Washington State Health Care Authority

Public Employees Benefits Board

March 9, 2023

REVISIONS

TAB 6: Legislative Update, Slide 8

TAB 8: Hearing Instruments Overview, Slide 3

Washington State Health Care Authority

Public Employees Benefits Board

March 9, 2023
9:00 a.m. – 12:45 p.m.

This meeting will be hybrid with attendance options both in person and via Zoom

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

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TAB 1

Washington State Health Care Authority

AGENDA

Public Employees Benefits Board
March 9, 2023
9:00 a.m. – 12:45 p.m.

This meeting will be hybrid with attendance options either in person or via Zoom. Masks are recommended.

TO JOIN ZOOM MEETING – SEE INFORMATION BELOW

9:00 a.m.*	**Welcome and Introductions**		Sue Birch, Chair	
9:05 a.m.	**Meeting Overview**		Dave Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information
9:10 a.m.	**Approval of Meeting Minutes:** • **March 10, 2022** • **April 14, 2022** • **May 12, 2022** • **June 9, 2022** • **June 30, 2022** • **July 14, 2022** • **July 20, 2022**	TAB 3	Sue Birch, Chair	Information/ Discussion
9:25 a.m.	**February Retreat Follow Up**	TAB 4	David Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information/ Discussion
9:35 a.m.	**By-laws Amendment**	TAB 5	David Iseminger, Director Employees & Retirees Benefits (ERB) Division	Action
9:45 a.m.	**Legislative Update**	TAB 6	Cade Walker, Section Manager Employees & Retirees Benefits (ERB) Division	Information/ Discussion
10:10 a.m.	**PEBB Program Financial Insights**	TAB 7	Molly Christie, Fiscal Analyst Financial Services Division (FSD)	Information/ Discussion
10:35 a.m.	**Break**			
10:40 a.m.	**Hearing Instrument Benefits Overview**	TAB 8	Sara Whitley, Fiscal Analyst Financial Services Division (FSD)	Information/ Discussion
11:20 a.m.	**Medicare Update**	TAB 9	Ellen Wolfhagen, Program Manager Employees & Retirees Benefits (ERB) Division	Information/ Discussion
11:45 a.m.	**Policy and Rules Development**	TAB 10	Stella Ng, Policy & Rules Coordinator Employees & Retirees Benefits (ERB) Division	Information/ Discussion

12:10 p.m.	**General Public Comment**			
12:40 p.m.	**Closing**		Sue Birch, Chair	
12:45 p.m.	**Adjourn**		Sue Birch, Chair	

***All Times Approximate**

The Public Employees Benefits Board will meet Thursday, March 9, 2023 at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8th Avenue SE, Olympia, WA. Attendance for this meeting can be in person or via Zoom. Masks are recommended.

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

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

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

Materials will be posted at http://www.pebb.hca.wa.gov/board/ by close of business on March 6, 2023.

Join Zoom Meeting
https://us02web.zoom.us/j/89377017978?pwd=dGVNdFordUxUaU83WG5QV3l6aTkwUT09

Meeting ID: 893 7701 7978
Passcode: 041825
One tap mobile
+12532050468,,89377017978#,,,,*041825# US
+12532158782,,89377017978#,,,,*041825# US (Tacoma)

Dial by your location
+1 253 205 0468 US
+1 253 215 8782 US (Tacoma)
+1 669 900 6833 US (San Jose)
+1 719 359 4580 US
+1 346 248 7799 US (Houston)
+1 669 444 9171 US
+1 386 347 5053 US
+1 507 473 4847 US
+1 564 217 2000 US
+1 646 931 3860 US
+1 689 278 1000 US
+1 929 205 6099 US (New York)
+1 301 715 8592 US (Washington DC)
+1 305 224 1968 US
+1 309 205 3325 US
+1 312 626 6799 US (Chicago)
+1 360 209 5623 US
Meeting ID: 893 7701 7978
Passcode: 041825
Find your local number: https://us02web.zoom.us/u/klbAMdvTD

Washington State Health Care Authority

PEB Board Members

Name	Representing
Sue Birch, Director Health Care Authority 626 8th Ave SE PO Box 42713 Olympia WA 98504-2713 V 360-725-2104 sue.birch@hca.wa.gov	Chair
Kurt Spiegel WA Federation of State Employees 1212 Jefferson ST SE #300 Olympia WA 98501 V 833-622-9373 PEBBoard@hca.wa.gov	State Employees
Elyette Weinstein 5000 Orvas CT SE Olympia WA 98501-4765 V 360-705-8388 PEBBoard@hca.wa.gov	State Retirees
Tom MacRobert 4527 Waldrick RD SE Olympia WA 98501 V 360-264-4450 PEBBoard@hca.wa.gov	K-12 Retirees
Michaela Doelman Office of Financial Management 302 Sid Snyder Ave Olympia WA 98501 C 360-790-8315 PEBBoard@hca.wa.gov	Benefits Management/Cost Containment

PEB Board Members

Name	Representing
Monica McLemore 10002 Aurora Ave N Seattle WA 98125 V 510-239-7162 PEBBoard@hca.wa.gov	Benefits Management/Cost Containment
John Comerford* 121 Vine ST Unit 1205 Seattle, WA V 206-625-3200 PEBBoard@hca.wa.gov	Benefits Management/Cost Containment
Harry Bossi 19619 23rd DR SE Bothell WA 98012 V 360-689-9275 PEBBoard@hca.wa.gov	Benefits Management/Cost Containment

Legal Counsel
Michael Tunick, Assistant Attorney General
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PO Box 40124
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*non-voting members

1/27/23

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

PEB BOARD MEETING SCHEDULE

2023 Public Employees Benefits (PEB) Board Meeting Schedule

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

February 2, 2023 (Board Retreat) 9:00 a.m. – 4:00 p.m.

March 9, 2023 - 9:00 a.m. – 1:30 p.m.

April 13, 2023 - 9:00 a.m. – 1:30 p.m.

May 11, 2023 - 9:00 a.m. – 1:30 p.m.

June 8, 2023 - 9:00 a.m. – 1:30 p.m.

June 29, 2023 – 9:00 a.m. – 1:30 p.m.

July 12, 2023 - 9:00 a.m. – 12:00 p.m.

July 19, 2023 - 9:00 a.m. – 12:00 p.m.

July 26, 2023 - 9:00 a.m. – 12:00 p.m.

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

7/5/22

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 12, 2022
TIME: 9:19 AM

WSR 22-15-022

TAB 2

Washington State Health Care Authority

PEB BOARD BY-LAWS

ARTICLE I
The Board and its Members

1. Board Function—The Public Employees Benefits Board (hereinafter "the PEBB" or "Board") is created pursuant to RCW 41.05.055 within the Health Care Authority; the PEBB's function is to design and approve insurance benefit plans and establish eligibility criteria for participation in insurance benefit plans for Higher Education and State employees, State retirees, and school retirees.

2. Staff—Health Care Authority staff shall serve as staff to the Board.

3. Appointment—The Members of the Board shall be appointed by the Governor in accordance with RCW 41.05.055. Board Members shall serve two-year terms. A Member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.

4. Non-Voting Member—There shall be one non-voting Members appointed by the Governor because of their experience in health benefit management and cost containment.

5. Privileges of Non-Voting Member—The non-voting Member shall enjoy all the privileges of Board membership, except voting, including the right to sit with the Board, participate in discussions, and make and second motions.

6. Board Compensation—Members of the Board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

ARTICLE II
Board Officers and Duties

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

2. Other Officers—*(reserved)*

ARTICLE III
Board Committees

(***RESERVED***)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings, except executive sessions *as permitted by law*, shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW.

2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.

3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.

4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.

5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 24 hours prior to the meeting date or as otherwise required by the Open Public Meetings Act.

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

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

ARTICLE V
Meeting Procedures

1. Quorum—Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.

2. Order of Business—The order of business shall be determined by the agenda.

3. Teleconference Permitted—A Board Member may attend a meeting in person or, by special arrangement and advance notice to the Chair, by telephone conference call, or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at Board meetings may also occur in conjunction with a public hearing or during the Board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Board Members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board.

6. Representing the Board's Position on an Issue—No Board Member may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on an issue unless the majority of the Board approve of such position.

7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the Chair, or upon request of a Board Member, a roll call vote may be conducted. Proxy votes are not permitted, but the prohibition of proxy votes does not prevent a Chair Pro-Tem designated by the Health Care Authority Director from voting.

8. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order. Board staff shall provide a copy of *Robert's Rules* at all Board meetings.

9. Civility—While engaged in Board duties, Board Members' conduct shall demonstrate civility, respect, and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

10. State Ethics Law and Recusal—Board Members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW. A Board Member shall recuse himself or herself from casting a vote as necessary to comply with the Ethics in Public Service Act.

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

1. Two-thirds majority required to amend—The PEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.

2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

Last Revised July 15, 2020

TAB 3

PEB Board Meeting Minutes

March 10, 2022

Washington State Health Care Authority

Draft

Public Employees Benefits Board Meeting Minutes

March 10, 2022
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 12:00 p.m.

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

Members Present via Phone

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

Members Absent

Yvonne Tate

PEB Board Counsel

Michael Tunick, AAG

Call to Order

Sue Birch, Chair, called the meeting to order at 9:04 a.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting was telephonic only.

Meeting Overview

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

Follow Up of January 26, 2022 Retreat

Dave Iseminger, Director, ERB Division. A couple questions came up at the Retreat related to AnnaLisa Gellermann's Health Care Cost Transparency Board presentation which I'll discuss today. Staff are also gathering information on spending trends and comparisons with other states to respond to those questions. I anticipate bringing information to the April Board Meeting to respond to those questions.

Tom had a question during the demographic presentation about the 16% median income state tax rate. The 16% of median income goes to state and local taxes in our state. That percent fluctuates depending on your relativity to that median income, which is something that we were describing in the presentation at the retreat. Tom, I think you were trying to learn more about the relativity of median income, which it was 16%.

Sue asked about the COBRA subsidy and what was the total amount spent by the federal government in our population to subsidize COBRA coverage. Over the course of that six-month expansion in coverage, a little over $2,000,000 was received or paid on behalf of the federal government rather than the COBRA enrollee self-payment amount. That $2 million was realized in our program alone.

The last question was John Comerford asking that when we batch the Board correspondence and materials we send in advance of the meetings, we provide insights about the resolution of those matters. We did a first run at that for this meeting that was sent last Friday with a brief synopsis. We have to be careful about oversharing potentially protected health information but trying to provide context. It's a work in process. I don't think we've landed on the final version, yet, but I hope Board members felt there was at least a first attempt to respond and give insights to the resolutions on those correspondence issues. We're committed to continuing to provide additional insight.

John Comerford: Thank you, Dave.

Sue Birch: Dave, on the COBRA amount of $2 million, I wish for you to convey to the staff that's pretty extraordinary to think about how we channeled those federal dollars out to our population of folks. Kudos and thanks to them. They made that happen, doesn't always happen in many other states, so thank you.

2022 Legislative Session Update

Cade Walker, Executive Special Assistant, Employees and Retirees Benefits Division. Today is the last day of the 2022 legislative session. It was a quick session this year.

Slide 2 – Number of 2022 Bills Analyzed by the ERB Division. This year the ERB Division had a number of bills we received at the beginning of session, and then it slowed down to where we saw more engrossments and substitutes. At the end of the day, we had about 165 total analyses, which is fairly light for a short session.

Slide 3 - 2022 Legislative Session – ERB High Lead Bills shows the progress of bills.

Slide 4 – Topical Areas of Introduced Legislation. House Bill (HB) 1052 was introduced last year at the request of the Office of the Insurance Commissioner about some aspects of the insurance code that didn't align with industry practices regarding contractor performance guarantees. It did pass and is on its way to be signed by the Governor.

The Educational Service District (ESD) bills we were tracking would require non-represented educational service district employees who otherwise, as of 2024, would be

required to participate in the SEBB Program. This was an ESD request to require those non-represented employees to participate in the PEBB Program. They felt it was more advantageous to them, or more aligned with their work patterns, or any number of reasons why they wanted to have their employees in PEBB. Those pieces of legislation did not get through the cutoffs and died this session.

There was one ESD piece of legislation with a nominal or no impact on the programs that required full state funding for ESD's represented employees. It's different because of the way ESDs are funded. It involves about 100+ represented ESD employees currently participating in SEBB within two ESDs. This bill passed but didn't have any other implications to either the PEBB or SEBB Programs. It was purely a funding bill.

The bills for retirees that would expand the definition of a separated employee to include retirees coming out of Plan 2 from either TRS, PERS, or SERS did not make it through.

Slide 5 - Topical Areas of Introduced Legislation (*cont.*). Of the pharmacy bills we tracked, HB 5610, RX Drug Cost Sharing, passed. If there is a rebate or coupon that pays a portion of the cost share for a member for a prescription drug by a third party (e.g., a manufacturer coupon), that amount is applied to the member's deductible. Moda reviewed this bill and there wasn't a substantial cost identified.

Senate Bill (SB) 5532, establishing a Prescription Drug Affordability (PDA) Board, passed this year. It will be a five-member Board appointed by the Governor to look into the pricing of pharmaceuticals. I think the Board is authorized to begin its work after HCA conducts a report to be submitted next year on prescription drugs and cost transparency. The PDA Board can then begin reviewing the cost of drugs. There are parameters when reviewing drugs and pricing, such as the drug needed to have been on the market for a certain length of time depending on what type of drug; whether it's a name brand or generic; the pricing of that drug, whether there's been a significant price increase in that drug in the last year; etc. The Board is allowed to apply a stricter review for up to 24 different drugs per year. Depending on their findings, they can establish certain pricing criteria, and have the authority to assess fines. The PDA Board will provide much-needed transparency.

Elyette Weinstein: There's something like the drug has to cost $60,000 a year. Do I understand that correctly?

Cade Walker: There are different criteria depending on the type of drug. My understanding is it applies for name brand prescription drugs introduced with a price of $60,000 or more per year for the course of treatment or drugs with a greater than 15% increase in a 12-month period. It could apply to drugs for Hepatitis C, (e.g., Sovaldi), those types of drugs that had a significant initial cost for the course of treatment. If they're biosimilar drugs, they have different criteria. If they had an initial price less than a certain percent, I think it's 10% -15% less than the reference brand price; and then for generic drugs if they cost more than $100 a month or increased more than 200% in a 12-month period. The breakdown is more than just a $60,000 price tag.

Elyette Weinstein: I've been tracking it for the whole session. The bill also had something about a drug has to be on the market for at least four years.

Cade Walker: I think there are different timelines. For some reason, I'm thinking seven years for a certain retail specialty or mail order.

Elyette Weinstein: You may be right.

Cade Walker: I know for name-brand drugs, if it has an introduction price at more than $60,000, there's a whole rubric, and I'm sure as the new Board forms the rubric for which drugs are qualified for review and what those criteria are will be spelled out.

Elyette Weinstein: I was very concerned about this bill because it might be able to bring down premiums because staff alerted me last year of the connection between premium costs and specialty drug costs. Thank you so much.

Sue Birch: It's important to note, just like the cost Board, it's like a needle in a haystack. If the Legislature wants these groups to be effective, they're trying to give them parameters to shine the light into the darkest areas, or most problematic areas, because many of these Boards could wander for years and not get to the heart of some of the biggest issues where we can try to create cost containment strategies. So, Cade, thank you for that important background. I believe there were a fair number of concessions made, but we got more movement in the pharmacy area than ever.

Tom MacRobert: Cade, HB 1052, where it talks about performance guarantees, can you give me more information about what exactly performance guarantees are, and their implications?

Cade Walker: It's what allows HCA to hold the health carriers' accountable for performing in certain areas identified in their contract. For example, the time it takes for their call center to answer our members' calls. We have metrics established in the contract to identify that percentage. HCA's expectation is that call centers will perform at a high standard. If they fail to meet that standard, there's a financial penalty paid by the carrier for failing to meet that performance guarantee.

Dave Iseminger: Another example would be accuracy in claims adjudication timelines. Some of our contracts have website metrics for the time and duration their website is available.

Sue Birch: Another example, Tom, is primary care network advocacy. Basically, Dr. Smith has a practice that's open and is seeing patients, but our members call and are told they can't get in for a year. There are performance guarantees that things have to run a certain way. Does that help?

Tom MacRobert: Yes, very much. Dave, going back to your example. If I'm Dr. Jones and I submit a bill, and I'm not happy with how quickly I am reimbursed, would that be a performance guarantee that I could look at?

Dave Iseminger: The provider wouldn't look at that, but we would have staff review each quarter. I don't have the exact percentages, but it might be like 97% of claims will be adjudicated within X-number of days. There's also a set performance guarantee of the accuracy of that claim being adjudicated, so that would be something we are monitoring across their entire performance on a quarterly or annual basis. It depends

on the performance guarantee. One individual late claim wouldn't necessarily trigger the performance guarantee, but it's usually something like 97% or 98% must be done within 20 or 30 days.

Other examples would be the processing of a life insurance claim or the medical underwriting processes within long-term disability and life insurance. The processing of reimbursement of claims when a paper form, instead of a card is swiped, for FSA or DCAP benefits. All of those types of things, but the guarantees all have a bit of wiggle room because sometimes mistakes happen. It's not about perfection, but it is about solid performance. There are instances where something doesn't meet our expectation and wouldn't be a perfection standard, but our performance guarantees don't demand perfection.

Sue Birch: We also have an appeals process. If that doctor wasn't getting paid, or there's a conflict resolution process, these guys have guarantees, or what I call service level agreements where we demand a certain service threshold. Dave's absolutely right, these fall into that threshold that we can monitor. It helps the team hold our third party administrator accountable for what they're paid.

Dave Iseminger: We have performance guarantees on meeting the timelines for the appeals process, so there's performance guarantees all over the place. We have these in our contract for Regence, our TPA for UMP; with Delta, the TPA for the Uniform Dental Plan; with Standard for long-term disability; with MetLife for life insurance. All of our contracts have performance guarantees in them, and this bill solidifies that so when we collect on a performance guarantee, it doesn't run afoul of the insurance code. There were some concerns technical violations were happening with the rate filing processing at the Insurance Commissioner's Office when the Health Care Authority collected on these, so this bill cleans this up. Performance guarantees are actually expected of state agencies as part of performance based contracting processes required by state law.

Cade Walker: Tom, as I heard your question, HB 1052 allows for large group employers to utilize performance guarantees in their contracting with insurers. This bill does not address the ability for providers to have any sort of performance guarantees in their contracts with carriers themselves. This is purely for large group employers, the state, HCA, and other large group employers to implement, to have performance guarantees in our contracting with health care. I heard your question of whether a provider had an issue with their reimbursement rate, that would be something wholly separate that this legislation does not address. It's purely the contractual terms between HCA as the large group employer, the holder of that contract, the insurer, all the terms that fall underneath it, and our ability to have actionable efforts against failure to meet certain standards.

