personal health purchasing decisions for my family. That's one thing. Unfortunately, folks tend to be reluctant to move to a CDHP if they're not understanding the financial levers.

**Dave Iseminger:** Yvonne, we'll draw from the experience we had in the SEBB Program because the SEBB Portfolio has many more plan options with AVs down to 80% and premiums that went as low as \$13. There was a theory that going into the SEBB Program launch people would purely shop based on premium amount. As we got to the end of open enrollment and saw the results, that hypothesis failed because the majority went to the higher AV plans with a higher premium. I think that happened partly because we were very diligent in the SEBB Program launch about not publishing the premium amount in isolation. We always aligned at least the deductible next to the premium. Depending on formatting constraints, we would include out-of-pocket maximum as well. We never left premium isolated as its own single data point.

This was discussed with Regence that going forward, their UMP communications needed to align the premium, deductible, and wherever possible, the out-of-pocket maximum.

We hoped these indicators would help people. If they aren't understanding what the deductible is on the page, they would at least know there's something they need to be asking about because why would this number be here next to the premium if it wasn't important for me to understand. Our education campaign is more a result of the SEBB Program to ensure we are always talking about at least deductible, and wherever possible, out-of-pocket maximum, alongside premium. We would do the same thing here.

**Sue Birch:** Can you help me understand the cash flow for the HSA that Tim mentioned?



**Dave Iseminger:** Tim mentioned in his opening comments a cash flow issue that might happen for some members. And I think that's good to elucidate more what that means.

When you come into a CDHP HSA plan, you start with no money in your Health Savings Account. The \$700 employer contribution is prorated across the year, at the end of each month. That means for the entire month of January, you don't have access to any HSA funds and you're facing the \$1,400 deductible. You are fronting that deductible throughout the year until December 31 when the \$700 contribution is complete. For individuals who don't have money in their HSA, that first year is particularly risky, especially for risk averse individuals that may have an unexpected expense and they have to front that money. The cash flow piece is a barrier and concern that I hear from individuals about stepping into CDHP.

I'll tell you my own personal story about CDHP. I was very skeptical of it at first myself. And I waited until I had a sufficient personal emergency fund to be able to cover that deductible. And we know, generally, Americans don't tend to be savers.

**Sue Birch:** Thank you for that information. Final call from Board Members for any last questions.

**Elyette Weinstein:** I believe everything staff has said. Comments that suggest we need to help the state balance its budget off the backs of workers, however, and I'm not saying that our staff is advocating or implying that at all, they're stuck in a very tough situation. However, having worked in the Legislature for years, I don't see such a concern about balancing the budget when certain industries come into the Department of Revenue and get tax exemptions. For example, the oil and gas industry and the nuclear industry. I have seen it myself. So, frankly, I am going to vote with Tim, because having seen the pipeline of money coming out of the Department of Revenue, foregoing tax revenues, I simply can't in good conscience try to balance the employers budget on the backs of workers, based on what Tim said. I just can't morally do it.

**Sue Birch:** Thank you for those comments. I want to make some closing comments and then I am going to call for the vote. As you all know, I'm a nurse. I have very strong feelings about maintaining coverage. I believe more choice gives more people the opportunity to figure out their coverage, and I was a skeptic until I saw what happened in the SEBB Program launch. The education the team has done about helping people pick the best plan for them is why I will be supporting staff's recommendation. I think all parts of this state, in total Elyette, not just from HCA, have to really pitch in and look, what are we going to do to keep driving efficiency and what are we going to do to maintain coverage?

I believe that it is wise for us to proceed with this, and approve this benefit design, because I believe the staff can handle helping members make the most appropriate choice. And I believe we are going to have some very unique circumstances about workforce, people coming on, government might having to swell up and employ people for a year or two while we are trying to restart this economy. And I don't think it diminishes our portfolio. It certainly didn't diminish our portfolio with SEBB. I think it just adds value to what UMP does and it adds value that employees have more choice. If we were in a very lush environment, I might think otherwise. But I don't think it hurts to move this forward.

