Washington State Health Care Authority

Public Employees Benefits Board Special Meeting
Meeting Minutes

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.

Slide 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% or 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 indeterminant.

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.