Tom MacRobert: Okay, thank you.

Cade Walker: HB 1688 – Out-of-Network Charges, is a consumer protection expansion of the out-of-network billing (the surprise billing expansion) more closely aligning with pending federal regulations regarding surprise billing.

Slide 6 - Topical Areas of Introduced Legislation (*cont.*). Under medical services, two bills passed, HB 1689 - Biomarker testing, which removes certain barriers to biomarker testing for certain cancer screenings, and SB 5702 – Donor breast milk coverage, which expands access for donor breast milk coverage under plans so infants are able to get access to important nutrition that comes from human breast milk and not necessarily from formula.

The legislation that passed has minor potential fiscal costs and HCA has no concerns about funding them.

Elyette Weinstein: I'm very gung-ho about this stuff. I've been tracking SB 5642 and I believe it keeps the price of insulin low. I think there's a ceiling on how much can be charged, and I think it's around $35.

Cade Walker: There's the price of insulin, insulin affordability, SB 5546, and it did pass and was signed. The prior limit set in 2020 was a $100 per month limit for a 30-day supply of insulin. That limit was to expire January 1, 2023. This new legislation starting in 2023 requires health plans to cap the total amount of a 30-day supply of insulin at $35. Your $35 figure is correct, effective January 1, 2023 and it expires January 1, 2024. They will need to take action again to extend or change that amount.

Elyette Weinstein: Thanks, Cade, I really appreciate your explanations.

2022 Supplemental Budget Update

Kate LaBelle, Fiscal Information and Data Analyst, Financial Services Division, provided an update on the supplemental budget.

Slide 2 – PEBB Funding Rate. Funding rates are set per eligible employee, per month. The current 2022 fiscal year funding rate is set at $936, which remains unchanged in the proposed budgets. The funding rate for fiscal year 2023 in both the Governor's proposed budget and the House proposed budget is set at $1,130 per month and set at $1,184 in the Senate proposed budget. While the funding rates are different between the versions of the proposed budgets, the Health Care Authority has no concerns in the underlying assumptions used to derive the funding rates. Both proposed funding rates are adequate to maintain the current level of benefits, plus a few additional items on the next slide.

Slide 3 – Proposed Budget Similarities. The decision packages shown were discussed in the January Retreat. The funding remains consistent in all three proposed budgets as well as the Conference budget. The FTEs and dollars for the customer service staff decision package are split between the PEBB and SEBB Programs.

The next decision package, Procurement Resources, is to procure for our existing contracts within our PEBB and SEBB Programs. Examples of these contracts include our wellness and dental contracts. Funding for the PEBB Program for the first year is approximately $1.4 million.

The Mental Health Parity decision package has a total funding amount of $700,000, which is split 50% between each program. The ongoing costs are $100,000 per year.

This funding is to complete an analysis of mental health benefits in the Uniform Medical Plan and implement necessary changes to meet federal requirements.

In addition to these three decision packages, both the House and Senate include language allowing for the continuation and expansion of our digital point solution for behavioral health. This adds and expands virtual options for behavioral health within our Uniform Medical plan for both PEBB and SEBB, which could increase member access to early behavioral health interventions. The PEBB portion of the funding is approximately $300,000.

Dave Iseminger: Adding customer service staff directly relates to our efforts to increase the timeliness of response time for people who call on the phone, which is an often talked about topic because there's always a lot of calls, especially at key parts of the year. We want to expand and have staff available as of July. We need to hire and train them to be as ready as possible for our Fall 2022 Open Enrollment.

Sue Birch: I also want to add for the Board's understanding that we're going into a highly volatile eligibility period, because if you think about what's about to come upon us, in the Medicaid Program there are 300,000 people that had to stay on during the pandemic that have to be reviewed, and they may have become state employees or school employees. There's going to be some confusion and there will be about 5,000+ refugees likely to be welcomed into Washington, and another 200,000 undocumented. We have significant changes in eligibility policy in Medicaid. We could have three quarter of a million people confused about what's going on with eligibility. It will impact our call center. It will impact our Medicaid call center more, but people confuse the parts of HCA, no matter what, they get confused. I want to shout out to Dave and the call center staff, and make sure the Board understands that all of this is going to be like the ACA beginning all over again, because I think people get confused.

Elyette Weinstein: Do you think that the Medicare direct contracting program will have an effect on this, too?

Sue Birch: There's a lot changing in this arena, and with some of the Medicare things, again, it all is confusing to everybody. They just want to see their doctor or know what hospital to go to. I personally think it will lead to more calls, but Dave works very closely with our call center leadership, and I am confident we are in the best position for as good of customer service as we can provide with a deluge of activity that's about to come. I'm reminding everybody that we have to be patient, and we will try to get to people as quickly as possible to meet their needs. Our partners Regence, Kaiser Permanente, Premera, everybody is pulling in this same direction of trying to help people navigate. We're in the best position as we possibly can be, and we thank the Legislature for the resources they gave us.

Kate LaBelle: Slide 4 – Medicare Explicit Subsidy is the amount the state contributes for Medicare retirees per month towards their PEBB health care premiums. The subsidy remains $183, or 50%, whichever is less, in all versions of the proposed budgets, as well as the final Conference budget.

Slide 5 – House Proposed Budget – Proviso Language.

Tom MacRobert: On Slide 3, it said "Procurement Resources - Funds are requested to maintain, enhance, and replace contracts within the PEBB Program." Is that basically what the study on Slide 5 will be doing? I know, for example, prior to 2010, the Health Care Authority actually administered health care, and then it was taken over by Regence, so I'd like a better picture of what this study is supposed to do. What is the goal? Are they actually looking at going back, for example, is that one of the things the Legislature is looking at, perhaps, having the Health Care Authority resume some of the things they did prior to 2010?

Dave Iseminger: There are a couple of things to unpack with your question. First, the bullet of Procurement Resources of $1.4 million on Slide 3 is not related to Slide 5. For Procurement Resources on Slide 3, we have a couple dozen contracts that HCA manages out of the PEBB and SEBB Programs. They're on a periodic cadence. Some have an end of life, and per state procurement, we need to go out for procurement on a regular basis. This is the natural occurrence of events of some contracts reaching their end of life. The UMP Third Party Administrator (TPA) contract is not one of those that's up for procurement in the next two to three years. An example of a procurement that's part of the funded Procurement Resources decision package is our wellness contract. The vendor contract for the portal used for SmartHealth has an end of life and we're gearing up for procurement. That's an example of just one of our day-to-day contracts.

HCA did a very large procurement for the UMP TPA contract. HCA started that work in 2015 culminating in a contract that went live in 2020. It was a four-to-five-year procurement process.

On Slide 5, this budget provision refers to the services prior to 2011 that the Health Care Authority directly administered for the Uniform Medical Plan, that in 2011 were contracted out for the first time. The winner of that procurement was Regence, and then the winner of our most recent procurement was a new contract with Regence, but it's saying to look at the services provided prior to the TPA contract and identify if there are pieces, some or all of that work, that might move back to the Health Care Authority for direct administration rather than through a third-party contract. An example is provider network contracting. HCA used to directly do the provider contracts with hospital systems and providers for the network for the Uniform Medical Plan, but in 2011, part of the TPA contract was having Regence, or having a TPA do the provider contracting instead of at the Health Care Authority. That's one example.

Claims administration is another example. It's important to know that even before 2011, HCA didn't do claims adjudication and administration directly. That also had a prior TPA. There's a lot of unpacking to do of what services were previously provided, what services are now provided, and what could be a future state? This budget provision language has a report due on June 30, 2023. That's the latest date the current proposed budget bill can require things during the two-year budget period of which they apply, so the authority for this budget bill ends June 30, 2023. That's the last day of the budget cycle. The thought process is that the report could be looked to see if there's future interest from the Legislature in transitioning resources back to HCA in the future, which would require additional staffing or infrastructure built, and that's a multi-year process. It's important to know that the current contract with Regence has an end date of December 31, 2029. While it might seem early to talk about this in 2022, it really isn't, because the procurement that led to a 2020 contract started in 2015. If there is

any directional difference the Legislature wants to put the agency on a path to do for these administrative services, this is a timely discussion.

Sue Birch: I want to assure the Board that there are so many moving parts to transforming the health care landscape. When we procured years ago, there was no public option, there was more dual coverage, there is so much more going on with pharmacy cost containment, and cost containment. There's more alignment going on with our different purchasing strategies, how we use Centers of Excellence, and the way we are all aligning about primary care. The infusion of the behavioral health services that the pandemic is really necessitating now is a way that we further integrate behavioral health. All these things have to be looked at vis-a-vis, what's the best modality? Should government take on and administer some of these pieces? Should we be outsourcing? I think it's fabulous that we have time to begin these conversations and we'll keep coming back to the Board. Exciting that the Legislature really is trying to get us thinking ahead about could we continue to drive toward greater health care cost containment, while also complying with the Health Care Cost Transformation Board, where do we get the best deals, the greatest value, what's the best structure? And I remind you too, that the universal health task force is in flight, and with the Legislature's clear signal about covering undocumented people, like the COFA Islanders already subsidized, bringing on school employee Boards, all these things play out with how people are insured, or co-insured, double-coverage, etc. Interesting landscape of things that are shifting. Exciting times.

Policy and Rules Development

Stella Ng, Policy and Rules Coordinator, ERB Division.
Emily Duchaine, Regulatory Analyst, ERB Division.

Stella Ng: Emily and I will introduce four proposed policy resolutions. Slides 2 – 4 are RCWs included for information as you consider the policies being discussed. We will bring these back to the Board at another Board Meeting for action.

Slides 5 & 6 – Introduction of Proposed Resolutions.

Slide 7 – Proposed Medicare Advantage Prescription Drug Plan Resolution

Slide 8 – Proposed Resolution PEBB 2022-03 Medicare Advantage Prescription Drug Plan – Enrollment During Gap Month(s). This Resolution is to address the gap months before a MA-PD plan begins. Currently, we have two MA-PD plans through UnitedHealthcare available to our retiree population. These plans require prospective enrollment because federal rule does not allow retroactive enrollment. Under our current rule, when a subscriber elects to enroll in an MA-PD plan and does not submit required retiree election forms before their PEBB retiree insurance coverage begins, they would have to wait until the annual enrollment, or a special open enrollment, to enroll in an MA-PD plan. This proposed policy would allow a retiree population to enroll in the Uniform Medical Plan Classic during the gap months before their MA-PD plan begins.

Slide 9 – Example #1

Slide 10 – Example #2
Slide 11 – Example #3

Elyette Weinstein: I have a gap in my knowledge, I'm relatively new. I wonder, why is the gap plan always UMP? There must be some historic reason that I've never heard. It's just a lack of knowledge on my part.

Dave Iseminger: These three examples are showing what the world will look like if the proposed resolution passes. UMP Classic is being selected because it's the most comparable to the two United plans. After procurement when we introduced and recommended these plan designs to the Board, they were built off a backbone, and the starting point was UMP Classic. It seems the most natural fit, if the member is intending to be in the United PEBB Complete Plan or one of the other United plans, to put them in UMP Classic in this brief period. Again, we're in this situation because federal law required a prospective enrollment in MA-PD, but UMP, again, is just the most comparable to the end state they're going to be in. That's why our recommendation is UMP Classic for the one or two month gap period.

Leanne Kunze: Is the enrollment in the Uniform Medical Plan for the gap months done retroactively? There's no way you would know this, since you don't get the paperwork until August, is that correct?

Stella Ng: That's correct.

Leanne Kunze: And then as far as cost, there is a significant difference between premiums. How is that handled?

Stella Ng: The member will have to pay the cost of the Uniform Medical Plan Classic. The member will need to be educated about the choice of plan during the gap months, because we are allowing this, if passed, this policy would allow more retirees to enroll in the UnitedHealthcare (UHC) plan. This proposal is intended so members will not have to wait until the next annual open enrollment, or the next special open enrolment, to enroll and be willing to pay for the cost of UMP Classic.

Leanne Kunze: That answers my question. It is a choice and the way to get access to retiree coverage sooner instead of having to wait. I appreciate that, thank you.

Sue Birch: You are spot on, and I would just share that this is actually an area where I get a lot of positive accolades about HCA, because potential retirees that reach out and understand the timing of this and plan accordingly don't get caught in this bind because they coordinate things with their retirement plan. It's those that don't, and this is why Dave and the customer service team has a steady drum beat of pending retirees wake up and get a hold of us so that we can work with you. I do want to send kudos to the team to really try to get people to be proactive, but we do have a good default action, even though it will cost them a little bit more.

John Comerford: This was a bit off track, but it's a question I had. How many Medicare Advantage programs do we offer retirees?

Stella Ng: We have two plans currently offered under UnitedHealthcare.

John Comerford: And what percent of our retirees opt for Medicare Advantage versus a supplement?

Dave Iseminger: Our current enrollment, the last time I looked, is around 2% of the retiree population. This plan was introduced for January 1, 2021. We've gone through two enrollment cycles and there was steady growth between year one and year two. It's still early in the product offering line.

John Comerford: When you added this to the program, what was your expectation, say after five years?

Dave Iseminger: I think I'm going to have to follow up, I'm afraid I'm going to mix up my product lines. I'll put that as a follow up piece for next meeting so I can get the right numbers.

John Comerford: Thank you, sir.

Elyette Weinstein: Dave, you touched on what I was searching for here. Why, and no one can answer for the federal government, so I understand if you don't have an answer, why did the federal government prohibit these retirees from immediately enrolling in UHC? It doesn't seem to make sense. I don't mean it's you guys, why did the federal government prohibit this?

Dave Iseminger: Stella will do some research and we'll bring this back to the Board in April.

Elyette Weinstein: Thank you very much.

Sue Birch: Elyette, I'm pretty sure it's because of the financial implications. There were safeguards put in place to advantage one side versus the other, but our diligent, capable staff will get back to us with a more objective answer.

Stella Ng: Slide 12 – Proposed Deferring PEBB Retire Insurance Coverage Resolution.
Slide 13 – Proposed Resolution PEBB 2022-04 – Deferring PEBB Retiree Insurance Coverage with the Subscriber Becomes Eligible for the Employer Contribution. This policy aligns with how HCA currently administers the PEBB Program when a subscriber becomes eligible for the employer contribution towards PEBB benefits. This policy is necessary because federal Medicare rules require employers to offer employees over the age 65 the same benefits under the plan, the same conditions as any other employee under age 65. There is no financial incentive for a subscriber to self-pay PEBB retiree insurance coverage due to high premium cost. HCA recommends the Board adopt this resolution, so the PEBB Program's practice of the automatic deferral is uniformly applied to both Medicare and non-Medicare retirees.

Slide 14 – Example #1

Emily Duchaine: Slide 15 – Proposed USERRA Policy Resolution
Slide 16 – Uniformed Services Employment and Reemployment Rights Act (USERRA) is included for your information.

Slide 17 – Proposed Resolution PEBB 2022-01 Employees Returning to Work from Active Duty. Currently, employees regain eligibility when they have at least eight hours of pay status in a month. Under USERRA, we need to restore benefits the day the employee returns. Only the Board can extend eligibility greater than what the federal regulation requires of us. HCA is asking the Board to treat those returning from USERRA, including those with less than eight hours of pay status in the month in which they return, the same as employees who regain benefits based on eight hours of pay status. Our recommendation is to have it start the first of the month in which they return because HCA's longstanding practice in the PEBB Program has been full months of coverage.

Slide 18 – Example #1. In reading this resolution, it came to our attention that it is written specific to health plan benefits. In this example, it is written all PEBB benefits to start at the beginning of the month for an employee returning from active service. Therefore, the language in the proposed resolution will change to say, "employer paid PEBB benefits" when we bring it back for action.

Slide 19 – Example #2

Sue Birch: I just want to thank the crew for making this so explicit. Given the times we're in and where we've been, we have so many here in Washington being called up, and/or who are in this predicament, certainly during the pandemic. I thank you for being proactive in being supportive to the veterans. Not just veterans but active duty. I might be misusing the terminology, but I would also ask this team to make sure our special Veterans Employee Resources Group (VERG) is aware of this. What a great way to show our support.

Dave Iseminger: I want to add one more piece of context for the Board. The challenge here is that we realize the current practice doesn't technically fit the requirements of federal law, by prospectively rolling the person who's returned from active military duty the first of the next month, anybody who comes back from active military mid-month, by definition, is not being enrolled the day they return because in our systems, our medical effective dates are effectively limited to 12 times in the year, the first of each month. The choices are prospective enrollment like we have, which doesn't really meet federal requirements, or retroactive enrollment. Normally if there's a federal compliance issue, the agency will make a change to the federal compliance. The reason we need to bring this to the Board is the retro to the first of the month is slightly an expansion of eligibility requirements, which is the Board's prerogative. But the whole reason I bring this up is I know there will be other stakeholders with other populations who may be interested in retroactive enrollment. The reason this one is here is because of the federal compliance issues. If you have something similar you see is rooted in federal compliance, we'll certainly look at it. That's why it's here, it's technically a slight expansion of eligibility but it's rooted achieving in federal compliance.

Sue Birch: I hope the Board applauds this proactive leadership of doing the right thing and warding off these issues.

Emily Duchaine: Thank you. Next slide, please.
Now I will move on the proposed dual-enrollment policy resolution. Next slide, please.

Slide 20 – Proposed Dual Enrollment Policy Resolutions
Slides 21 – 22 – RCWs for your reference
Slide 23 – Dual Enrollment Policy Resolution Language
Slide 24 – What Did Employees Do During Open Enrollment to Resolve Their Dual Enrollment

Slide 25 – What Can Employees Do to Avoid Dual Enrollment? Decisions must be made within 31 days of gaining or regaining eligibility, or within 60 days for a special open enrollment.

Slide 26 – Proposed Resolution PEBB 2022-02 Employees May Waive Enrollment in Dental. This resolution is intended to resolve the issue of an employee who waives PEBB medical for a reason other than to enroll in SEBB medical, but is eligible for SEBB dental and SEBB vision as the dependent of a school employee, and would therefore need to be able to waive PEBB dental in order to enroll in SEBB dental and SEBB vision, and not have a dual-enrollment conflict. HCA recommends this resolution. Current policy does not allow an employee to waive PEBB dental for any reason other than when waiving PEBB medical, to enroll in SEBB medical, SEBB dental, and SEBB vision.

Slide 27 – Example #1
Slide 28 – Next Steps

UMP Pharmacy Benefit Management (PBM) Update
Jenny Switzer, Senior Moda Account Manager, ERB Division.