And finally, I would just suggest that there are enormous gains when we look at consolidation for PEBB and SEBB Programs. In lieu of us moving away from SEBB Program, I think it is unwise, and at this point, I would urge the Board to carefully consider their votes.

I want to thank the staff that really worked hard, and worked with our actuarial team too, to look at this to make sure it was still viable and suitable for employees to choose. With that being said, I'd like to do a roll call vote.

Voting to Approve: 3  
Voting No: 4

Voting Yes: Yvonne Tate, Leanne Kunze, Sue Birch  
Voting No: Harry Bossi, Elyette Weinstein, Tim Barclay, Tom MacRobert

**Sue Birch:** Resolution PEBB 2020-06 fails.

**Sue Birch:** I thank the Board for their lively comments and discussion, and the staff for bringing this issue forward.

**Agenda Item: UMP Vision Proposal**

**Shawna Lang**, ERB Division Account Manager discussed a Uniform Medical Plan Vision Proposal.

Slide 2: Background. In 2018, the Uniform Medical Plan (UMP) procured and Regence included the Vision Service Plan (VSP) in the bid for vision care.

For 2020, UMP's former Regence vision solution continued for PEBB Program members for one year only. The SEBB Program launch needed many procurements and HCA had resource constraints.

Slide 3 – PEBB UMP Current Vision Benefit. The current vision plan for adults is 12 months between exams, 24 months between fittings, and 24 months for lenses (12/24/24). It's the same for children, except children get scratch resistant coating, polycarbonate lenses, and one pair of glasses per year. There's an out-of-network benefit at 60%, with the only exception of 50% for UMP Plus.

Slide 4 – Proposed PEBB UMP Adult Vision Benefit. The VSP Vision Care option for 2020 is also 12/24/24. In-network is zero copay for exams, a \$30 copay for in-network contact lens fitting fee, and \$150 allowance every two years for frames.

Slide 5 – Proposed PEBB UMP Pediatric Vision Benefit. This benefit is 12/12/12, with no cost for exam and 100% allowed for glasses and contacts.

Slide 6 – Overview Summary. Advantages for UMP members going to VSP are lower out-of-pocket costs when using VSP providers, lower claims cost because of provider discounts, nationwide network of over 96,000 access points including Costco Optical, Walmart, and VisionWorks. There is also collaborative management of members with

chronic conditions like diabetes through eye health management. A concern may be that some members may need to find a VSP Choice network provider to receive the highest level of benefit.

**Sue Birch:** Slide 7 - Resolution for vote.

### **Resolution PEBB 2020-07 – UMP Vision Benefits.**

**Resolved that**, beginning January 1, 2021, the vision benefits for all UMP plans in the PEBB Program will align with the coverage as presented at the April 15, 2020 Board Meeting.

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

Voting to Approve: 7

Voting No: 0

**Sue Birch:** Resolution PEBB 2020-07 passes.

### **Agenda Item: Expanding PEBB Medicare Options Update**

**Ellen Wolfhagen**, Senior Account Manager, ERB Division. Slide 2 – Background. At the January Board Meeting, we talked about MA-PD, which are Medicare Advantage Plans, including prescription drug, or Medicare Part D coverage. Today's discussion doesn't replace an existing plan but is in addition to the current Medicare Advantage portfolio offerings.

Slide 3 – Medicare Advantage - Plus Prescription Drug (MA-PD) Recap. MA-PDs are private insurance plans that cover all Medicare benefits, including Part D drug benefits. Centers of Medicare and Medicaid Services (CMS) pays the carriers for the cost of administering Medicare Part A and B, known as Original Medicare. Drug benefits are subsidized under MA-PD, allowing plans to set their own copays. Many plans offer supplemental benefits such as alternative therapies. Dental coverage is not included in the proposed plans.