Slide 2 - Background

Slide 3 – Overview of Moda's Structure

Slide 4 – Moda and Navitus Roles

Slide 5 – Benefits of Navitus outlines the benefits of Navitus over MedImpact

Slide 6 – Member Experience Impacts

Slide 7 – Net Changes to Network Pharmacies. CVS left the network and Walgreen's joined, which represents a net loss of 47 CVS locations, but offers an additional 133 Walgreens locations.

Slide 8 – Net Changes by Zip Code

Slide 9 – Member Communications. HCA provided several different communications to members, e.g., brochures, publications, pre-recorded video, newsletter, just to name a few.

Slide 10 – Additional Communications. In addition to the communications listed, Moda's customer service staff were trained on the changes to network pharmacies so when

members called, Moda staff was able to provide additional information related specifically to their issue.

Elyette Weinstein: What's an activity tile?

Jenny Switzer: The SmartHealth wellness virtual platform has activities that members can complete to earn points or to be notified of changes. A custom activity was created and targeted towards specific members. This activity tile was targeted towards PEBB-UMP members notifying them of the change.

Dave Iseminger: We often use our wellness platform and create these types of activities for communication opportunities. When we rebooted the life insurance benefit, we had a life insurance calculator. When we did LTD, we had something that described the enrollment process for LTD and what medical underwriting is. We have a tile that's specific to the Centers of Excellence select hip and knee replacement, to learn more about that. We often use our wellness platform as another communication tool for people who are actively using that platform.

Jenny Switzer: Slide 11 – Implementation Related Member Impacts. To date, there have been zero appeals related to implementation activities due to Moda closely watching claims and addressing issues as they're processed. Moda created nine new customer service positions and provided additional training for them. Those nine customer service positions will remain post-implementation as well. Moda staff also worked through the holidays and overtime so members had access to customer service when they needed it so the issues were addressed as soon as Moda became aware.

Some member concerns Moda received included member inquiries on differences including some changes to concurrent drug utilization review edits. The implementation activities caused some claims to be denied for high dose when they were previously approved. Moda handled those issues as they were received and manually processed those to ensure members had access to the drugs they needed. They entered overrides to allow those claims to process and system edits to return a message to the pharmacy, rather than having the claim place a hard stop, so members could get their drugs.

Another noted issue is with compound claim partial rejections for non-formulary ingredients. When these partial rejections were received at Moda, they reviewed previous claims data and would enter an override if the ingredient was previously approved as part of the compound adjudication.

Moda did receive a small amount of pricing complaints; many were changes that take place on a regular or annual basis and are outside HCA's or Moda's control. Price changes in 2022 indicate cost savings for some members and prescription cost increases for others. Price changes were a result of drug source classifications, maximum allowable cost list changes, and changes to network pharmacy guarantees as contracted with those pharmacies.

Sue Birch: Do we have a summary of what the net financial impact is?

Jenny Switzer: I had Moda pull some of that data and it shows that overall, it's a cost-savings, but as I indicated, some people are going to see a higher price on their prescriptions, where maybe they were paying 58 cents before, and now they're paying a $1.58, but overall for the group we're seeing about a 4% improvement in costs for our members that were affected by this change. Moda is tracking that very closely and will notify us if they see big variations in those numbers.

Sue Birch: Jenny, that 4% reduction is what I was looking for, that's great information. It sounds like for such a significant modernization and increase in the volume of the distribution sites for pharmacies, it has gone rather smoothly. Kudos to the pharmacy team, and you, too.

Jenny Switzer: It did go extremely smoothly. It was a very positive experience.

Tom MacRobert: I was wondering, it was my understanding that CVS purchased Rite Aid. Is that correct? Because there are obviously a lot of Rite Aids, if that is true, and Rite Aid has been purchased by CVS, will that mean that Rite Aid would no longer be involved with us, as well?

Jenny Switzer: I'm not sure. That change didn't take place for 2022, but I can check with Moda to so see if they have information on that. Pharmacies notify us 180 days prior to leaving the network, and we haven't heard anything currently on that.

John Comerford: I can shed some light on that. Rite Aid acquired Bartell's, and CVS acquired Rite Aid, but they didn't acquire the stores in Washington state, for some reason.

Sue Birch: Thank you, John, for that clarification. Market consolidation and changes might be something this Board needs to periodically discuss. Staff will do a little more exploring, Tom, and bring that back Rite Aid customer involvement in Washington.

John Comerford: Let's say I have a generic drug that I've been taking, and I've been getting my prescription filled at CVS. Now I could switch to Walgreens, or I could go to some others. Am I going to be paying the same price at Walgreens as I would be at Fred Meyer, or other pharmacies in our network? Am I going to pay the same price at Walgreens that I would be for that same drug, or am I going to see differences in pricing?

Jenny Switzer: You could see differences in pricing. Each network pharmacy has a financial guarantee, or a contracted amount they've entered into with Navitus on Moda's behalf. There are maximum allowable costs, a cost limit put in place for generic and brand drugs. You shouldn't see a huge jump, but you could save money, or you may end up paying a few cents more. Moda has a price check tool on their website where you can compare any pharmacies to compare drug prices. Also, when members contact Moda, which was indicated on those letters that were sent out, they could contact Moda to get more information on available pharmacies for their specific drugs. Moda uses a price checker for local pharmacies and lets members know where they can go to get that prescription for a comparable cost.

John Comerford: Okay, thank you.

Sue Birch: And I remind you and other Board members, the overlay with the cost containment efforts in this area is the value formulary option approved by the Board. That puts downward pressure, that's the Moda and Navitus. You've given them directions, you said you go find this pricing, cost containment, but whether things shift 12 cents up or down depends on your drug.

Second thing I wanted to comment about, Dave has been very involved at the national level with the Purchaser's Business Group on Health (PBGH), and if you listen to the president's state of the union speech, he is committing, and there is significant movement that Dave has been participating in, in pushing more downward cost containment efforts on Medicare pricing, which will move the whole market down. There's the first time ever kind of commitment to keep moving pricing down. This is a significant thing that HCA and this Board have been doing to lean in on cost containment efforts, specifically in the pharmacy realm.

John Comerford: I'm wondering Dave, didn't I hear a year or two ago when Ryan was doing a presentation that Walgreens specifically had refused to join because they believed that since they were a corner drug store they didn't need to follow these cost containment efforts?

Jenny Switzer: I can speak to that one. Yes, Walgreens was very hard to get in-network. They weren't willing to sign the financial guarantees of the contracts for the rates we required. Their rates were well above what we thought was appropriate for our members and that's why it was such a big win when Navitus was able to get them to reduce their costs and enter into a contract with them to provide drugs at the rates that are appropriate based on our considerations for members.

John Comerford: Okay, thank you.

Elyette Weinstein: This is Elyette. It was Walgreens that acquired Rite Aid.

Dave Iseminger: We will definitely bring back some insights about the relationships between CVS, Walgreens, Rite Aid, and Bartell's in the Pacific Northwest.

Sue Birch: And it's likely to change, like, on a quarterly basis, is what is happening in the industry. It is a very interesting thing to think about market consolidation and all of this movement.

2024 Uniform Dental Plan (UDP) Benefit Design Introduction

Ellen Wolfhagen, Senior Account Manager, ERB Division. Today's presentation is about potential design changes for 2024 for the Uniform Dental Plan.

Slide 2 - Background

Slide 3 – Board Timeline

Slide 4 – Remaining Benefit Design Cycle

Slide 5 – Current UDP Design. UDP is a preferred provider organization (PPO) plan. There are different types of providers, with preferred providers having the best contracted rate and the most coverage. Premier providers are also contracted, but at a higher rate and a higher cost to the plan and members, which may be reflected in lower coverage percentages.

Slide 6 – Market Comparison – Plan Coverage.

Dave Iseminger: As Ellen goes through potential benefit design changes, you'll see some benchmarking with the book of business. On every slide you will see the Washington Education Association (WEA) and its pre-SEBB portfolio. I want to give context as to why that's one of our benchmarks. It's no secret that we have a SEBB Program now, a separate sister program to the PEBB Program. One of the areas that had the most questions, advocacy, or an interest into looking at the benefit offering from school employees has been the dental benefit design. The WEA benefit was used by many, but not all school districts prior to the SEBB Program. It had a very different structural model compared to the Uniform Dental Plan. Because many of the conversations and advocacy has come specifically from school employees, or the WEA who are having the same presentation and conversations with the SEB Board, we wanted to use benchmarking because it's certainly relevant and asked for by the SEB Board. We wanted to give the same information as the PEBB Program.

For years, the SEBB Program slides saw PEBB Program information and now you're starting to see SEBB Program appearances more on the PEBB slides. Ultimately, when a decision package is put forward, and anything that's picked up and put in front of the Governor's Office and Legislature, would move both programs in the same direction. It's important context for the SEB Board, and we thought it would be important context for this Board as well.

Sue Birch: I think of our commitment of equity. I also think we need to see a column about Medicaid. I think what it will portray is the vast generosity of all these plans compared to Medicaid. HCA is trying to help the public and Legislature understand that if we want a healthy society, we need to level things out. I'm not suggesting that we need to bring our dental benefit design down, but it's an important way for us to showcase what's going on in society and how we need to aspire to have more equity. If you wouldn't mind in the future, Dave, it would be a smart move to include Medicaid.

Elyette Weinstein: It relates to the Delta book of business, what is that?

Ellen Wolfhagen: Elyette, the Delta book of business is a major employer. It would include companies like Amazon, Boeing, or Alaska Airlines. These are preferred provider organization (PPO) plans only. There's no managed care comparison in here. That's the setting for the Delta book of business. The WEA plan, as Dave mentioned, is pre-SEBB Program. As you can see, there are changes across the different columns, and I want to note a couple of things. Class II also includes periodontia care, oral surgery, and root canals. Class III includes crowns of porcelain, composite, or gold. This is a comparison, generally, across the Board.

Tom MacRobert: I was wondering about SEBB benefits, because this WEA plan that you're showing is pre-SEBB, did the current dental SEBB plans mirror the PEBB plans?

Ellen Wolfhagen: Yes, they're exactly the same. When SEBB dental plans were created, we leveraged the PEBB plans.

Slide 7 – 2024 UDP Options. The options introduced on this slide are not in priority order. These are the kinds of differences that are very common when we look at benefits across different groups. HCA is keying in on the major differentials in benefit design.

Slide 8 – Incentivize Preventive Services. Preventive services include cleanings, X-rays, periodontal maintenance, fluoride treatments, etc. HCA is considering increasing the plan percentage for Class II and Class III based on having a preventive visit the year prior. Having a preventive visit will increase by a standard increment up to a maximum, and then benefits could be decreased for non-use to an established floor.

Slide 9 – Incentive Benefits.

Slide 10 – WEA Plan Incentive Example

Slide 11 – Amalgam and Composite Comparison. Composite for front teeth is covered the same way amalgam is covered. For posterior teeth, molars, UDP coverage is different. Composite is covered as an elective and is not provided the basic coverage for Class II fillings. HCA is looking at covering composite materials at the same coverage level as amalgam materials.

Slide 12 – Composite Materials for Filings

Dave Iseminger: I want to highlight that part of this benefit idea is to address equity. Current, generally, pervasive dental insurance practices, are saying if you can afford to have white teeth, then you can have white teeth, otherwise we'll cover your mercury filling level. That simple statement lets your socioeconomic status determine the color of your teeth when getting fillings. Based on what your filling needs are, it squarely puts this one as something that needed to be discussed as a potential opportunity. I don't want to miss the opportunity to highlight that aspect of this particular benefit design lever. The important equity lens rears its head here and it's a specific example.

Sue Birch: Absolutely, spot on. It's the perfect example, really trying to drive it toward health and well-being for people.

Ellen Wolfhagen: Slide 13 – Annual Plan Maximum Adjustment. On average, people use two preventive visits per year and between $325 and $350 for those two visits.

Slide 14 – Annual Plan Maximum Comparison. One way of dealing with differences between the plans is changing the percentage of coverage or changing the plan maximum, which is what the pre-SEBB WEA plan did.

Slide 15 – Market Comparison – Deductibles.

Slide 16 – Waiving Children's Deductible. Waiving the deductible is something to consider applying to restorative care, which is Class II or Class III. Another possible factor is looking at the age limit of how we define children.

Slide 17 – Differences in Children's Benefits

Slide 18 – Temporomandibular Joint (TMJ) Benefits
Slide 19 – TMJ Benefits Comparison
Slide 20 – TMJ Lifetime Benefits

Slide 21 – Next Steps

Scott Nicholson: I appreciate Dave bringing up and always being conscious about equity, certainly that is an initiative of the Governor's Office, something that we all need to be cognizant about as we press forward administering these plans. One thing to comment on was the pre-SEBB WEA plan and the incentive of 70%, 80%, 90%, and 100% every year preventative care that you could get a reduction in the annual or increase in the amount of covered services. I'm a little concerned of that from an equity lens because there's no income threshold or connection for that. If you had to make a difficult choice perhaps for providing for your family, and then not getting self-care for dental care, you're then put at a disadvantage early on to really catch that up. So that's one, and then I'm putting on my HR hat. It does make our benefits look a little less attractive early on to people, compared to maybe 100% preventative services being covered. If you're trying to recruit and retain individuals early on, you have to stay on a certain time to achieve full maximum benefits. Those are the two items I'm concerned with from this presentation. I'd love to hear other thoughts on that. Thank you.

Sue Birch: A comment, but I do think that this summer, the Governor and OFM are going to lead a pretty significant talk about a great resignation, a pretty significant review of compensation benefits, so it's something that I think will keep elevating.

Dave Iseminger: I just want to be clear that, when Ellen comes in April, there'll be very specific proposals. The goal today was to introduce some foundational information. I could already tell you that, don't just look at the WEA incentive-based column and think that's what's going to be proposed. There's definitely differences from what are being looked at, but it was to describe general concepts, so keep that in mind. I didn't want people to incorrectly assume that the proposal, specifically with the incentive benefit design, was going to be exactly like something that was in one of the other columns on the chart. We wanted to lay the foundation to show what the market has been and currently is, and then there'll be a very specific proposal brought to you.

Harry Bossi: Thank you for the presentation, really superb. I want to echo what Scott said totally, all his comments, as well as the complexity associated with trying to manage an incentive or disincentive program, keeping track of it, looking at all those kinds of things. The second comment I'd like to make is, of course I agree with looking at all the different potential options, but I wonder if there's a possibility to, and maybe I missed it, but consider not including the preventive care visits into the annual maximum, similar to what we do typically in medical plans, where we encourage those things, so we don't hold it against you or make you pay for it. I realize that preventive visits are covered at 100%, but perhaps there's a way to fold some of that into the annual

maximum by not counting it against the annual maximum. If that's not possible then I guess I would encourage you to look at an annual maximum coverage increase.

Elyette Weinstein: The two preceding comments from the Board are right on about the preventive care measures being covered because this also impacts senior members as well. I do know, just for the little part that I've been researching is that seniors often can't afford dental care. That's a thing they let lapse because of their need for medications and medical care. I'm grateful that my co-Board members brought this up.

Sue Birch: Elyette, thanks for that comment, and I'm going to help feed off that a little bit. There's quite a bit of public health work about seniors that have had nutritional information that they don't have adequate dental care, so then they fall and are hospitalized. If you could dig deep into dental related emergency room admissions, I know with kids, I think there are reports out a few years ago about it - dental pain being the number one driver of them not going to school. Those are things that help us with these disease impacts, the burden of disease, and with the Board's thinking. Again, as much of that as we can get into our line of thinking, and I really applaud staff and the Board, we are coming into modern times. We are recognizing now more than ever that the mouth is a part of the body, and we really need to try to equalize. We're seeing that movement in behavioral health, so it's very exciting that everybody's willing to look at this and try to have that equity lens.

Tom MacRobert: I'm wondering, currently, we offer three dental plans. 80% I think was the figure used that are in the Uniform Dental Plan, but 20% are covered, and if I remember correctly, Delta Dental is another plan, what's the third one?

Ellen Wolfhagen: Both Delta Dental and Willamette offer managed care plans. Willamette is just called Willamette, and the Advantage Care plan under Delta is called Delta Care.

Tom MacRobert: Could we possibly have a comparison of those two, along with Uniform Dental, when we come back?

Ellen Wolfhagen: We can, certainly, Tom, but I just want to point out, that because they're managed care, they're structured very differently. There's a set copay; under UDP, there are coinsurances, so it's a percentage. I can provide a comparison for you.

Procurement and Benefit Planning Cycles

John Partin, Manager, Benefit Strategy and Design Section, ERB Division. As you are probably aware, HCA already started the annual procurement and benefit planning cycles. Two separate pieces of work but closely related.

Slide 2 – PEBB Procurement Cycle. This cycle takes 18-24 months to complete. It's tied to the funding cycle and timelines. This cycle started last year in the summer when the Board approved the plan for 2022. The effective dates are for plan year 2023. This is generally looking at two main bodies of work, what payers in the industry are finding of value and use based on an entire book of business review, not just our members,

and then also around the procurement cycles, where we have existing procurement arrangements that need to be either performed or revisited.

Slide 3 – PEBB Benefits Planning Cycle. This cycle is also 18-24 months to complete and also tied to the finance funding cycle and review. This cycle is an additional 12 months into the future. HCA is looking for potential new benefits or major modifications for implementation in 2024.

The cycle starts with generating new ideas. Today I'd like to start there, given your knowledge and connection to the members that you represent. HCA will then review and develop those ideas for advanced into proposals for consideration in the funding review. We bring those successful candidates back to the Board for further refinement and move on to implementation and execution.

HCA is also assessing what other large employer groups are doing, what we're seeing from the payor book of business review, and looking for real innovations that might have significant positive impacts for the residents in the state of Washington, even beyond what we'd be leading with, for our own public employees as a major group, cohort of members.

Now I'd like to brainstorm to gather your thoughts for future considerations.

Sue Birch: I'll kick us off! I think the new reality about hybrid workspace might necessitate an ergonomic, in-home evaluation or some adaptations in this space of hybrid work environments. I would ask that you explore this area. There are interesting articles coming out, and I think we really have to consider that this is likely to be a remote working, hybrid working permanent impact. How do our benefits need to change and be reshaped?

John Partin: Just to clarify, Chair Birch, I assume you're thinking more wholistically than just in-home evaluations but also for in-home care?

Sue Birch: Yes, that's correct. I understand too, that Amazon is doing quite a bit of adaptation of sending supplies to the home, getting rid of more of the setting location, and getting care delivery at the home. I think this is a very interesting thing going on in King County, with Amazon using drones to deliver, for example, different infectious disease kits, having self-care. If things aren't resolved in hours, then a nurse practitioner or doctor shows up at the front door. I think we need to continue to explore more of this shifting settings environment.