Slide 4 – National MA-PD Coverage Recap. The national MA-PD coverage means that members can see any provider who accepts Medicare, and there's no differential in copays for in- or out-of-network nationwide, including the US territories of American Samoa, Guam, Northern Marianas, Puerto Rico, and the US Virgin Islands.

Slide 5 – MA-PD – A Proposed Addition to Medicare Coverage. The MA-PD is a proposed additional plan offering. UMP and Kaiser Medicare Advantage plans are still available, and the Premiera supplemental Plan F and Plan G are still available.

Slide 6 – Current Medicare Plans' Basic Medical. Current plans cover about 99,000 Medicare retirees across all plan offerings. UMP has a deductible, the Kaiser plans do not. The maximum medical out of pocket is separate from the pharmacy out of pocket. The maximum medical out of pocket is \$2,500 for UMP, \$1,500 for Senior Advantage, and \$2,500 for Kaiser WA Medicare.

Slide 7 – Proposed MA-PD Basic Medical. Two plans are proposed. Plan 1 is the zero-deductible plan, zero copay. It has the higher potential premium. Plan 2 is a balance between copays and a lower premium cost.

Slide 8 – Current Medicare Plans' Supplemental Benefits. Under our current medical care plans, CMS categorizes supplemental benefits as more than basic medical. These would include chiropractic, acupuncture, massage therapy, as well as vision, hearing, gym membership, etc. The worldwide travel benefit is not under UMP because UMP is an original Medicare program. It doesn't have that kind of coverage.

Slide 9 – Current UMP Medicare CAM Utilization. HCA looked at the current UMP Medicare chiropractic, acupuncture, and massage benefits (CAM) utilization. There is a very high usage of massage benefits. The difference between the top table and the bottom table, is the bottom shows people who use the benefits above and beyond their full benefit allowance. In 2019, more than 2,700 people used more than the base amount of massage. Based on these tables, massage is the most commonly used benefit.

Slide 10 – Proposed MA-PD Supplemental Benefits. As we looked at the proposed MA-PD Plans, we talked with United about increasing the massage benefit. The proposal includes an adjustment to 30 visits per year. Based on utilization in UMP, we decided to propose increasing the flexibility for members to choose either chiropractic or acupuncture by combining and increasing the benefit allowance numbers. Members can choose all of one, or they can mix and match.

We also propose increasing the vision hardware benefit, which is higher than under UMP, and the hearing aid benefit, which increased to \$2,500 every five years. It's more coverage but less frequently than under UMP. Mental health counseling is part of basic medical, but these plans also provide tobacco cessation counseling.

Slide 11 – Creditable Drug Coverage vs. Part D. The proposed plans include Part D coverage. The difference between creditable drug coverage and Part D is that creditable coverage means it's as generous as, or more generous, than Medicare Part D. The plan costs are reflected in the rates. Part D plans receive subsidies from CMS for about 74.5% of costs, which allows for lower prescription costs.

Slide 12 – Current Medicare Plans' Creditable Drug Coverage. There is a pharmacy deductible for UMP and a cap on what members pay out of pocket. This is a separate out-of-pocket maximum, separate from the medical. The Kaiser plans do not have a cap on pharmacy expenses, which means it is possible there is no maximum. Members are on the hook for the total coverage of drugs.

The UMP plan has specialty drugs, but their coverage only applies for drugs listed in Tier 1 and Tier 2. The amounts are for a 30-day drug supply.

Slide 13 – MA-PD Part D Coverage. The proposed MA-PD Part D coverage has only one table because it's the same in both plans. There is a pharmacy deductible. It's zero dollars for Tier 1 drugs and \$100 for Tier 2, Tier 3, and Tier 4, with an exception, which I will talk about in a minute. The maximum pharmacy benefit out of pocket would be \$2,000. The quoted prices are for a 30-day supply. The difference about the copay

is on preferred insulin brands, which would be \$10 per month maximum, is not subject to the deductible for 5% of the cost. The specialty drugs are included in the formulary. That's different than our current offerings. I would also note that the formulary is substantially similar to the UMP formulary, but there are differences in some brand name drugs.