I think the only other area that I would comment about is some of the enhanced behavioral health care that needs to occur given post-COVID, given the war tension. I continue to be very worried about numbers on several depths, and the whole thing, skills, and whatnot, so everything is a behavioral health problem.

John Partin: Last year we had a couple of really good ideas generated from these discussions around behavioral health. One of those is advancing, and what we're looking at implementation for that now. We also have several holdovers from last year, that didn't make it through the process successfully, and one new one that's come up. We're also looking at it through the lens of what impact that might have on rural access,

as well as the equity lens of ensuring that everyone has similar opportunities and access that it makes sense and it's usable and valuable.

I thank the Board for the opportunity to present, and if you have other ideas you think of after today, don't hesitate to reach out to me directly. I'd be happy to hear from you.

Public Comment

William Martin: Thank you very much for hearing my comment. I'm a professor at Eastern Washington University, and the issue I'm commenting on pertains to HealthEquity, who is the custodian of HSA funds, for HSA eligible health insurance plans in the state. For quite a while, I've been experiencing significant issues with HealthEquity that are not being resolved. As of right now, I've been trying to transfer some assets from HealthEquity to another HSA custodian, Fidelity, because HealthEquity's fees for investing their HSAs are about, literally ten times higher all together, than what the fees are for me to hold these funds with Fidelity, and for at least two, I think we're going on three weeks now, HealthEquity has had all the documentation, and will not make the transfer. I've called, I've asked them about it, and they say we don't know why, and we can't give you any ETA on what's happening. Frankly, that's just unacceptable for firms like this to be able to hold on to their clients' funds for weeks with them being in limbo, and no knowledge of what's going on, what's the problem, or when it's going to be resolved, nothing. That's just unresolvable.

The two things I would like to see happen, for most, and this may be unrealistic, is for us to have some choice regarding who our HSA custodian is, and not for us to be forced to go with one single provider who can then do whatever they want, because they have a monopoly, basically. If that's not possible, if nothing else, I would like to see this Board put some pressure on HealthEquity to say what you're doing here with holding peoples' funds and not transferring them in a fiduciary capacity within a reasonable amount of time is just unacceptable and that the Board won't stand for it. If there are any questions I will certainly respond, but that's basically my comment, so thank you.

Sue Birch: Thank you for bringing this to our attention. I see Dave is writing furiously, and I'm certain he'll be following up with you for more specific information. Again, thank you, this is the very reason we open up for public comment and performance. You heard throughout this Board meeting a real commitment to performance. Staff will be following up with you.

Allen Burke: Thank you, Sue. Allen Burke, Executive Director of Washington State School Retirees Association. We have about 17,300 members. I'm five years in the job and what I'm going to do in the next three minutes is to do a little bit of a deeper dive into what you talked about earlier, Uniform versus the United HealthCare split on the Medicare self-pay part. Just to make sure you got the numbers right, according to the information Dave Iseminger gave me, UMP has 38,964 Medicare subscribers and 2,607 in UnitedHealthcare Complete. I'm focusing on that United plan because that's the same basic coverage as the other one. I'm not going to talk about the other ones including Kaiser or Premera this time. 38,964 compared to 2,607 with the same coverages. So, really what you have is if you line 16 people up along a wall, 15 of them are going to choose Uniform, and one's going to choose UHC Complete, and that is in spite of the fact that Uniform is literally $2,500 a year more expensive, or $5,000 more

expensive for a couple. I know we're into the second year of this and people haven't figured it out. I really appreciate the Medicare Advantage option, because that's saving a lot of money, but it's stunning to see that many people have chosen to spend additional money when they're older, and frankly can't afford it. That's what I've been hearing from my clients here the last couple of months, as well.

What's going on? My opinion from what I picked up is retirees love Uniform Classic. That's what they've been doing for a while, there's a real lack of comfort for changing. They want to stay with the same thing. They prefer a government-run program to a private program. These are K-12 and government employees that tend to line up a little bit that way, and they especially fear losing a major coverage. I've heard that a number of times when they have experience with people getting $300,000 for a cancer thing totally paid for by Uniform, and they're worried about switching back and forth, as well. But $2,500 a person? That's a little bit tough.

So, what's going on here? I think in many cases, it's just people are in the dark about this. And I think what really has to happen is you have to do three things, which I'll talk about in a second. I'll cut through this. First of all, I want to thank Ellen Wolfhagen. She's spent a lot of time with our group, in two webinars, plus she's going to present at our convention in September. Dave Iseminger has been very good to deal with as well. I don't have any problem with the staff and the information we have here as well.

What are we going to do down the road, here? I think, three things:

1. We need more outreach. I think the problem with the outreach is you've got to deal with a different clientele. These are older people. We have about half of our people without email addresses. Whatever you do in terms of technology, it's got to be cut down to the level of people that are frankly dealing with paper and pencil scenarios. Some are getting old. Some have lost a little bit of their acuity mentally, and they need some help. Frankly I think help in filling out the paperwork is important, because a lot of people say to me that they are scared about the paperwork, scared, can't figure it out, or worried that they are going to get it messed up. By the way, all the people I've talked to that have changed to UHC are happy with it. They've struggled with the process of getting there, but once they get there, things have been really, really good.

2. I think you obviously have to work at continually getting the prescription drug prices down. I know you're doing that as well, but obviously the prescription drug prices are what's killing us on Uniform.

3. And here's the one that's probably the big takeaway today. You're going to have to, in my opinion, realize the tipping point is going to get met. If we have finally, people that are healthy decide to move away from Uniform Classic into UnitedHealthcare, eventually, you're going to have left people that are unhealthy, and then all of a sudden the costs are going to go, instead of $360 a month, to $400, $500 or whatever, and then finally the tipping point will be reached, and Uniform Classic will have a tough time hanging in there. Ironic you talked earlier today about doing more with Uniform, less contracting out. If the numbers keep going up, and there's a good alternative with UnitedHealthcare Complete, people are eventually going to switch. And, then what are you going to do then, back and forth?

I know you offer lots of things, I know that you can argue basically that there's all sorts of things here, but the fact of the matter is that if you line up 16 people and 15 of them choose Uniform and are willing to pay $2,500 a person more, either we have an outreach program, or we have something we have to do to make sure people are aware. I know you're aware of all this, but I wanted to pass on from my reactions for people that are in our membership about the fact that this is a big deal, and eventually, the cost of Uniform is going to push people out of those other options. Thank you.

Sue Birch: Thanks for those comments, Allen, I again see staff taking copious notes, and I'm sure the Board will be discussing this.

Elyette Weinstein: I'm very aware of RPEC and I do have my finger on the pulse of many state retirees. I agree with you, Allen, that as our population ages, and as these premiums go up, you're going to have only the sickest people in UMP. The thing, and I've read copious Medicare articles, this is what I did during the interim, on coverage, the problem with Medicare Advantage plans, the idea in the George W. Bush administration is to privatize medical care and to let the markets manage it, because the markets are smarter than government. However, these private organizations are answerable to their shareholders first. That's not because they're evil, it's under the law. That's what their legal obligation is, to put shareholder profits above anything else. So, what happens is, the reason the older, sicker people will stay in UMP is that they will have more coverage. Sure, we're looking at the front end, and I agree, premiums are way too high, I agree with you, you're absolutely right. But what I've also done is an exploration of how many claims are paid. And I have heard from hospital administrators and from providers, and from the people that are the billers. It's the incentive of these private organizations to make a profit, and not handle claims, not pay as much on the other end. I mean, Dave is going to laugh and say she's not going to mention something I told him, but I got an invitation to the UHC benefit presentation that was fancier than my cousin's bar mitzvah invitation, and we get fancy. I mean, a lot of money's going to that. So, you know, if you like slam and glam and glitz, that's terrific, but I think for older people, having coverage for their condition is primary. We're not stupid, we're not ignorant, we know what's covered and what isn't down the road, and we're all getting older, thank you.

Allen Burke: Just a couple comments about that, all I was saying is, and I do get pushback about government vs private as well, the people I've talked to, the couple dozen that have switched over, have been happy with the UnitedHealthcare plan and I'll leave it at that. That's what I've been hearing back and forth as well too. I think obviously Ellen and folks there, you can get data on complaints and all the other good stuff back and forth, but until we get more people into the UnitedHealthcare Complete, you're going to have a tough time having apples to apples comparisons, but right now all I can say is that eventually there's a tipping point, and eventually politics will be trumped by the cost, and then at that point, what is Health Care Authority going to do?

Sue Birch: Thank you, Allen, for bringing this provocative information forward. Elyette, again, thank you for your response. Allen, we constantly balance our mission with the margins and the resources we have to stretch. This conversation will continue as we continue to balance and have a choice.

Allen Burke: Well aware of that, and thankful for Health Care Authority for all you do.

Sue Birch: Thank you, Allen. I will convey that to Dave and his team. They are remarkable.

Fred Yancey: Good morning chair Birch and members of the committee. Thank you for your work this morning. I am calling today on behalf of not only school retirees but also on behalf of myself. I'm a PEBB Program member as a retiree, and when Mr. Partin mentioned he wanted to know if there were any other ideas, I would like to suggest that the Health Care Authority look at seeing what it would take to offer some standalone prescription medication plans. I personally, and my wife, are in the Premera plan, the one that's closed, but there is an alternative Premera plan which does not include pharmaceuticals. We had to go on the open market to buy and do research to find pharmaceutical coverage. I think it's conceivable, theoretically, that if Health Care Authority went into the field and sought proposals for offering standalone pharmacy plans, they could get a much better deal for the average person that is availing themselves of that option. Just a suggestion since Mr. Partin suggested that. Thank you.

Sue Birch: Fred thank you for that, we will note that a prescription supplemental benefit is something to look into. John Partin is listening in and Dave has written it down as well.

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

Preview of April 14, 2022 PEB Board Meeting
Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the April 14, 2022 Board Meeting.

Meeting adjourned at 12:05 p.m.

PEB Board Meeting Minutes

April 14, 2022

Washington State Health Care Authority

Draft

Public Employees Benefits Board Meeting Minutes

April 14, 2022
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 1:30 p.m.

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

Members Present via Phone

Sue Birch, Chair
Harry Bossi
Elyette Weinstein
Scott Nicholson
Tom MacRobert
Leanne Kunze

Members Absent

John Comerford

PEB Board Counsel

Katy Hatfield, AAG

Call to Order

Sue Birch, Chair, called the meeting to order at 9:03 a.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting was telephonic only.

I say this with a heavy heart. This morning, we are going to do introductions, and for the first time in a long time, we will not be calling on Yvonne, who has passed on. Dave will share some memories about her in a bit, but I do want to call out that it's a milestone since she served our PEBB family for 27 years. Board member interactions are the greatest gift we can give to her as she wants us to carry on and do good work. So that's what we are going to do in honor of her.

Meeting Overview

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

Sue Birch: I have one impromptu item. Another person we need to celebrate today is Scott Palafox. This is his last PEB Board Meeting. Scott has served the State for 40 years and has been Dave's deputy. Many of you have worked with Scott. Scott, we are honored that you are joining us today. We celebrate you and your years of commitment.

Scott Palafox: Thank you, Sue. I do want to offer thanks, as well. I first want to acknowledge and extend my condolences to the Tate family. There are two things I will always remember about Yvonne. She didn't have much to say, but when she spoke, everyone listened. The other thing I appreciate about her is that she always expressed her gratitude and appreciation for the staff and the work they've done behind these Board meetings and presentations. I want to thank the Board for the past eight years of serving this Board. I truly believe it's the work done by this Program and the decisions that were made by this Board that gave the Legislature the confidence for giving us the gift of the SEBB Program to implement and create.

I'd like to thank you, Sue, for bringing your vast clinical experience to this Board. Not only do you bring the tender loving care and compassion of a nurse -- and I know that because I'm married to one -- but also you bring a deep understanding of the health care policy that helps to clarify and provide additional orientation as to what is the driving force behind our initiatives.

I'd like to thank Dave, commander of this starship PEBB and SEBB Programs. You have certainly established yourself as a true leader and making your own imprint on the programs, especially following behind Lou McDermott. I want to thank all our partners, the AG's Office, our external stakeholders, and certainly the public for keeping us on our toes, your patience and understanding, and your trust in building a good relationship. You have seen good outcomes and results from that. I'd like to thank that admin team that's sitting in that room with Dave because they are the heart and soul of putting these events together. Thank you for your countless hours of prep work and your extended hours burning the midnight oil, especially you Connie, as you guys all rock.

And then lastly, I want to extend the appreciation to the Health Care Authority staff. What can I say? You're absolutely a fantastic group. Without you and all the work that you put forth in getting through these presentations in front of the Board, we would not have been as successful as we have been. I have all the confidence that you will continue to make things happen in the future. I wish you all the best of luck by keeping a watchful eye and ear. And it may be on occasion I might participate in a Board meeting providing public comment, as well. Thank you.

Sue Birch: Scott, we look forward to hearing from you anytime. You be well and enjoy this next chapter of life. You have earned it. We will do a good job making sure your benefits are all the best.

Scott Palafox: Thank you, Sue.

Approval of April 14, 2021 Meeting Minutes

Scott Nicholson moved, and Leanne Kunze seconded a motion to approve. Minutes were approved as written by unanimous vote.

Approval of May 12, 2021 Meeting Minutes

Elyette Weinstein moved, and Leanne Kunze seconded a motion to approve. Minutes were approved as written by unanimous vote.

Follow Up of March 10, 2022 Meeting

Dave Iseminger, Director, ERB Division. There are four questions that didn't fit into other presentations.

Slide 2 – Medicare Subscriber Enrollment as of 2/28/22. These numbers are subscribers only, not member lives or dependents.

Slide 3 – MA-PD Plan Enrollment Insights.

Slide 4 – Retail Pharmacy Market Insights. The question raised was about the transition to Navitus from MedImpact as part of the UMP pharmacy benefit.

Slide 5 – Health Savings Account Administration. Responding to questions in public comment about investment fees.

Remembering Yvonne Tate

Dave Iseminger, Director, ERB Division. Before sharing memories of Yvonne, I want to publicly thank Scott Palafox. The past few years as we were doubling work to create the SEBB Program, I definitely needed a confidant, and Mr. Palafox was part of that. Thank you, Scott.

Now I'm going to move us into another celebration because Yvonne's family is having a celebration of life service to honor her impact. I want to take a moment to talk about her impact here at HCA, the state of Washington, for residents of the state of Washington, and the PEBB Program. I thought quite a bit about how to talk about Yvonne's impact. Her obituary in the Seattle Times on Sunday shared a bit of her journey that led her to Washington State that helps to understand her background.

Yvonne was a military child and bounced around different parts of this country as well as Europe. That ultimately led her to undergraduate studies at Kent State University, where she was president of the residence halls and present during the 1970 Kent State shootings. Talk about a perspective she had on the world and being part of that moment in history that hopefully we're all aware of, the impact and thinking about how that shaped her as a leader, being in a residence hall leadership role at Kent State at the time. It's an interesting part of her journey in life and just the perspective she brought to the Board and to the world.

She ultimately went to law school in Colorado, which led her to working at a former iteration of the Office of Civil Rights in DC for a federal agency, and then she transferred to Seattle. She planted more permanent roots in the Northwest in the 1980s. She then

transferred into human resources roles at various organizations in the Northwest, first with Group Health Cooperative.

After talking with her daughter, I started to hear about the commitments she had to equity, diversity, and inclusion from the very beginning. She helped found one of the original LGBT groups at Group Health for employee support. Her daughter talked with me about remembering marching with Group Health in the Seattle Pride Parades in the late 80s and early 90s. Certainly, from a historical standpoint, there was something controversial, particularly at that point in our nation's history. She then became the Director of Human Resources at the Port of Seattle, and that's where she entered her PEBB work. She was appointed by Governor Locke in 1998 right after she became Director at the Port of Seattle, and she's been on the Board ever since. And while she was on the Board, she then transferred to become the HR Director for the City of Bellevue, where she retired in 2014, but she continued to serve on the Board.

Those are some experiences that led Yvonne to us. As we look back, Governor Locke appointed her; Governor Gregoire reappointed her for her entire administration; and Governor Inslee continued supporting Yvonne on the Board by appointing her up through a recent reappointment last fall. She had 24 years of service on the PEB Board. I found footage of the 1998 meetings. Yvonne's first meeting was in May 1998, almost exactly 24 years ago. One of the topics in May 1998 was the new long-term care benefit being offered under the PEBB Program, which ultimately closed in 2014. We all know where the long-term care debate is today in our state.

At the end of that same Board season, there was a discussion on whether Viagra should be approved as coverage within the Uniform Medical Plan. Yvonne immediately brought up gender equity, and how she had concerns about approving Viagra when there was no gender equivalent contraceptive coverage to her satisfaction for women. That speaks to the very beginning of her push for diversity, equity, and health care. I wanted to share that story about her first season on the Board.

I think it's also important to look at what changed over time in her 24 years of service. One of the next big topics speaks to the testament and power of a Board like this. In 2000, the Board took a very courageous step to approve benefits for same-sex partners and a domestic partner registry that was run by the Health Care Authority. This was just two years after the Legislature overrode a veto of the Defensive Marriage Act that prohibited same-sex marriage in the state. The minutes and record of that meeting show that it was quite the trial and tribulation for Board members. There was heavy lobbying on both sides on that issue. The Board took the step of approving same-sex couple benefits, recognizing those partners, and creating access to benefits. Again, it's a testament to the things this Board can do and the power it can have on individuals' lives. Something I know after talking with Yvonne's daughter is that she was very proud to be a part of that now less controversial decision, but certainly a controversial decision in the year 2000.

The entire concept of the retiree deferral rule being able to maintain eligibility while having access to other types of benefits didn't exist when Yvonne started on the Board. The entire modern iteration for a retiree being able to have some choice and access to come in and out of PEBB benefits within certain parameters. That was part of Yvonne's tenure on the Board. We talked about two-year averaging and higher education for

part-time workers. That was a concept that didn't exist when Yvonne started on the Board and came into fruition in the mid-2000s. The creation of the Consumer-Directed Health Plan and the tax-advantaged account that allows people to be more participatory in their health care benefits and have investment strategies for the future, another change that Yvonne saw.

In the last couple of years, there was access to transgender benefit coverage. Again, in those Board meetings, there was intense lobbying and some scrutiny for the decision the Board made to advance coverage for transgender benefits. I think of some of the most recent pieces during my tenure as director. I know that Yvonne would always laugh when I would say, “Well, if we are going to work on the life insurance benefit, which hasn't been worked on since 1993 or 1970,” she would say, "That's longer than my tenure!" I know she was very happy to be able to support advancements both on the life insurance benefit and the long-term disability opt-out change last year. Those are just a few of the changes.