Slide 14 – Comparison Highlights. Less out-of-pocket expense for retirees: lower premium, no deductible or lower maximum out-of-pocket limits; a plan option with zero cost share; and reduced pharmacy costs.

Enriched benefit design: more alternative benefit options, a combined and increased chiropractic and acupuncture visit limit, increased massages, an over-the-counter drug benefit, meal delivery service, enhanced vision and hearing aid hardware benefits.

National network of Medicare providers: no difference between in-network and out-of-network, in terms of cost share; extensive provider network, which allows for ease of access to care; and an enhanced worldwide travel benefit.

Part D coverage: retains the \$10 insulin cost share, which is what is under UMP Classic; retained maximum out-of-pocket limit, like UMP Classic; includes specialty drug coverage; expanded national pharmacy network; and includes both large chains like Walgreens and Walmart, but also smaller local pharmacy retail.

**Tom MacRobert:** In “Comparison Highlights,” it says one of the enriched benefit designs is combined and increased chiropractic and acupuncture visit limit. Isn't that incorrect, because you said you combined it, but the total is 20. Under the current plan, you actually have 26, I believe 10 acupuncture and 16 chiropractic. I could have them reversed. So actually it's less visits, you just get to choose how you want to use them.

**Ellen Wolfhagen:** I'm sorry, Tom. You're right, it's the 20 visits. And that's true, it is smaller than the 26 currently available, but those are limited by the split. So having the combined benefit means that people can choose how they prefer to use those benefits and could get more acupuncture or more chiropractic visits than under the UMP Classic design.

**Tom MacRobert:** Right. I understand that, but I was just correcting the number because it seemed to imply that there are actually more total visits and there's less. For the record.

**Ellen Wolfhagen:** Thank you for pointing that out.

Slide 15 – Board Process. Today, you'll be asked to look at a resolution on split accounts, which is coverage for non-Medicare eligible dependents. But the rate resolution will come to you for a vote in July.

Slides 16 -17 – Communication Strategy. Pre-open enrollment, United Healthcare will do some town hall meetings and they will almost certainly be in a virtual format. They will be coordinated with, and approved by, HCA.

In terms of open enrollment, benefit experts will be involved with benefits fairs, whatever form they are. There will be some sort of breakout session or webinar to explain new options. Plan guides will be available at the start of open enrollment providing a summary of benefits and a short list of the most common drugs included in the Part D benefits.

**Agenda Item: Policy Resolutions**

**Rob Parkman**, Policy and Rules Coordinator, ERB Division. Slide 2 – PEB Board Policy Resolutions. There are two resolutions before you today for action. One deals with Default Enrollment for An Eligible Employee Who Fails to Make a Timely Election, and the other for Medicare Advantage Prescription Drug (MA-PD) Plan Enrollment.

Slide 3 – Resolution PEBB 2020-04 Default Enrollment for An Eligible Employee Who Fails to Make A Timely Election. This resolution deals with eligible employees who fail to make elections within the timeframe and what would happen to those employees' elections. Since the last meeting, there's been no changes to this resolution as it was presented at the April 15 Board Meeting. We are bringing it back today for action.

**Sue Birch:** 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.

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

Voting to Approve: 7

Voting No: 0

**Sue Birch:** Resolution PEBB 2020-04 passes.

**Rob Parkman:** Slide 4 – Resolution PEBB 2020-05 Medicare Advantage – Prescription Drug (MA-PD) Plan Enrollment. This slide has strikeouts and underlines under this resolution. We received feedback on this resolution requesting we change “elects to enroll” to “selects.” This clarifies that a subscriber could be the non-Medicare enrollee, and they will be enrolled in the Uniform Medical Plan UMP Classic and not in the MA-PD Plan. When I introduced this at the last Board Meeting, I had two examples. The concern was the resolution as presented at the April Board Meeting did not support Example 2 well. We believe this change will support both Example 1 and Example 2.

Example 1 is Sally, a 67-year old retiree. She is Medicare eligible. Her 60-year old husband, Fred, would be a non-Medicare employee or enrollee. If retiree Sally, the subscriber, selects the MA-PD Plan, in this case her husband Fred would be enrolled in UMP Classic if this resolution passed.

Example 2 is the reverse of Example 1. Retiree Sally, 60 years old, is a non-Medicare retiree at this point. Husband Fred is 67 years old and Medicare eligible. Since Sally is a subscriber, she selects the MA-PD Plan for her husband Fred. Sally, who is the non-Medicare person, is enrolled in UMP Classic. We're recommending the change to remove "elects to enroll in" and add "selects" in its place.

**Sue Birch:** Resolution PEBB 2020-05 Medicare Advantage - Prescription Drug (MA-PD) Plan Enrollment

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

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

**Fred Yancey,** Washington State School Retirees. I'm a little confused here. What if I'm Medicare eligible, I pick an MA-PD Plan, but my wife is not Medicare eligible and she's in Kaiser. She would have to shift to Uniform Medical? Is that my understanding?

**Dave Iseminger:** Yes, Fred. That's the exact scenario we're describing. If your non-Medicare spouse is on a separate account with complete independent enrollment eligibility and enrollment benefits, and you're not enrolling them as a dependent, they can stay on their account and do everything. But if it's all synthesized on one account and you have, for example, a married couple where one's Medicare age and one's non-Medicare age, and they're on the same subscriber account being enrolled as a subscriber and a dependent, the non-Medicare person would be on UMP Classic, if the Medicare person is on MA-PD. This is if they are on the same subscriber account. We call that a split account because it's literally one account that has a Medicare and non-Medicare eligible individual on it.

That exists today in the portfolio. What happens today is that you stay with the same carrier for both parts of the account whenever possible. The challenge here is United doesn't have any plans in the non-Medicare portfolio. There has to be some linkage to a plan for that split account feature. That's what this proposal is saying in that specific scenario, how the enrollment would happen on this account.

**Sara Whitley:** This is the same scenario for Medicare retirees enrolled in our Premera plans now. If there's a non-Medicare dependent, then that dependent is defaulted into UMP Classic or enrolled in UMP Classic Medicare.

**Fred Yancey:** I'm in Premera and my wife, if I move to MA-PD, would have to then move to Uniform Medical Plan Classic in this scenario?

**Dave Iseminger:** Fred, if you are enrolled right now in a Premera supplemental plan, and your wife is a non-Medicare eligible individual who's enrolled as a dependent on your account, she should already be enrolled in UMP Classic per prior implemented Board decisions. But if she's on a completely separate account, she can be enrolled in whatever she wants.

**Fred Yancey:** Right, I understood. Do you have any sense of how many people this is going to affect, who have to shift into Uniform Medical, or it sounds like maybe nobody does.

**Sue Birch:** Fred, it would be if they choose to do the MA-PD Plan through United, it impacts them if that was their selection. Then they've got to come over.

**Dave Iseminger:** If nobody switches, nobody's forced to do anything. In those instances, with the split account, that's why this resolution is before the Board so we can educate people while they're making an open enrollment selection if they were choosing an MA-PD Plan. This is what comes with it if you have a non-Medicare spouse you're also covering on the same account. That way they can make an informed choice. It's part of the calculus as the member is deciding whether or not to pick the MA-PD Plan themselves.

**Fred Yancey:** But my question is, the only people that would be affected would be the ones that are currently non-Medicare eligible and they have a Medicare eligible spouse, but they're not enrolled in Uniform. The question is, how many people is that? Because I wonder in Uniform, they're just going to shift over into the Classic, or maybe don't change at all, that are already in Uniform. Did that make sense?