On a federal level when Yvonne started on the Board, Medicare Prescription Part D didn't exist. The Affordable Care Act didn't exist. All of these massive changes while she was on the Board had a ripple effect on decisions that the agency brought questions and policy positions for her and all of you. When I think about Yvonne's tenure, I really think Scott said it well. She was very deliberate in the words she chose. She was never jaded. She was always proactive, calm, and measured, and a real stabilizing force. Yvonne was someone new Board members looked to for her tenure. She saw many Board members come and go over 24 years. I hope that you, as Board members, experienced some of what I experienced. When I became the Director, I looked to Board members to understand their perspectives. She had such a valuable perspective. I think, importantly, about last January when we had the equity panel discussion. We were about to close out the panel and move on to the next topic, and Yvonne slowly raised her virtual hand. She said something that I still think about to this day when we have equity conversations. She said she gave birth in a DC hospital and everyone in the room looked like her. When she came to the Pacific Northwest, if she had another baby, she never expected everyone in the room to look just like her. What she really wanted and needed were providers who were culturally competent to understand what she needed based on her experience and her race and ethnicity.

That struck a chord with me because as an openly gay man, I think about that with my own providers. I don't need to have an LGBT provider. I need somebody who's going to ask the right questions, and also not ask the questions that shouldn't be asked in 2022. I think about that profound voice, and when she said it, it immediately resonated with me, and I hope it resonated with others because that's the kind of power her viewpoint brought to our discussions.

I also reached out to past directors of the program that she was a Board member under. When she first joined the Board, MaryAnne Lindeblad was the then PEBB Director, our recently retired Medicaid Director, and she sent me this message to read.

> “It was over 20 years ago when I first met Yvonne. Yvonne was always a voice of reason on the Board. She truly cared about individuals served by the PEBB Program and worked to find ways to improve benefits. She used her background to help find common ground and balance on how

best to serve PEBB members while being cognizant of our important role in assuring costs were balanced against benefits. During difficult benefit design discussions, Yvonne put members first, and her advice and direction and help guided support staff in resolving the areas of disagreement. She will be missed."

Lou McDermott: Two things. One, Scott, I just wanted to wish you the best in your retirement. Scott and I have worked together for over 25 years. He knows how I feel about him. If it wasn't that he put in 40 years, I would be begging him to stay. But I suppose after someone puts in 40 years, there is really not much you can say when they want to go spend more time with their grandkids. So, Mr. Palafox, I wish you 100% the best.

Scott Palafox: Thank you, Lou.

Lou McDermott: As far as the Board goes, I just wanted to say the relationship between the Director of PEBB and the Board is extremely special. I know sometimes it might feel like we are just going through the process and getting to the next Board meeting and trying to get through the season. We've got certain things we are trying to advance, and we are dealing with certain circumstances that happen outside of our control. But as an agency, it is very difficult to manage a Board and to ensure the will of the Board is implemented. Board members are all different, but Yvonne was no different than any of you. She was her own person. She spoke infrequently but powerfully.

During my time, I would always make sure that when I spoke with Yvonne that I knew what her thoughts were about various subjects. What I didn't want to happen is me going off in one direction that I think is the right answer, but the agency thinks it has the right answer, and then something happens during the Board meeting. If Yvonne disagreed with it strongly and took us by surprise, her voice carried a lot of weight, and that could cause a lot of issues on our end. You know it's a delicate balance between the Board, the agency, the Governor's Office, and the Legislature. Trying to maintain that balance and get things done is difficult. I always appreciated her presence, the power of her voice, and her calmness. And yet, don't let her calmness fool you because she was a force, and if she felt strongly about something, she was going to make sure it was well known.

I wanted to come today and thank her for the time she spent with us. I'm sorry she's gone, but she contributed greatly, obviously, to this program and her fellow Washingtonians. It was just an honor to work with her. I'm sad to see her go. I honestly thought I was going to retire before she ever left the Board. I'm going to her service, and I would like to be able to speak at her service as well and say a few words about her. Thank you. And, Dave, appreciate everything you and your staff do. You take care.

Sue Birch: Thanks, Lou. I too, have a special place for Yvonne. I think it says it all when I was talking with her daughter. She said she didn't want to tell you guys what was really going on because she didn't want to leave this work and the team. I think it really says so much about her, her public service, and her commitment towards equity and health, so engaged, always available, and just really poured her heart and soul into

the work we all do together. I think we have to stand on her shoulders -- the shoulders of giants -- and continue her work. I think it's the best tribute we can do, and we are so fortunate to carry on.

We will be looking for a new Board member nomination in a commitment to push for greater diversity, equity, and inclusion. I think it's really important that we try to continue to balance out our Board composition in her honor. So, Dave, I think she would probably now be saying, "Come on you guys. Get on to work. Enough."

But what two superstars we've all crossed paths with, both Yvonne Tate and Scott Palafox. Honestly, we celebrate both of you and we'll carry on. That's what we can do.

Policy and Rules Development

Stella Ng, Policy and Rules Coordinator, ERB Division.

Emily Duchaine, Regulatory Analyst, ERB Division.

Stella Ng: Slides 2 – 4 – Provided for your reference.

Slides 5 – 6 – PEB Board Policy Resolutions

Slide 7 – Follow-up Questions from March 10, 2022 Board Meeting. A question was asked as to why the Uniform Medical Plan Classic is the default plan. Dave provided the following reasons: 1.) UMP was the basis when beginning to develop the benefit design for the UHC plans, so it should be an easy transition from one plan to the other. 2.) UMP is the plan with the most enrollment, so for many, the transition will be easier. 3.) UMP is available to all of our retirees and not limited to a regional service area.

An additional reason is because the Board adopted PEBB 2020-05 in 2020 by enrolling non-Medicare enrollees to the UMP Classic Plan when a subscriber elects to enroll in an MA-PD plan. By using UMP Classic as the plan during the months prior to when the MA-PD coverage begins would maintain consistency when addressing passport policy. Resolution PEBB 2020-05 is in the appendix for your reference.

Slide 8 – Why does the federal government not allow Medicare enrollees to enroll or disenroll from Medicare Advantage plans at any time? Why are they restricted to Special Election Periods? The response on this slide was extracted from a response by the Centers for Medicare and Medicaid Services (CMS) when implementing the Medicare Modernization Act of 2003 during public period comment in 2005. Many of the special enrollment periods we have today were established when Congress implemented the Balanced Budget Act of 1997. Specific parameters were set in which election changes could be made.

CMS has historically included in the regulations those Special Election Periods (SEP) that have been specifically named in statute and established for exceptional circumstances in their operational guidance. For employer-sponsored Medicare Advantage plans, all annual open enrollments and our special open enrollments are considered Special Election Periods as allowed by employer-sponsored group health plans.

David Iseminger: I want to acknowledge that Stella did a lot of work to identify this. It is very clear from documentation from the Congressional record, as well as CMS regulations, that it was very purposeful. It is quite clear from the pieces Stella identified in the federal record that it was very purposeful, that it's supposed to be prospective to avoid the gap situation.

Stella Ng: Slide 9 – Resolution PEBB 2022-03 Medicare Advantage Prescription Drug Plan Enrollment During Gap Month(s) – Revised. The revision in this resolution reflects non-Medicare dependents will also be enrolled in the UMP Classic during the gap months prior to when the MA-PD coverage begins. Slide 10 is the final revised version with the added verbiage. The original proposed resolutions and examples are placed in the Appendix for your reference.

Sue Birch: Vote - Resolution PEBB 2022-03 – Medicare Advantage Prescription Drug Plan Enrollment During Gap Month(s) Revised

Leanne Kunze moved, and Tom MacRobert seconded a motion to adopt.

Voting to Approve: 6
Voting No: 0

Sue Birch: Resolution PEBB 2022-03 passes.

Stella Ng: Slide 11 – Resolution PEBB 2022-04 Deferring PEBB Retiree Insurance Coverage When the Subscriber Becomes Eligible for the Employer Contribution received one stakeholder feedback and questions on other topics not related to the resolutions were also addressed. Feedback related to this resolution regarded faculty who returned to teach post-retirement and don't want to disenroll from their retiree medical to enroll in coverage for three months and then have to re-enroll in retiree medical. Federal Medicare secondary payer rules require employers to offer employees over the age of 65 the same benefits under the plan and the same conditions as any other employee under age 65. Federal law prohibits an employer from offering any financial or other incentive for an employee entitled to benefits not to enroll under a large group health plan, which will be the primary payer of claims to Medicare.
For the PEBB Program, there is a Medicare retiree premium subsidy provided to subscribers and spouses enrolled in PEBB retiree insurance coverage. Employers also may not contribute to Medicare supplemental plan for those who have and whose spouse has current employment status. The proposed PEB Board Policy Proposal PEBB 2022-03 for automatically deferring PEBB retiree insurance coverage is being recommended. So, all employees will be treated the same and in line with the Medicare rule.

Sue Birch: Vote – Resolution PEBB 2022-04 – Deferring PEBB Retiree Insurance Coverage When the Subscriber Becomes Eligible for the Employer Contribution

Leanne Kunze moved, and Tom MacRobert seconded a motion to adopt.

Voting to Approve: 6
Voting No: 0

Sue Birch: Resolution PEBB 2022-04 passes.

Emily Duchaine: Slide 12 – Uniformed Services Employment and Reemployment Rights Act (USERRA) for your reference.

Dave Iseminger: Slides 13 and 14 – The year on the resolution is incorrectly noted. It should be corrected to say 2022, not 2021.

Emily Duchaine: Slide 13 – Resolution 2022-01 Employees Returning to Work From Active Duty – Revised. This resolution language was revised to include "employer-paid PEBB benefits."

One stakeholder had a technical question on the use of the words "health plan coverage." Our response explained that the final proposed language would be revised to say "employer-paid PEBB benefits."

Slide 14 – Final Resolution 2022-01 with revised language.

Sue Birch: Vote – Resolution PEBB 2022-01 – Employees Returning to Work From Active Duty

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

Voting to Approve: 6
Voting No: 0

Sue Birch: Resolution PEBB 2022-01 passes.

Emily Duchaine: My apologies for the error. I did peek ahead at the next resolution. It also says 2021. The record will reflect it is 2022.

Slides 15 – 16 – RCWs are included for your reference.

Slide 17 – Resolution PEBB 2022-02 Employees May Waive Enrollment in Dental. HCA did not receive any feedback on this resolution.

Sue Birch: Vote – Resolution PEBB 2022-02 – Employees May Waive Enrollment in Dental

Tom MacRobert moved, and Scott Nicholson seconded a motion to adopt.

Voting to Approve: 6
Voting No: 0

Sue Birch: Resolution PEBB 2022-02 passes.

Slide 18 – Next Steps.

2022 Annual Rule Making

Stella Ng, Policy and Rules Coordinator, ERB Division. Slide 2 – Rule Making Timeline.

Slide 3 – Focus of Rule Making.

Slides 4 – 5 – Administration and Benefits Management.

Slide 6 – Regulatory Alignment. A few changes will be made to align with federal regulations. An example clarifying the special open enrollment: Emily and Aaron have a son named Bobby. Both Aaron and Bobby are enrolled in Emily's PEBB insurance coverage as dependents. Aaron goes to work for Boeing, and he becomes eligible for the Boeing employer group plan, and he wants to enroll Bobby in his coverage. The current special open enrollment rule doesn't allow the child to be disenrolled, and we will clarify a rule to allow both the child and the spouse to be disenrolled so that they can both be enrolled in the Boeing plan.

Elyette Weinstein: Stella, you totally anticipated my question. I'm going to recommend both in the rule when it's published. And I would have loved it in the materials if you had the excellent example that you just gave me. If I don't understand this, having an example helps. I urge you to include that example when you publish the rule.

Stella Ng: Thank you for the suggestion. We will include that in our communication materials.

2022 Legislative Session Wrap Up

Cade Walker, Executive Special Assistant, ERB Division. Slide 2 – Number of 2022 Bills Analyzed by ERB Division.

Slide 3 – 2022 Legislative Session – ERB High Lead Bills.

Slides 4 – 5 – ERB High Priority Lead Bills – Passed. House Bill 1052 – Group insurance contracts pertains to allowing performance guarantees in our contracts with our carriers.

House Bill 1688 – Out-of-network Health Care. Further expands protections regarding balance billing or surprise billing.

House Bill 1689 – Biomarker Testing Prior Authorization. Removes some barriers for individuals with certain types of cancer.

Senate Bill 5532 – Rx Drug Affordability Board. This establishes this Board that will be housed within the Health Care Authority. There are parameters around which type of medications can be reviewed by the Board. The Board will make recommendations about pricing subject to legislative session timing.

Senate Bill 5546 – Insulin Affordability – expands legislation that passed a couple years ago that capped the price of a 30-day supply of insulin at $100. SB5546 for 2023 plan year caps the price of a 30-day supply of insulin at $35.

Senate Bill 5610 – Rx Drug Cost Sharing helps reduce out-of-pocket costs for members when there is a third-party payer. That cost is applied to the cost-sharing portion for the member either prescription cost-sharing or their overall cost-sharing obligations.

Senate Bill 5702 – Donor Human Milk Coverage. This bill ensures human donor breast milk for newborns can be covered under insurances.

Slides 6 – 7 – Other Passed Legislation. House Bill 1329 codifies some of the emergency provisions put in place when the pandemic started regarding open public meetings.

HB 1651 – Postpartum Contraceptive ensures coverage for contraceptives closer to postpartum time for recently pregnant women.

HB 1675 – Dialysate and Dialysis Devices. Removes administrative barriers for manufacturers of certain devices used for dialysis.

HB 1728 – Insulin Work Group Reauthorization. The insulin Workgroup has been reauthorized with additional funding. They will submit a report to the Legislature.

HB 1761 – Opioid Reversal by Emergency Department Nurses allows emergency department nurses to provide opioid reversal medication prescriptions to individuals who present to the emergency room for an opioid overdose.

HB 1851 - Abortion Care. Expands the authorization of providers authorized to provide abortion services.

HB 1881 - Birth Doulas. Requires the Department of Health to create a license or certification program for birth doulas so they can be covered under insurance plans.

Sue Birch: I want to point out to the Board that everything on Slide 6 are all significant equity issues for those we cover that have unique needs and/or might be on less livable wage incomes. These advances help create continuity and are all efforts to move into greater diversity equity inclusion and health equity space.

Cade Walker: This year HCA analyzed bills with an emphasis on diversity, equity, and inclusion, but also making conscientious efforts to view bills from a health equity standpoint. The ERB Division was part of an HCA pilot program to have our analysts be trained and provided with additional material to help build a lens to view legislation with a focus on health equity.

David Iseminger: I want to comment on House Bill 1328 – Public Meetings. I want to reassure the Board and public and clarify that while the state public health emergency is in effect, we will continue to host Board meetings for the PEB and SEB Boards exactly how we have been hosting them for the last two years. Once the state public health emergency is lifted, we will move to a hybrid meeting with a physical space at the

Health Care Authority like we did pre-pandemic but will continue to provide access to the meeting in the same manner we provide today. We will continue to have the visual experience like today using Zoom or whatever platform the agency is using. Board members will be able to attend in person or remotely at their discretion, as well as the public.

Cade Walker: The last few bills that were passed have significant impacts on diversity, equity, and inclusion in the health equity space.

HB 1893 – EMTs/Public Health authorizes emergency medical technicians to expand their scope of services they can provide in an emergency crisis.

HB 5508 – Insurance Guaranty Fund increases availability of the state's insurance guaranty fund to a different types of newer insurance type providers.

SB 5518 – Occupational Licensure Compact authorizes the state to join the OLC. It allows certified and licensed occupational therapists to practice both in Washington and also in states who participate in the Compact.

SB 5539 – Educational Service District Funding. This bill requires the state to pay for the benefits for employees who are covered by a union within the educational service districts. The educational service districts were initially included in the 2020 launch of the SEBB Program. They are not school districts. There are nine ESDs serving school districts on a regional basis. There are approximately 3,500 employees in the nine ESDs, about 100 of which are represented when the ESDs lobbied for legislation prior to the launch of the SEBB Program. They were exempted out from participating in SEBB until 2024, except for those employees who were represented because of collective bargaining, who joined the SEBB Program in 2020. This legislation requires the state to provide full funding for those employees, so their benefits are covered under the SEBB Program. Currently, seven of the nine ESDs participate in the PEBB Program. They will transition to SEBB in 2024.

SB 5765 – Midwifery expands the scope of licensure for midwives, allowing certain devices and prescriptions to be provided by midwives.

SB 5793 – State Boards, etc./Stipends. This is equity and inclusion legislation providing stipends be made available to participants on State Boards, Commissions, or other non-compensated positions that serve the state for individuals who are of a lower socioeconomic status, or whose participation may be creating a financial hardship on them.

Work has started on a report regarding UMP, the third-party administrators, requested by the Legislature in a budget proviso asking HCA to provide considerations about returning part of the third-party administrative functions to an in-house function. That report is due next June to the Board, then to the Legislature.

There is a requirement of proviso where the HCA will work in tandem with the Office of the Insurance Commissioner to conduct an analysis of a fertility benefit, which pertains to a sunrise review that was done by the Department of Health a year or two ago. We are starting that work.

The PEBB and SEBB Programs will be involved in a palliative care report that will be spearheaded by the Medicaid side the Health Care Authority. This information and data will be rolled into an overall report on palliative care for the Legislature.

2024 Uniform Dental Plan (UDP) Dental Design

Ellen Wolfhagen, Senior Account Manager, ERB Division. Slide 2 – Objectives.

Slides 3 - 4 – Follow Up Questions from March Board Meeting. Tom MacRobert asked about a comparison of the current dental portfolio.

Slides 5 – 6 – Medicaid and UDP. Chair Birch asked for a comparison between Medicaid and the UDP.

David Iseminger: We wanted to go over some of these to compare and contrast on foundational elements of Medicaid versus the self-insured Uniform Dental Plan. Numbers on a chart don't tell the whole story. It's important to think about these aspects as Ellen goes over the charts. There are different pre-authorization requirements, age limitations, and the definitions of Class I, II, and III aren't aligned between the two portfolios. The funding fluctuates. There are cost shares in UDP but not in Medicaid. There are other components to consider – more than a table on a page – to keep in mind.

Ellen Wolfhagen: Slides 7 – 8 – UMP and Medicaid Comparison.

Slide 9 – Current UDP Plan Design. As a reminder, the plan payment is different than how we look at medical expenses. On the medical side, it's a maximum out-of-pocket for the patient. On the dental side, it's the amount the plan pays toward services.

Slide 10 – 2024 UDP Options, listed in order of population impacts and the number of people who would benefit from the plan change.

Slide 11 – Current PEBB Program Membership, which includes subscribers, dependents, and children up to age 15.

Slides 12 – 15 – Current UDP Annual Plan Maximum Details. I want to discuss bullet #3, Premium and Preferred providers. Preferred providers are those who have the best contract rate with Delta Dental, and the patient has the highest level of coverage and the lowest amount of co-pays. The opposite is true on Premium providers, who have a lower coverage rate, and generally a higher percentage picked up by the member. However, UDP does not prevent anyone from seeing a Preferred provider. For example, the preventive services are covered at 100% for Preferred providers, they're covered at 80% currently for Premium providers. Class II fillings are covered at 80% for Preferred providers and 70% for Premium providers.

For Preferred providers, preventive services are covered at 100%, and currently count towards the plan maximum.

Slide 15 – Preventive Service Visits.

Slide 16 – Current UDP Annual Plan Maximum Example. Allowed amount means the dentist cannot charge balance billing for the difference between the allowed amount and the billed amount, although, the patient will see the difference on the bill.

Slide 17 – Example of Katy's Claims.

Slide 18 – Proposed Annual Plan Maximum Benefit Change. As a reminder under the medical plans, the patient pays neither a deductible nor do preventive services count against the maximum out-of-pocket for medical expenses.

Slide 19 – Example of Katy's Claims Under Proposed Change.

Slide 20 – Comparing Katy's Out-of-Pocket Costs. It's important to note that a patient having periodontal maintenance usually has three to four visits a year, which adds up quickly. It is unusual for somebody to have just preventive services use up their full plan maximum, but if you had a lot of periodontal maintenance, it might be the situation.

David Iseminger: Periodontal maintenance might cost $500-$600 a year for your standard cleanings. But the non-periodontal maintenance might be about $250 a year. No one is really getting to a plan maximum of $1,750 coverage just on preventive services. The idea here is to take away any potential perceived financial barrier to getting preventive services. We all know that health literacy in medical, dental, and all benefits is very challenging. Going back to a point Ellen made earlier of trying to normalize and treat preventive services similar to dental as it is in medical. It's much easier for messaging to be able to say there is absolutely no cost associated with preventive services, no matter how you slice it rather than, you have gone through your preventive services. We're trying to eliminate some of those cost barriers and get people focused on good oral health and good oral health practices and not worrying about paying out of pocket.

We wanted to bring you very specific proposals and focused first on preventive services after looking at the overall cost and breadth of the population that would be impacted. Of course, there are other ways to address the annual plan maximum just as there are going to be other specific ideas that come up for the other options Ellen described.

We wanted to bring very specific vetted proposals and start getting very specific financial pricing.

Elyette Weinstein: So periodontal maintenance would be considered preventive care, would it not? This ties in with the previous themes about equity. For older people, and I'm speaking out of experience, periodontal services affect usually people of a certain age. You're looking at equity also for older people to take care of themselves. The other problem I have heard of is that there is some kind of connection with heart conditions. Maybe Ellen knows more about this and health care. Again, this has a direct impact, or it can have an impact, on older populations, at least probably more than young adults. You're looking at an equity feature in this proposal, as well, I think.

David Iseminger: I feel sorry for anybody who has just unfortunate teeth genetics. I would say I'm a younger adult, and I have unfortunate teeth genetics. And I have said it

several times before in other meetings, I have periodontal maintenance and have for a long time. It affects a wide range of people. You're correct, Elyette, it can impact older adults, as well as people who maybe didn't have good oral hygiene habits at a younger age and are still course-correcting on their oral hygiene. There is definitely a tie to overall health.

Ellen Wolfhagen: Elyette, those are correct observations. Dave, thank you for the explanation.

Slide 21 – UDP Annual Plan Maximum Benefit Change Insights, is an illustration of the impacts. While 73,000 members of PEBB were not seen at all in 2021, we hope that taking preventive services out of the plan maximum might encourage some of those people to go forth and have preventive services, which has overall health impacts. But the 239,000 people who did have those services would realize savings in terms of the plan maximum. This affects everybody in the PEBB Program.

Slide 22 – 23 – Composite Fillings – Current UDP Posterior Composite Fillings Coverage Detail. Composite materials are different than amalgam. Amalgam is the metal material used for fillings. For anterior teeth, anything in front of the pre-molars, composite fillings are routinely used and covered up to the allowed percentage amount. For UDP currently, for posterior fillings, composite fillings are considered an elective procedure, and the coverage is limited to a percentage of the amalgam allowed amount.

Slide 24 – Current UDP Posterior Composite Fillings Coverage Example. We are assuming Joe's deductible has been met. There is a difference in the network allowed amount, not in the PEBB allowed amount.

Slide 25 – Proposed Composite Filling Benefit Change.

Slide 26 – UDP Composite Fillings Benefit Change Insights. In terms of the number of people that took advantage of fillings, the number of members is lower than the other numbers because, on average, people have about 1.6 fillings per visit. The number of procedures is greater than the number of members.

Elyette Weinstein: On Page 24, I'm still confused about the difference between the network allowed amount under the composite row versus the PEBB allowed amount. Why is it different? Obviously, there is something I don't understand.

Ellen Wolfhagen: The network allowed amount is what Delta allows all of the dentists in their network, the preferred provider network, to charge as the allowed amount. Through the contract negotiations, there has been a limit on the PEBB allowed amount. It's been limited to the same as what is covered for amalgam.

Elyette Weinstein: So, for example, if I have a non-preferred provider, the PEBB allowed amount would be $125.

Ellen Wolfhagen: No. Even if you had a Preferred provider, under the PEBB amount, you currently are limited to just a percentage of the $125. If you had, for example, Delta Dental through Boeing and you went to a preferred provider, if Boeing did not have a restriction, that preferred provider could charge $150.

Elyette Weinstein: Thank you. I had no idea.

David Iseminger: Elyette, before we move on, this proposal that Ellen has presented, on the next slide, is specifically homed in on that bottom, middle box, the PEBB allowed amount composite filling. Changing what we consider the allowed amount to be greater than the amalgam. That is the box being proposed of having a change.

Elyette Weinstein: Thank you for explaining this.

Ellen Wolfhagen: Slides 27 – 28 – Incentive Plan Design Promoting Preventive Services and Current UDP Coverage Limits.

Slide 29 – Incentivize Preventive Services.

Slide 30 – Preventive Service Visits.

Slide 31 – Incentive Plan Example illustrates how the incentive plan would work.

Leanne Kunze: Do we have statistics to compare participation in the preventive services prior to the pandemic versus what's being provided now? A lot of folks are impacted by the pandemic and choose to delay care. It seems to be a different incentive. I want to make sure we're looking at the statistics of what that is.

Ellen Wolfhagen: Yes.

Slides 32 – 33 – Child Deductibles / Current UDP Deductibles.

Slide 34 – Proposed Child Deductible Benefit Change.

Slide 35 – UDP Child Deductible Benefit Change Insights.

Slides 36 – 37 – Temporomandibular Joint (TMJ) Limit / Current UDP TMJ Coverage.

Slide 38 – Proposed UDP TMJ Benefit Change.

Slide 39 – UDP TMJ Benefit Change Insights.

Slide 40 – 41 – Prioritization Discussion / Prioritization: Using Population Impacts. The impacts listed are in the same order as presented, based on population impacts.

Slide 42 – Prioritization: Using Estimated Premium Impacts (lowest impact to highest impact). A reminder that most SEBB Program employees become PEBB Program employees when they retire. There is a difference between lines three and four for both programs due to the demographic difference in the populations under PEBB and SEBB.

Slide 43 – Who Pays Premium Reminder.

Slide 44 – Funding for All Five Benefit Proposals. These amounts are based on pandemic period utilization. The actual premium increases may vary. And as a self-

insured plan, ultimately, the state has claims liability. The amounts are per subscriber not per member.

David Iseminger: I want to add context to the first bullet. What does $5 and $7 PSPM really mean? If all five of these proposals were funded, that means retirees, COBRA members, leave without pay member, would see monthly premium increases in that $5 to $7 range. HCA is not saying that all five proposals would get funded. This is a building process, and we'll see where the chips fall at the end of the day. For the employer side of the equation, I'll extrapolate what that means for an overall scope of a funding decision package. $1.00 in the funding rate for each program is roughly $1.5 million. If you take the $5 low end and the $7 high end, multiply each by $1.5 million, you get a range of $7.5 to $10.5 million. That's for a single program.

We have two programs, PEBB and SEBB. When we put forward decision packages in our modern era, we describe the effect of both programs. Double those numbers and you get decision packets on the magnitude of $15 to $21 million. You remember the agency put forward a decision package on long-term disability to potentially increase the employer contribution to change that benefit in PEBB from $240 to $1,500 a month. The magnitude of that decision package combined with the PEBB and SEBB Programs, was around $18 million to $19 million. The proposal of all five of these benefits designs is similar to the scope and cost of the LTD package.

Earlier I said, there are many ways that each of these proposals could have been costed out in different ways. We were also trying to target something in the $5 to $7 range that will equal that $15 million to $20 million range for the overall decision package, because experience suggests after that range it really becomes challenging to have a realistic discussion about that much of an investment at one time. There is no guarantee that the decision package would be picked up in whole or in part. We were trying to balance incremental realistic change, an emphasis on preventive services, and looking at various equity lenses.

The agency decision paper will ultimately be put together this summer. We are having simultaneous discussions with both Boards. Absent anything different coming up between the Boards, the plan is to describe things focused on the impact of the breadth of the population. Similar to the order presented here during the presentation but then also to give some language to what we hear at both Board meetings, or from the stakeholder community, about prioritization. That way if the Legislature and Governor's Office decide they want to invest $3, they can shop down the list while also knowing what both Boards felt was the prioritization if everything couldn't be invested in at this time.

That's why we're having a prioritization discussion and not asking for a formal vote from both Boards. In fact, there might be different parts of these options that would be considered more beneficial to one program over the other. What does this Board think for the population you're serving. In what areas would you like to invest? If both Boards think something shouldn't be on the table, we can take it out of the decision package writing process in its entirety. It would be important to hear about that, too.

Elyette Weinstein: What will help me prioritize is to know if you, or anyone else, have an idea of what's most likely to pass. I can't speak for anyone else but that will help me

prioritize. I may think something is important, but the Legislature might eat it up because it will get them votes. And I have no concept of what is a big vote-getter?

David Iseminger: It's very hard to predict what a majority of 147 people think. It will depend a little bit on what the financial status of the budget projections are in the next biennial budget. We could all agree, but then there is no money! That's why we thought about anchoring the conversation in the breadth of the population served because the more you can describe something to be broad-based for addressing specific equity issues, those seem to be particularly compelling points. We tried to put together options that check those boxes.

Ellen Wolfhagen: Slide 45 – Initial Premium Insights on TMJ & Child Deductible Proposals.

Slide 46 – Initial Premium Insights on Incentive, Composite Fillings, and Annual Plan Maximum. The next three options together are very expensive. Any of these changes individually would impact the funding rate.

David Iseminger: That's the first two, the child deductible and the TMJ, being around a quarter or a little less. We're trying to get rough ranges because inevitably we will refresh the numbers, and we don't want people to get stuck on the pennies and nickels too early, but the final decision package will have very specific numbers. The first two, the child deductible and TMJ, are the sorts of things that don't necessarily impact the funding rate could just be language in the budget that says claims are assumed to be able to account for these expenditures and authorize those changes.

A couple years ago, that occurred. It was the only change in recent history to UDP where replacement crowns could occur every five years instead of every seven years. It didn't require additional funding, but it was noted in the budget that there is an assumption it is covered by the existing funds.

Looking at the incentive, composite, and annual plan maximum from a retiree standpoint, to make one of these changes, multiply the number by 12 and think about the range of out-of-pocket expenses.

I think there is interest from this Board to be very clear about preferences among retirees based on years of conversations regarding medical rates, and every dollar does matter when you're on a fixed income. These proposals will impact the retiree population directly because the retirees pay the premiums in a way that no one in SEBB feels and employees in PEBB also don't feel. I don't want anyone to be blindsided.

Ellen Wolfhagen: Slide 47 – Prioritization Discussion.

Scott Nicholson: I'm very supportive of the non-deductible for children. The burden of childcare is most felt by those in the lower income. We have a lot in the state of Washington where our average wage hovers around $70,000, although I'm sure Leanne can correct me. Given the demographics of the distribution of wealth, especially for those that may be on the lower end, I see that as an equity issue and something we need to do. Similar to the Child Care Tax Credit, where you are raising people out of poverty, especially those that are people of color. This is a way to do that, and that's for

children, and they're not going to be sacrificed by difficult decisions their parents have to make on getting them access to care.

I'm struggling to support an incentive structure. With inflation, families are struggling with difficult decisions. Making the decision between going to the dentist or paying the rent is real for some. I think in the current environment, and as I talked about it before, the disproportionate impact of being in a lower income, especially for people of color, I don't want those difficult decisions, which are real and big decisions that families have to make to be penalized later. I'm recommending we take the incentive off the table. It's not something I can support. Obviously, I'll keep an open mind and listen, but I'm really struggling to be honest. You've probably heard that a little bit in my conversations or my comments in the last Board meeting when we were talking about the WEA plans.

Tom MacRobert: I want to go back to the Slide 44, funding for all five benefit proposals. The overall estimated per person per month increase for each program is $5 to $7. Is that correct? Or is that for the total were we to adopt all of them?

David Iseminger: $5 to $7 for PEBB and $5 to $7 for SEBB.

Tom MacRobert: If we were to adopt all of them, in this case, for PEBB, we could expect our monthly premiums to go up approximately, at the most, and I know you are ballparking this, $7. Is that correct?

David Iseminger: Per month. That's the ballpark.

Tom MacRobert: Currently, I believe Uniform Dental is $48 a month. You are saying it could rise to $55 a month. Is that correct?

David Iseminger: Yes.

Tom MacRobert: I have mentioned this before, but unlike other programs where cost has seemed to go up almost every year, I went back and looked at Uniform Dental going all the way back to when I retired, which was in 1999. Uniform Medical Dental has not gone up every year. In fact, it has varied between a high of $49 and a low of $42, with the lowest point not being the year I retired. I'm guessing there are other external forces that affect the cost of dental care besides these kinds of programs. In other words, yes, this would raise it, but that doesn't necessarily guarantee that the next year those rates are going to be $7 more. It could be $5 more. It could be even $3 more because there are other external factors that drive the costs of dental care based on the last 21 years of increases or decreases in dental care.

David Iseminger: A couple of things, Tom. These $5 to $7 estimates are based on projected utilization and assumptions of what utilization would change in the population with the changed benefit. That's the importance of the last bullet. Ultimately, the state has claims liability as a self-insured plan because we all have regional confidence in those utilization change estimates, but if they're off in either direction, you could have lower rates if the utilization doesn't change as much, or it could be higher if the utilization ends up being more than what is projected. There is that piece to keep in mind. There have been very stable rates over a multi-decade period. It's also because the benefits design hasn't had any substantial changes over a multi-decade period.

If we had this discussion 10 years ago and some of these were implemented, rates would have gone up due to an enhanced benefit. Because of the stability in benefit design, it helped reinforce stabilized rates.

HCA has tried multiple ways to encourage and increase the utilization of preventive services. Based on our data, the greatest success was with SmartHealth and an additional focus through health literacy, points, and encouraging preventive care. It moved the needle, but there's a long way to go when it comes to accessing preventive services. The stability of the benefit design has also contributed to the rate, and the $5 to $7 is also based on projected utilization assumptions, which could be off in either direction.

Tom MacRobert: What I'm getting at is we automatically assume it's going to go up this much each month. It's not necessarily going to go that way because of the stability that we have had over the last 21 years. That's how I would interpret that. I think that's something to consider when we look at the benefit design packages in front of us. The stability of our dental costs is remarkable, especially when you compare them to our medical costs.

Elyette Weinstein: I do have to premise my questions with the fact that I was staff attorney to the State Dental Board for 12 years. So that does affect a bit of my comments. I believe and agree with everything Tom said. On top of that, I think it's short-sighted. That's not going to help us with the Legislature necessarily. Logic doesn't always work. But in the long run, you save money by people going in for the preventive work. It's preventing them from getting more expensive work down the road, more composite fillings, more crowns, or even dentures. I've seen that in my 12 years of working with the Dental Board, hearing expert testimony, and being at hearings. It makes a big difference, so I think it's short-sighted. That's number one.

Number two, I think removing the deductible for children is good, too, because you are teaching children to have good patterns of getting dental care. In the long run, it's going to save money down the road. And again, there is an equity issue here. I'm saying go back to equity for older persons as well. I've heard from many older people that they don't go in for preventive work because of the situation that is here, the way the benefits are designed, so they let their teeth rot, and get dentures. I think for poorer folks, it's even worse. They tend to forego dental care. That's the thing that's easy to overlook until you've got a really big blown out problem.

The last thing I'd point out with respect to the composites and, again, this is because of the work I've done, composites on baby teeth don't make sense. You're going to have to pull those molars anyway unless they are permanent molars. Why would you put a composite in? The practice I've seen over my years is that you put in a stainless-steel crown. That helps poorer families. It shows we are being reasonable. We're saying if it's a temporary molar, of course, stainless steel crown, amalgam. But composite for a permanent molar, that's a different story. Based on my experience, composites on teeth that are going to be pulled out makes no sense. You could save cost by not putting composites on baby teeth.

Leanne Kunze: I want to thank fellow Board members for these really thoughtful discussions. I want to echo what Scott said earlier. I think the incentive piece, while it

may be something appropriate to continue to consider for the future, I'm not comfortable with it at this time for the same reasons that children don't get to choose. It is parents or guardians who would be responsible for that. Incentives for marginalized communities many times end up being more punitive than incentivized. I'd like to suggest we do more research, look at those impacts, and come back at a future date.

Harry Bossi: Thank you to Ellen for putting this all together. I really appreciate the effort that has gone into this. I want to answer the question that was asked, but before I do, to me, our focus should be on cost containment, while concurrently looking at ways to enhance the dental benefits for the broadest membership. Those aren't always in sync with each other. That's part of several of our roles.

Getting to the question, I don't support the incentive concept for several reasons. To my knowledge, there is no documented study to demonstrate such a concept results in improved dental health or has a positive return on investment. While I respect Elyette's comments, it makes sense. It seems sensible that if you have preventive checkups, you will have less health care requirements down the road. I have not yet seen documentation that proves that.

That is troublesome to me fundamentally, that if a person who is covered does not have a premium share, has two visits covered 100%, no charge, why do they need to be incented? On the other hand, I can't support disincentivizing or, in my view, punishing someone who for whatever reason, why forego an annual checkup. It's not for us to judge. I feel strongly about that and I'm hearing at least three voices that are not comfortable with that. I would propose we do not take this one any further.