**Dave Iseminger:** The part that's confusing me, Fred, is that anybody who right now is signed up on the UMP account, everybody who's on that account is in a Uniform Medical Plan. Some of them might be non-Medicare, some of them might be Medicare. They're already on the UMP account. If somebody is on a Kaiser Medicare Advantage plan, their non-Medicare individual is on a Kaiser Non-Medicare plan. If they're on a Premera Supplemental Medical plan in the retiree population, their spouse is on UMP Classic. There's already a coupling that happens in every instance in the portfolio today. This is just describing the coupling that would happen for the new scenario. I'm struggling to identify that there's anybody that fits the scenario you're describing because there's already a policy coupling for all split accounts in today's world.

**Sue Birch:** Do we have projections on how many we think are coming over?

**Fred Yancey:** Gotcha, I think I understand. I mean, if it would be anybody that's Kaiser currently, whose spouse is Medicare eligible or under a Medicare plan, if that spouse chose this United plan, then they would have to get out of Kaiser, and shift to Uniform?

**Dave Iseminger:** Okay, that scenario clarified your question. So that's something we can look at to see if we'd be able to describe that. We obviously have more time in the Board season to talk about it. Maybe that's something we can work to follow up on.

**Fred Yancey:** My question would be how many would have to make that shift in the end?

**Sue Birch:** Thank you Fred for that question. Staff do not have that number at their fingertips. Dave, I'd ask that you and your team try to come back to us with some projections.



**Tom MacRobert:** I just want to make sure. When I'm listening to what Fred was saying and Dave's response. I am 67 and my wife is 62, both enrolled in Kaiser Permanente. When the option for me, as a Medicare eligible person, opens up and I say I want to switch to the MA-PD Plan, I switch, and she has to go to Uniform Medical Classic. Is that right? Is that how it works currently?

**Dave Iseminger:** Yes, you are correct.

Voting to Approve: 7

Voting No: 0

**Sue Birch:** Resolution PEBB 2020-05 passes.

**Agenda Item: Annual Rate Process**

**Megan Atkinson**, HCA Chief Financial Officer. Today I will wrap up the resolution presented to you in January, but also foreshadow what Tanya will be sharing at a future Board Meeting on rate setting and procurement updates.

Slide 2 – PEB Board Premium Setting Authority. This slide highlights the RCW that gives the Board the final authority of authorizing employee premium contributions. It will probably be a reminder that when Tanya comes forward at the end of procurement, what she's highlighting for you is the employee contribution split. She's giving you all the details leading up to that, but really asking you to take action on the employee premiums. As a reminder, until the Board takes final action, the rate development and premium setting process is not complete.

We will give you procurement updates at various stages throughout the summer. We will go back and forth getting information from the carriers and our own actuaries on our self-insured products. There may be things on which Board Members want more information. There's a lot of back and forth in the process. But until the Board takes action to adopt the final premium, the process is not complete. The Board can clarify again what information you want brought forward as you consider setting premiums.

Slide 3 – Resolution PEBB 2020-01 Rate Development Procedure. This resolution to clarify our procurement process. We'll adopt clarifying legislation in our RFRs and in our procurement process, that the PEB Board will not review or consider unsolicited revised rates from the carriers after the proposed employee premium contributions have been published publicly.

I want to highlight a couple of words in this resolution, “the PEB Board will not review or consider unsolicited revised rates.” Again, many times during the procurement process, in the past you have directed us to go back and get revised rates, even if you just think we need to do another round of negotiations, or if you make changes around the benefits offered. This resolution is coming out of an experience we had on the SEBB products last year, where a particular carrier offered revised rates after rates were published. This resolution clarifies for everyone that the Board will not review or consider unsolicited revised rates once the entire portfolio rate offerings are public.