I do have concerns about eliminating a deductible for children. I'm fully supportive of equity and all the other comments that have been made. But, to me, that is too segmented a group and probably of less value to retirees who likely have older children, so there is no benefit. For many people, it's limited or segmented, yet everybody gets to pay into it. I'm open to that being further considered, but I do have concerns about it.

David Iseminger: I want to highlight one thing. There is a theme of preventive services, and I don't want the concept of the focus of preventive services to only be on the incentive design. Remember they wrote the annual plan maximum piece removing preventive services from counting against that annual plan maximum, which is also a concept of incentivizing and focusing on preventive services.

Elyette Weinstein: In response to one of the member's comments, representing the older citizens and retired state employees, a lot of us older folks have grandkids, and we're more concerned about our grandkids than we were about our kids. Even if we have adult children, we're very focused on the care for our grandkids, so we do care. Some of us would gladly pay premiums of $7 a month to make sure they’re covered.

David Iseminger: Elyette, I had to check because I remember there was a SEB Board member, when she came on the Board, announced, "I pay $35 more a month to have a son-in-law." She said, "I'm more than happy to have a son-in-law that only cost me $30 a month." Board members commented on that being a good relationship, but it's not all that. Just sharing a light-hearted comment!

Tom MacRobert: When I retired, I had a long, lengthy conversation with my dentist and one of the topics was heart health, the preventive care we mentioned, and all the different pieces covered are what we want people to be utilizing. It helps with things you might not consider being part and of what you do when you get your teeth cleaned. The periodontal work, all of those things are important to the rest of your body. It's one of the things I've made sure I've taken care of over the last 21 years. The idea of incentivizing that, when you stop and consider what could be a relatively low-cost benefit, we should continue to explore.

Sue Birch: Thank you for those comments. I've been carefully listening, and I commend this Board for the robust conversation and input. In general, Dave, anything in the preventive arena should be brought forward for this Board to continue to explore, investigate, and to consider. I think we culturally have had such a disconnect from dental to our medical care, as Tom's last point was being made, and I think anything we can do to start creating that culture shift will get us toward better health and ultimately better health care because we won't have that shift by knowing there is the social to medical mix. This dental piece is a huge part. I want to commend the Board for the richness of the conversation. I count on our team really living up to these principles they're pushing. Prevention is so critical. We to continue being a leader in this area.

I totally agree, Harry, there is a cost-containment component of this, but I would also remind you that we have made some very bold shifts with our Accountable Care Network making primary care not fall under a deductible. That creates wonderful incentive shifts, too, with people getting preventive care.

Harry Bossi: Getting back to the incentive comment/question, to me, looking back at the chart that was shown earlier, says it's 73,000 or thereabouts out of 312,000 members. We're not seeing it all. Why weren't they seen? How do we incent them as opposed to incenting somebody already using it? That's what I'm trying to understand.

David Iseminger: I think that's the million-dollar question. Of all the benefits in our program, this is one I struggle relating to. I personally love going to the dentist! I have no fear of dentistry. I go all the time, but I know that is atypical. That's where a lot of the focus is maybe on the children's piece and instilling good behavior. Good experiences as a child could possibly break that cycle of fear of dentistry. I'm irrationally afraid of snakes that I can't explain. I know people are irrationally afraid of dentistry. There is always going to be some part of the population challenged with going, but anything to reduce barriers is ideal. This topic will come back in May for additional discussion.

I would be interested in hearing at the next meeting what you think is most important? If you could have one thing, what would it be? The SEB Board members are ruminating, too. I will share the tenor of this Board's comments with them and will bring the tenor of their comments back to you. The SEB Board asked us to prepare options for crown coverage. If something could be done, what would the cost be to increase the 50% coverage of crowns in Class III to something else.

Preliminarily that is more expensive than the combination of benefits put before you today. But we are looking at that because the SEB Board, in particular, wanted to see that, knowing that pre-SEBB many school employees had crown coverage higher than

50%, even though 50% coverage is pretty standard in the market. I want you to know the flavor of what's happening in SEBB so far.

Elyette Weinstein: Actually, I want to pick up on something Harry brought up, which was excellent. I would like numbers to back up the fact that when people go for preventive care, it's kind of like people saying, "I don't need a vaccine. I'm fine." When you go for preventive care, does it reduce the likelihood that you will have more expensive treatment down the road? I know there are articles on what Tom pointed out, the link between heart disease and dental care and the lack of people, if you don't go for an exam, how will they know that there's a problem with your heart before it gets worse? It's like going for a mammogram because there's no evidence that there's any link to my getting breast cancer. It's preventive and they can diagnose it. There must be stats.

Sue Birch: I appreciative of those comments, Elyette. I remind everybody that staff is going to keep mining this and talking to other critical partners.

Leanne Kunze: I do agree. I think we all have a role in providing that education, too and not just expecting that from the plan providers. That's definitely clicked with me of why we need to be educating and demonstrating. What does prevention mean and what demonstrates the impact? I was also wondering from a previous comment, could we look at incentivizing in a positive, rewarding way for preventive care versus it being what appears to be a punitive way? Maybe from that, we would be able to look at data that would pull us closer towards what is needed – to be disincentive versus incentive. I think of the impact of that little $25 Amazon gift card for people completing a survey and doing their SmartHealth.

I continue to take into consideration that it may be COVID related, and people have to cut certain things out, and sadly, that's one of the things people have cut out is keeping up on their SmartHealth. But that's wellness – a preventive investment. Important points have been made about why preventive is difficult for those who don't grasp it early on or weren't taught it. It does have an impact, and without that education, you don't know what that impact is until it's too late. I would love for that to be considered if maybe we're looking at a reward incentive, and then really look at that as education and being able to demonstrate how that preventive participation has had an even greater impact. From there, everyone's had the education and we've changed that culture. Do we now need to re-evaluate and look at the possibility of a disincentive? We may want to go with the reward first to ensure the education and culture change are taking root.

Tom MacRobert: Is Uniform Dental also referred to as Delta Dental? There is Delta Care, Willamette, and sometimes Uniform Dental has been referred to as a Delta PPO?

Ellen Wolfhagen: Yes. One name is Delta PPO. If you are on the Delta Dental website and looking for a provider, you would look under Delta Dental PPO in order to find a preferred provider. But the name of the plan is Uniform Dental Plan, and it's different within Delta Care. We're working hard with Delta to brand all of our communications appropriately so people understand which belong with which.

Tom MacRobert: I bring it up because someone I know thought they were signing up for Uniform Dental, and they signed up for Delta Care. Then the dentist they wanted to see was not available to them. Now they have to wait a year. They were confused by

Delta being involved with both names. I bring this up so we can make sure people understand they are not the same thing.

Ellen Wolfhagen: Thanks, Tom. We have received that comment, and we have been working for years to help Delta differentiate the different plans. Thank you.

David Iseminger: Tom, we have seen improvement over time on confusion between Delta Care and Uniform Dental as administered by Delta Dental Plan. The volume of appeals related to plan confusion has definitely gotten smaller over the years, but it is a never-ending quest to continue to differentiate them for sure.

PEBB Modernization Project Updates

Chatrina Pitsch, Manager, PEBB IT Project Director, Enterprise Technology Services.

Slide 2 – What is PEBB Modernization?

Slide 3 – Objectives.

Slide 4 – PEBB Program Current Systems.

Slide 5 – What Changed?

Slide 6 – What Changed: Scope?

Slide 7 – What Changed: Timeline?

Scott Nicholson: I would be interested in a demonstration of the enhancement. I would be interested to see the capabilities and the functionality that is anticipated to be there once we go live.

Chatrina Pitsch: I'd be happy to help provide that. I can provide you with a demonstration of what we have built so far.

Public Comment

Two people provided public testimony. Their testimonies can be found in the audio recording for the April 14, 2022 meeting at:
https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials

Next Meeting

May 12, 2022
9:00 a.m. – 2:00 p.m.

Preview of May 12, 2022 PEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the May 12, 2022 Board Meeting.

Transition to Executive Session

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

Meeting adjourned at 1:08 p.m.

PEB Board Meeting Minutes

May 12, 2022

Washington State Health Care Authority

Draft

Public Employees Benefits Board Meeting Minutes

May 12, 2022
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 1:15 p.m.

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

Members Present via Phone

Sue Birch, Chair
Elyette Weinstein
Tom MacRobert
Harry Bossi
Leanne Kunze
Scott Nicholson

Members Absent

John Comerford

PEB Board Counsel

Michael Tunick, AAG

Call to Order

Sue Birch, Chair, called the meeting to order at 9:05 a.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting is telephonic only.

Meeting Overview

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

Follow Up from April 14, 2022 Meeting

Dave Iseminger, Director, ERB Division. The questions on dental benefits asked at the March meeting will be addressed in Ellen's presentation today. The request from Scott for a demonstration of PEBB My Account is scheduled, but there will also be a demonstration for all Board members early next Board season as we get closer to the launch date.

2024 Uniform Dental Plan (UDP) Dental Design Options

Ellen Wolfhagen, Senior Account Manager, ERB Division. Slide 2 – Objectives.

Slide – 3 Follow-up Questions from April. Can we provide data on the savings based on having preventive services? According to Delta Dental, the cost increases every year people don't have a preventive visit. If there are no visit in two consecutive years, there is about a $368 difference between the cost per member. For children who have sealants, which is one of the preventive services that can be provided, see costs of about $127 less. We do have information on health risks associated with poor dental care. We'll make this information available through our various communications, like a highlight in one of the newsletters.

There is a connection with diabetes, stroke, heart disease, premature birth, and low birth weights that can be highlighted in dental news. Dental offices can address side effects from chemotherapy, which is another benefit we can highlight.

We were also asked about composite fillings in posterior baby teeth. Currently, there is no distinction between pre-molars and molars as they come in for children. There is no difference in the contract coverage now for baby teeth.

Information on pre-pandemic data for people who did not have preventive visits is a bit counterintuitive. Pre-pandemic, the number of people in PEBB was fewer than it is now. 261,381 total members. Of those, 61,381 did not have a dental visit. That's about 28%. But in 2021, which was a pandemic year, although we had an increase in total membership to 312,200, 73,162 members did not have a dental visit in that year, and that's 23%. We had a drop of about 5%. And I think this is just my thinking on this. Do not take this as anything other than that. Perhaps COVID drove people to re-evaluate the need for good overall preventive health.

Elyette Weinstein: I don't know how statistically valid this is, but in my area, several of the dental clinics had to shut down for a while because they had to sterilize and change how they operated to conform to the new requirements. That backed up their calendar.

Slide 4 – UDP Provider Networks - Coverage

Tom MacRobert: When you were talking, you referred to it as Delta Dental. And I mentioned in our last meeting that there is some confusion between the Delta Dental Plan, which is managed care versus the Uniform Dental Delta Dental, which is not. I'm wondering, just to make sure that people don't get that confused in their heads, if there is some way that we can clarify that a little bit.

Ellen Wolfhagen: The managed care plan is always referred to as Delta Care. Delta is the carrier, and their network has many plans, of which the Uniform Dental Plan is one. When we talk about UDP, we are talking about the UDP Preferred Provider Organization plan. Going forward, we'll keep reinforcing it's UDP PPO to help cement that difference. Thank you for pointing that out.

Slide 5 – Benefit Proposal Reminders.

Slide 6 – Market Comparison – Crown Coverage.

Slide 7 – Crown Coverage Benefit Insights.

Dave Iseminger: Crown coverage is an expensive benefit enhancement for discussion. The SEB Board has expressed a significant amount of interest in, and one of the top things we hear from school employees about the benefits design, is the difference in coverage in SEBB benefits, which are exactly the same as PEBB benefits compared to the dental benefits that they had prior to the SEBB Program.

Elyette Weinstein: I calculated the most expensive one. A senior self pays. It would be an addition of $66 per year as I understand it if you went with the highest option and $27 per year if you went to 60%. Given the numbers Ellen talked about and the savings and preventive cost, it might be something seniors would be interested in since they self-pay and there wouldn't be as much of a hit for employers in the budget.

Dave Iseminger: Elyette, just to clarify because I want to make sure you're thinking that many retirees may find the $66, the rough estimate, an acceptable investment given the amount crowns cost?

Elyette Weinstein: That is correct. And I can only give my own experience. I have a UDP-covered dentist, and it cost $650 for my crown, and that was last year.

Dave Iseminger: Definitely appreciate your perspective on it because you're right that one of the key differences between the programs is the retiree population in the PEBB Program self-pay for this benefit. That is an important reminder. They would bear 100% of the premium costs, whereas the premium costs for employees in both programs are borne by the employer. There is no dental premium paid by employees or school employees.

Elyette Weinstein: I also want to point out is that the dental plan still has big holes. It is not mandatory that a senior elect dental coverage. They don't have to join.

Dave Iseminger: That is correct. For retirees, dental is optional. For employees, it's a mandatory benefit. But there is no premium for employees whereas there is a premium for retirees.

Slide 8 – Prioritization Discussion.

Slide 9 – Initial Insights on Incentive, Composite Fillings, and Annual Plan Maximum.

Dave Iseminger: That upper range for these three proposals presented prior to this meeting ranged up to about $2.25. The compare and contrast with the crown slide from a few moments ago is where we were saying the individual costs of crowns at just 60% is a higher incremental PSPM than any one of the three most expensive benefit design ideas presented previously.

Slide 10 – Initial Premium Insights on TMJ and Child Deductible Proposals.
Slides 11-12 – Funding for All Five Benefit Proposals.

Elyette Weinstein: I found the summary inspiring, frankly. I went and looked up the cost of the state budget this year. It's $64.1 billion, and the cost of a $21 million benefit would be three one-hundredths of 1% of the total budget for 2022. That gives that another perspective.

Dave Iseminger: Another interesting point, the PEBB and SEBB Programs together represent around 9% to 10% of the annual budget expenditures for the state, around $5 billion annually. Every agency and every program has great ideas for how to improve things for Washingtonians. If just the PEBB and SEBB Programs had five proposals that reached $20 million, that's $100 million!

Sue Birch: I think we learned in COVID the equity and disparity challenges. I'm channeling Yvonne Tate! Dave, I appreciate your perspective, comments, and how you summarized, and Ellen, all the work you've done. As a Board, we have to constantly keep thinking about parity and how we push between PEBB and SEBB. I think about other covered lives in the state and other resources needed. If we keep spending in the Health and Human Service sector and crowd out environmental and economic issues, I hope we can continue to take an evidence-based approach and be thoughtful.

Ellen Wolfhagen: Slide 12 shows reminders of some of the factors affecting these numbers, which are estimates only.

Slide 13 – Prioritization: Using Population Impacts.

Dave Iseminger: To be as transparent as possible, there was a question by the SEB Board about the 79% and 246,000 members impacted by preventive services and some nuances with that number. That 79% represents two types of people, individuals who would have less money coming out of their pocket, those people who are already hitting the plan maximum, or we estimated within $250 of the plan maximum because that's typically individuals who when they got those services would then reach their plan maximum. There is only about 4-ish% of the population that literally has hit their plan maximum, and another 8% to 10% that are within $250 of that plan maximum. So, about 14% to 15% are people who literally could see a difference in their pocketbook, The rest of the population counted as 80% are people who are getting preventive services. In dental, preventive services counts against you in your annual plan maximum expenditure. If we can get preventive services absolutely free, that would hopefully change the behavioral economics of how people interact with their dental benefits.

I wanted to be very clear because I thought it was an astute point by a SEB Board member if we were saying everybody was saving money, it's not that 79% of people will have more dollars in their pocket. It's probably more like 10% to 15%, but it's the experience everybody has with this type of benefit.

Ellen Wolfhagen: Slide 14 – Prioritization: Using Estimated Premium Impacts (lowest impact to highest impact). The differences between the PEBB and SEBB Programs is due to the demographics of the two populations.
Slide 15 – Feedback from May SEB Board Meeting.

Dave Iseminger: I want to add two things about the SEB Board meeting. The first one is to help people understand the tenor of the conversation around the incentive plan by the SEB Board. They, too, agreed with the general theme of promoting preventive services. There were specific comments highlighting that the school employee experience pre-SEBB with the incentive plan design was viewed as encouraging preventive services because by getting preventive services there was a lower cost-share for more costly services if they were ultimately needed. That's not the same type of comment I heard from the PEB Board. I want to draw attention to how SEB Board members, particularly those who are school employees themselves, were highlighting that school employees perceive that incentive plan design as a way to encourage preventive services. That's a different context than I heard from the PEB Board.

Secondly, we described this as a low likelihood of receiving full funding. Or what would you pick among these if you could only have one or two things? I do want to be very clear that there is no guarantee that any of it will be picked up during the budgetary processes.

Elyette Weinstein: I'm grateful for your comment. However, I do find that sometimes it takes years. There is nothing more important than an idea whose time has happened. And I think if we don't throw it out, when do you start? They can come back to it another time. The Drug Affordability Board was not a new idea when it passed this legislative session. It's certainly worth a try. I think it's showing your leadership at getting the idea out there.

Ellen Wolfhagen: Slides 16-17 – Feedback from April PEB Board meeting. The one thing I want to add since our last meeting is we found that King County extended to county employees' coverage for composite fillings for posterior teeth, as of January 1, 2022.

Slide 18 – Discussion.

Harry Bossi: Would there be a possibility to have a high-low option? We have so, many different variations of the medical plans. Would it be possible for employees to voluntarily opt-in or take a higher plan that would cover additional things like 60% for crowns or some of the other various proposals? I'm not in favor of the incentive plan. I'm in favor of incentives, but I think it's targeting the wrong people. I think the composite is a strong proposal. I would like to see the crown fit in here somewhere.

Dave Iseminger: Harry, regarding your question about two-tiered options. It's like you're reading my mind and thinking about the strategy of the future. I'm always trying to think about what the next type of proposal could be if the first proposal doesn't go anywhere. Looking at the LTD three-year conversations, we tried different options. Often, what is described is something else that could be looked at. You are correct in your inference it would require collective bargaining impacts, given the language in the current collective bargaining agreement. That's not a short-term option, but it's certainly something that could be evaluated. There may be other iterative proposals down the road if employer fully funded benefits don't gain traction from a budget standpoint. You are reading my mind for the future parallel world.

Elyette Weinstein: I think Harry's idea is great when it applies to the senior plan. If it's self-paid, give them an option. Maybe they can't afford the high end, but at least they can get 50% and someone else can get 80%. Have a rising scale on what their options are if they are self-paying. You don't have to bring it to the Legislature for funding. Especially with respect to the preventive side of things. What I have seen is that seniors will often go without dental care when they retire because it costs them more for the medical benefits. This would reach a group that's not being reached.

Sue Birch: Dave, I think the emphasis on prevention is significant. I appreciate it's continuing to be the top priority.