**Sue Birch:** Resolution PEBB 2020-01 Rate Development Procedure

**Resolved that**, beginning with the rate development process in 2020 (to set premium contributions for plan year 2021) and annual rate development processes thereafter, the PEB Board will not review or consider unsolicited revised rates after proposed employee premium contributions are published publicly by the Health Care Authority on its website.

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

Voting to Approve: 7

Voting No: 0

**Agenda Item: COVID-19: Potential Financial Impact**

**Megan Atkinson**, HCA Chief Financial Officer. We want to take this opportunity, since so much has changed in the world from the COVID pandemic and our state's response, to provide background on what HCA is doing and what we're seeing in the agency.

In late February, when the Governor issued his Stay Home, Stay Healthy directive, and the directives about limiting elective medical procedures, HCA has had a lot of what we call utilization contractions in the health care system in Washington. At the same time, we've had pockets of health care utilization, predominantly on the inpatient side in treating COVID positive individuals. We continue to ramp up COVID testing activities.

These are unprecedented times in health care, both in our current year financials, as well as going into 2021 procurement.

For our 2020 financials, there are a couple of ways to think about our financial flow. First, we have our capitated, per member/per month rates we pay our fully insured partner Kaiser Permanente. Those funds have continued to flow to Kaiser. They have a unique health care model in having so many of their facilities and professionals owned and under salary, that they manage their own expenses. While we've been in numerous conversations with them, that's really the entirety of our COVID action within this conversation of understanding how they're responding and understanding what their experience is, and the conversations that they've had on aligning, making sure we're in alignment with the OIC directives and other care directives in HCA.

For our self-insured UMP portfolio, it's managed differently. While we have a contract with Regence, our third-party administrator, we pay them a per member/per month administrative fee. The claims costs and claims fund are administered and managed by the state. We've had these utilization contractions, essentially, a build-up now of what we call "fund surplus." However, we are not through this calendar year or plan year, and we don't know what kind of utilization we will have in the second half of the calendar year.

Another background piece is that medical claims tend to mature very slowly. It's a slow process from when a person seeks and receives care at a doctor's office or a facility to when the medical claim works its way through claim adjudication and actually gets paid. When the dollars would leave our self-insured funds. Because we have that lag in

claims, we have a bit of a blackout window now where we know utilization is contracting, but we don't know precisely how much and in what sectors. You can think about the inpatient utilization, outpatient utilization, and then professional and pharmacy utilization.

Ben Diederich and his team at Milliman are doing an analysis on utilization as of April 30. We should be getting that utilization analysis in the next few weeks. That will help inform an understanding of the amount of contraction we've had thus far. How much utilization we've had in the second half of the year is still anyone's guess. It depends on how the state experiences the COVID infection rate, how counties move through the four phases of reopening, and how much care individuals seek. That's calendar year 2020.

When we look into setting rates for calendar year 2021, because claims and the financial experience mature rather slowly and have a long run out, we typically use two-year old experience, adjusted and trended forward. In a normal world, we would have used 2019 experience, trended or adjusted forward, to set rates for 2021. That period where we would be trending forward, we have to take into consideration the world we're in right now and crystal ball projections of how that will play out into 2021. Quite frankly, where we are now is working with our actuaries, talking with other plans' actuaries, and settling in on our assumptions. The crystal ball is clear at this point in terms of how the current COVID experience will impact our 2021 rates.

**Sue Birch:** I think that's important context for the Board. I want to punctuate some of the things Megan said. As you are probably seeing and hearing, there is extraordinary fear factor about going in to see your doctor, going into your health system. HCA is working with organizations to get people to move towards evidence-based care. We are concerned about low immunization rates for kids and people foregoing necessary evidence-based things.

What I think we are all experiencing is the massive cracks in the system. Milliman has done quite a bit of work with the Alliance on the waste calculator and we know there was a lot of elective, or non-urgent things going on in the system that we hope, quite frankly, never come back.

We also know extraordinary things got done, like the use of telehealth. There's a movement towards more primary care alternative sites of care that we want to accelerate and build upon. We need these for the future as we keep reining in costs and affordability, and a movement towards sustained quality and greater evidence. Frankly, we need crisper data and a lot of analysis as we keep moving through this unprecedented experience.

We are doing a lot of work with our sister agencies and public/private partnerships. I was on a large panel presentation yesterday at the Alliance about a future of COVID, the things we're bracing for, and the things we are trying to reshape. We aren't just doing this as a state. We're doing this as a region with other West Coast states and other large purchasers who are also wanting rebates, for example, from a dental industry that was closed down for a while, or from health care providers, where the intermediaries or the third-party administrators got paid, and this contraction occurred. These are extraordinary amounts of changes and dollars we're talking about. All these

things are in play and in discussion and we want to make you aware from a high-level perspective.

Lastly, I'm very proud of the HCA team that really leaned in. We've moved on non-government time like you can't imagine. We have sprint teams, we work in four-to-six week increments. We're extraordinarily concerned about the equity, the inequities, and it was part of bringing the benefits choices to you, because we think as a society that everybody needs to be covered. We need all sorts of design options as we move forward. We, as a state and as a nation, can do better going forward. We're so not out of this. We also know we have to stay hypervigilant about things like PPE supply chain and testing, what are the details that get built into a benefit, where is government covering those expenses? Where are our carriers, plan partners, and whatnot carrying expenses? Where do our members experience some of those expenses?

As we move into budget realities, we will update you on what we're hearing from our OFM partners and our federal partners as we keep looking at stabilization, not just for individual health, but the economic realities we don't just face in the health care sector, but in the social sector, and in the state's overall economy.

**Tom MacRobert:** I want to let you know, all of you, the appreciation I have for the work you're doing. I realize how incredibly stressful this must be in dealing with this new reality. I appreciate the work you're doing putting the effort into figuring this out. So thank you.

**Sue Birch:** Thank you, Tom. I, too, would echo that. As your lead executive here, I'll just say the team has been extraordinary, truly some of the nation's best and brightest minds working on this, and really pushing forward. I'm pretty proud of what Washington has had to deal with, being first out of the gate. We keep influencing all the way right up to the White House. We will pass those kudos on to the entire HCA team because it truly has been a team effort.

### **Public Comment**

**Fred Yancey:** I want to make sure -- two things. One is to thank everybody working at the agency. I know it's been wild and crazy. I don't see an end in sight, but that's me. I trust when you're looking to identify the cuts that OFM has mandated, you will share any cuts that are maxed out in SEBB and/or PEBB Programs. That's all I've got to say.

**Sue Birch:** Thank you, Fred. Yes, as we are going through this process and our things are available publicly, I'm certain our communications team will be involving the public as we are able to share. We'll be back at you as we know what that timeline is and if there's a special session. We really don't know at this point what's next, other than Monday. We have a lot of homework to put in.

**John Comerford:** Dave? I checked the by-laws when we were talking earlier about my seconding a motion. It allows me to make and second motions. I just wanted to make sure you looked at that.

**Dave Iseminger:** Thanks for pointing that out. It's been a long time since we've dug into that. Thank you for reminding me of something, I'm always learning every day. You are correct, John. You have the right to do everything except vote.

**John:** I didn't want to say anything during the course of the meeting, but I just wanted to bring it up before the end of the meeting.

**Sue Birch:** Thank you for that clarification. I apologize as Chair for not catching that at the time. Thank you, John. Everybody be safe, wash your hands, and wear your masks. Thank you.

### **Next Meeting**

June 17, 2020  
12:00 p.m. – 5:00 p.m.

### **Preview of June 17, 2020 PEB Board Meeting**

**Dave Iseminger**, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the June 17, 2020 Board Meeting.

Meeting Adjourned: 3:34 p.m.