Scott Nicholson: Thank you, Ellen and team for this great presentation and all the work and details. We've had this discussion for a couple of Board meetings now about the impact of these considerations on equity. The concept of equity and the idea that we are helping each other, even if we don't benefit from something, is a core component. I think it's a core component of the health insurance risk pool in general. I would ask my colleagues to be mindful of when we make decisions, whether we're talking about childcare dependence and their ability to have certain types of services at no cost, we would be mindful of the fundamental ideas of equity are helping people who may need that help when you, yourself, are not being positively impacted or perhaps having to provide money or other resources that you will not enjoy. That's how I think about that.

I appreciate the emphasis on preventive services. I think there is a lot of great work, and I would like that to be ranked. I'm still not interested in this incentive plan. I still think it has serious significant equity concerns. And I would like to emphasize child and dependent care just because we know the burden of childcare gets pushed to the most marginalized groups and things like childcare tax credits as well as dependent care. Dependent care-focused benefits really do help. Thank you.

Elyette Weinstein: I also, agree with the previous speaker that eliminating the children's deductible is important. But if you have seniors paying for it, the other option and the preventive care, I don't see that hurting your argument to the Legislature to pony up some money for the kids.

Tom MacRobert: I would like to make sure that I have a clear understanding of if we were to adopt all of these proposals as currently stated, would the active public employees and the active school employees see any effect on what they have to pay out of pocket?

Ellen Wolfhagen: The out-of-pocket, which is what you pay above and beyond what the plan covers, with the annual plan maximum design, there is the potential that you would have more monies available for higher-cost services. All of this depends on utilization, Tom, so, it's hard to predict any one person's use of dental services. Eliminating the child deductible would also lessen the burden on parents who are paying the deductible for higher services for their children up to age 15. There would be a reduction there.

Tom MacRobert: My second question is for retirees. They are the ones that have to pay a monthly fee for their dental care were we to adopt the proposals that could potentially raise the monthly rates up to $7 a month. Is that also, correct?

Ellen Wolfhagen: That is correct.

Dave Iseminger: Not crowns though. If you added crowns, it would be even more.

Tom MacRobert: Correct. I know that I shared with research some research I did. There was concern about the impact on retirees that the rates they would be paying would be significantly greater. I actually have been following Uniform Dental rates for quite some time. I retired in 2001. At that point I was paying for Uniform Dental $23.43 a month. In 2010, there was a significant jump from $41.69 to $47.63. Since then, the rates have remained incredibly stable. If you adjust for inflation in today's dollars, we actually were paying $62.80 a month as a retiree. Now, by comparison, we're paying $48.64. In fact, if you adjust for inflation, 2022 is the lowest it's been since 2003. I think we're overly concerned about rates. Uniform Dental has been, in my mind, one of the best plans that we have on the market for anyone.

Dave Iseminger: The stability of the rates in the Uniform Dental Plan has a direct relationship to the benefit design. There has not been a significant benefit design discussion on the Uniform Dental Plan in easily 20 years. It's stable benefit design, which includes a capped maximum amount of coverage per member that has not been adjusted for even inflation. Your plan liability is extraordinarily stable, too.

Your points are well taken that there has not been a substantial change. It is a robust plan. It is stable. I did just want to highlight part of my thinking every day when we're looking at benefit design pieces are those public comments I heard loud and clear in the summer of 2017, and it has shaped the way I think about things that we bring to the Board and ways that we look at policy proposals for those on fixed incomes.

Elyette Weinstein: Two other things that I appreciate what Tom had to say. There is now a new 3% COLA bill for PERS 1 retirees. As you know, PERS 2 and 3 have built-in COLAs, and PERS 1 is going to go for another COLA this year. They are going to press for a permanent COLA. That may be a factor as well. Social Security has a COLA, as well.

Slide 19 – Next Steps.

<u>Vision Benefit Discussion</u>

Beth Heston, Manager, Senior Account Manager, ERB Division. Slide 2 – Objectives.

Slide 3 – ERB Vision Benefit Survey.

Slide 4 – Vision Benefit Survey Goals.

Slide 5 – Survey Creation and Promotion.

Slide 6 – Survey Results – Of which ERB Program are you a member? Of 22,645 total participants, 13,400 were PEBB, and 9,212 were SEBB. We found that PEBB had a 3.5% response rate and SEBB had a 3.4% response rate. We felt those using the benefits were those likely to respond.

Slide 7 – Survey Results – Which vision hardware do you use? Participants could check more than one box. Our results show about 33.5% of our participants are wearing contacts.

Slide 8 – Survey Results – How satisfied are you with your current vision plan? The goal was to be 6 or above in this survey, with 10 being very satisfied. Six or above was 43% on PEBB, but only 39% on SEBB. The ambivalent vote was 15% on both plans, proportionally. The number of people not satisfied for PEBB was 37% and 41% for SEBB. About 925 people elected inapplicable.

Slide 9 – Survey Results – Rank the following enhancements in order of preference.

Slide 10 - Survey Results – How much do you spend out of pocket on vision each year? The bulk of our population fell in the $300 and under category. survey results?

Slides 11-12 – Current PEBB and SEBB Programs.

Dave Iseminger: For the PEB Board, in the PEBB Collective Bargaining Agreement, if a standalone vision benefit is established, the premium would transition to 100% employer paid. Both versions exist in the Collective Bargaining Agreement. And if there were a change to a standalone vision, the impacts of that have already been bargained should that ever happen.

Beth Heston: The other difference between the plans and the programs is that PEBB uses the medical plan network, while SEBB vision carriers have different networks established in the areas of the state they cover.

Tom MacRobert: If I'm a member of SEBB, do I have the option to not have vision care?

Beth Heston: Only if you don't seek it. It's part of the benefits package paid by your employer. You cannot opt-out of coverage

Slide 13 – Possible Changes to ERB Vision Benefit.

Slide 14 – Board Timeline.

Slide 15 – Remaining Benefit Design Cycle.

Slide 16 – Other Possible Benefit Changes.

Harry Bossi: I have been advocating for a standalone or carve-out for some time. I'm glad to see it. One of the good things I saw that could potentially come out of the SEBB Plan was negotiations would have already been done, and there could be an opportunity if the Board and the other decision-makers saw fit to go to a standalone that

there could be a vehicle. I do have a question. If we were to move from embedded to a carve-out or a standalone, that 15% of state employees contributing now, would that have to be made up by the state because that would have to be 100% funded? What kind of dollar value would that require? How would that affect the funding rate? Would we have to give up something else in medical or dental?

Dave Iseminger: Harry, that will definitely be in a future piece. That is the cost of the decision packet, that 15% incremental increase.

Elyette Weinstein: I'm not sure how the covered providers were picked by VSP. My question related to that is the problem of not liking the preferred providers would be resolved by a standalone program?

Beth Heston: Not necessarily. The provider networks would be different under stand-alone. Currently, Regence, our TPA, has a VSP as their network, but EyeMed, Davis, and MetLife offer slightly different networks. It would depend on where you lived and how many providers in your area were participating in those networks.

Elyette Weinstein: You might not be with a particular provider who is aligned with any of those offered?

Beth Heston: It might happen. Yes.

Dave Iseminger: Elyette, this piece I'm about to add might help. By sheer coincidence, VSP is the network for the Uniform Medical Plan in PEBB Program. The most prolific membership within the PEBB Program is the PPO population, obviously. In the SEBB Program, we do have Davis, EyeMed, and MetLife. MetLife has the majority of memberships in the SEBB Program, and the backbone of their network is the same VSP network, but MetLife has additional wraparound providers. For the most part, somebody who is in PEBB UMP will have a VSP provider that should be a MetLife VSP, but they might also have additional choices.
We can do a little bit more on provider disruption, but the core of the UMP and the core of the MetLife benefits are a similar network. It's just MetLife has a wrapped network that is supplementing that same VSP.

Elyette Weinstein: That is helpful.

Sue Birch: I'm wondering if it would make sense to push eyewear related to computer eye strain as a necessary tool to some other part of the budget, such as DES or some other part of how we think about things and get it out of our health benefit? I know for HCA, 85% of our staff are remote and Zooming all day long. I see an optometrist online and would like to use discretion in asking if he could provide insights relevant to this topic.

Dr. **Jeske**, Tumwater Eye Center, a 30-year provider in the state of Washington. Thank you for this. It's wonderful to hear that and to see the research. That is helpful for us. We are VSP providers, but the comments that are pertinent to what you're doing is really just threefold. Number one, if you ever want to have a provider that's in the area to be able to ask questions and get the provider's perspective, I want to offer my services for that.

Number two, I wanted to clarify the contact lens examination portion of the examinations that are now provided by SEBB and PEBB, particularly the PEBB change, because I get a lot of comments from my patients about this. Prior to the 2021 change, the contact lens exam portion was actually covered yearly by the insurance. And after January 2021 change, the contact lens examination portion, or the fit of the contacts is now only covered every two years. I have a lot of people that are asking about that and complaining about that.

I heard a comment regarding the $150 allowance. I wanted to make sure I clarified the $150 does not go toward the examination itself. The exam is covered 0% copay for the PEBB VSP portion. The $150 is only for hardware. It is only for glasses, lenses, or contact lenses. It's not for the exam. People can't really go to a different provider and have more available for the examination portion. It's only for the glasses and the contact lenses. And that's it.

Beth Heston: Dr. Jeske, I do have to clarify the $150 allowances on the fully insured plans in PEBB go towards their contact lens fitting that comes out of that hardware allowance.

Dr. **Jeske**: Thank you, Beth, for your comments. That is why I want to make sure you really look at that because the $150 historically has been for hardware only, and the fitting is a different section, and the exam is a different section. Thank you so, much for allowing me to comment. Appreciate all that you do, and thanks so much.

Sue Birch: We will note that you have offered up to be a respondent if there are questions. Beth, I'm sure, will be taking you up on that. Thank you. We have that noted in the record for public comment.

Tax-Advantaged Accounts Procurement Overview
Kelsie Pele, Senior Account Manager, ERB Division.

Slide 2 – Overview.

Slide 3 – Benefit Recap.

Slide 4 – Recent Refinements.

Slide 5 – Significant Scope of Work Changes.

Slide 6 – Additional Agency Program Support.

Slide 7 – Procurement.

Slide 8 – 2020 Procurement Lessons Learned.

Slide 9 – 2022 Procurement.

Slide 10 – 2022 Procurement Timeline.

SmartHealth Update

Kristen Stoimenoff, Manager, Washington Wellness Program, ERB Division.
Jenny Switzer, Senior Account Manager, ERB Division.

Kristen Stoimenoff: Slide 2 – Limeade ONE Launch.

Jenny Switzer: Slide 5 – Wellness Procurement.

Slide 6 – Background.

Slide 7 – Program Wellness Procurement Goals.

Slide 8 – RFI Timeline.

Slide 9 – Preliminary Procurement Highlights.

Slide 2 – Limeade ONE Launch. The usability of the site is a different making it easier for members to find information about resources and benefits.

Slide 3 – E-Communications has information about how we ensure members had adequate knowledge of the upgrade experience. HCA and Limeade launched multiple communications before, during, and after the upgrade.

Dave Iseminger: I can provide some insight on how many signed up for the new ONE Launch. By the end of last week, about 9,600 PEBB Program members have transitioned over. A total of just under 12,000 total members between the two programs have transitioned and began using the new platform. We've also, seen a couple hundred increase in newly registered users who had never been part of the platform before. We're seeing a good transition.

Jenny Switzer: Slide 4 – Upcoming Promotions.

Tom MacRobert: When you did the request for information, how many vendors submitted ideas?

Jenny Switzer: There were 13 vendors that participated in the request for information. We met with the first 10 vendors that submitted materials because of time constraints. It was on a first come first serve basis.

Public Comment

Two people provided public testimony. Their testimonies can be found in the audio recording for the May 12, 2022 meeting at:
https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials

Next Meeting

June 9, 2022
9:00 a.m. – 2:00 p.m.

Preview of June 9, 2022 PEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the June 9, 2022 Board Meeting.

Transition to Executive Session

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

Meeting adjourned at 2:00 p.m.

PEB Board Meeting Minutes

June 9, 2022

Washington State Health Care Authority

Draft

Public Employees Benefits Board Meeting Minutes

June 9, 2022
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 2:00 p.m.

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

Dr. Monica McLemore was introduced as the newest PEB Board Member. Dr. McLemore is a tenured Professor in the Child, Family, and Population Health Department at the University of Washington School of Nursing. She retired from clinical work in 2019. Her research is focused on reproductive justice. Her peer-reviewed articles, op-eds, and commentaries have been cited in five amicus briefs to the Supreme Court of the United States and three National Academy of Science and Engineering medicine reports. She became Editor-in-Chief of Health Equity in 2022.

Monica, we are honored that you are committing your time and energy. You know in our discussions you have some big shoes to fill in Yvonne Tate's role on the Board. We want to welcome you and thank you for your participation.

Monica McLemore: Thank you so much for having me. Yvonne Tate's work is not just specific to the state of Washington, but she is nationally known as a vanguard leader, a moral conscience, a person who really served the public for all of her life, and it's a huge honor to be able to join you and to be able to engage in this role. I look forward to supporting the work of the Board as well as becoming a public employee. Thank you for having me today.

Sue Birch: We are eager for you to blend in your voice, your knowledge, and your wisdom.

Members Present via Phone

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

PEB Board Counsel
Michael Tunick, AAG

Call to Order
Sue Birch, Chair, called the meeting to order at 9:03 a.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting is telephonic only.

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

Approval of June 9, 2021 Meeting Minutes
Tom MacRobert moved, and Leanne Kunze seconded a motion to approve. Minutes were approved as written. New Board member Dr. Monica McLemore abstained.

Follow Up from May 12, 2022 Meeting
Dave Iseminger, Director, ERB Division. A question was raised about blue light lenses and their for workers. Our policy folks, and partners in our vision benefits, have indicated there is mixed research and not much clear evidence about the efficacy of blue light filters. The evidence at this time is taking a break from the blue light is more efficacious than extra filters on our lenses.

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

2023 Annual Procurement Update
Beth Heston, Senior Account Manager, ERB Division.

Slide 2 – Annual Renewal Timelines.

Slide 3 – Kaiser Foundation Health Plan of the Northwest (KPNW) Proposed Changes.

Slide 4 – Kaiser Northwest Proposed Changes. Kaiser Northwest operates in Clark and Cowlitz Counties in southwest Washington and some counties in Oregon.

Slide 5 – Out-of-Pocket Maximum in Portfolio.

Slide 6 – Kaiser Northwest Book of Business (BoB) Changes. There was a question at our last meeting about the Diabetes Control Program and the co-pay for zero to 17 age members. Kaiser Northwest clarified that the co-pay information wasn't actually a change, but it was a correction to their exhibit from 2022. It won't be a change in 2023 because they are already charging this co-pay to pediatric members.

The Diabetes Control Program is part of managed care. All Type 1 diabetics would be enrolled regardless of age, though a member may choose not to participate in the

program. The actual number of members in their population with Type 1 versus Type 2 diabetes was too low to release because of HIPAA protections. However, Kaiser Northwest data indicates that diabetes prevalence for members is about 4.8% of the population. For retirees, it is 8.3%.

The new benefits for 2023 include Advanced Care At Home (ACAH), Naturopathic services update, and adjusted cap on monthly insulin charges to $35.

Slide 7 – Kaiser Foundation Health Plans Accumulators.
Beth Heston: Slide 8 – Kaiser Foundation Plan of Washington (KPWA) Proposed Changes.

Slide 9 – Kaiser Washington Proposed Changes.

Slides 10-11 – Kaiser Washington BoB Changes.

Slide 12 – Other PEBB Program Benefits.

Slides 13-14 – Dental Plans.

Dave Iseminger: A reminder that Delta Care is one of our Managed Care Dental Plans. It's administered by Delta Dental, which also administers the Uniform Dental Plan. We have had multiple discussions at the past few meetings with the PEB Board about potential changes or benefit enhancements to the Uniform Dental Plan as early as 2024. Some of what you see on this slide is similar to pieces discussed with the Uniform Dental Plan. All of our partners and carriers for all of our benefits, dental, life insurance, LTD, our medical plans, our administrators for pharmacy, and the Uniform Medical Plan, listen in our Board meetings. Delta and Willamette have monitored the discussions about the Uniform Dental Plan, and Delta came to us with these proposals.

Willamette, I know is considering in a future year, as well, potential enhancements. I think this is a precursor to other changes after a decision package is evaluated at the next biannual process for the Uniform Dental Plan which could prompt even more change. I appreciate that our carriers are participating in our calls and thinking proactively.

Beth Heston: Slide 15 – Other Benefits.

Uniform Medical Plan (UMP) RFR 2022 for Benefit Year 2023
Christine Davis, UMP Account Manager, ERB Division.

Slide 2 – App-based Behavioral Health Program. HCA received authority in the 2022 Supplemental Budget to offer this program. HCA's intent is to increase access to behavioral health resources through an app-based solution.

Slide 3 – Costco Mail Order Pharmacy.

Slide 4 - HSA Qualified Consumer Directed Health Plan.

Slide 5 – Proposed Resolution PEBB 2022-05 IRS Minimum Deductible for Consumer Directed Health Plan.

Slide 6 – IRS Notice 2019-45 provides context to the notice.

Slide 7 – Pharmacy Aspects of IRS Notice 2019-45.

Slide 8 – IRS Notice 2019-45.

Slide 9-11 – Preventive Care for Specified Conditions (Pharmacy).

Dave Iseminger: I want to level set what happens today in the Consumer Directed Health Plan and what is subject to the deductible. These drugs we are about to talk about, right now the member has to meet their deductible before plan coverage kicks in. What IRS Notice 2019-45 did was identify certain things that could be brought in front of the deductible that can have plan coverage *before* that member meets their deductible. Christine highlighted that last year HCA brought forth recommendations and the Board passed a resolution on certain medical parts of the medical plan that could be brought in front of that deductible. Now Christine is bringing information about specific drugs. I don't want people to think they are now going to pay a 15% cost-share.

What is happening with this entire debate, and this entire notice, is that you don't have to meet your deductible first before any plan coverage kicks in. It's getting 85% plan coverage and the member pays 15% in these cost-share scenarios. It's getting that 85% coverage before you meet your deductible. It is an advantage to the member. With Consumer Directed Health Plans that are Health Savings Account qualified, a lot of it is about tax-advantaged aspects, which is why we hear so much from the IRS.

Leanne Kunze: I appreciate that very important clarification. Could you also just confirm whether that 15% cost-share that would expand access before meeting their deductible, will that cost-share also count towards their deductible?

Dave Iseminger: We will bring that as a follow-up when we bring the ultimate resolution back at the end of the month to clarify how this relates to meeting a deductible.

Christine Davis: These tables show specifics of what is allowed under the notice in terms of preventive care for specific conditions and diagnoses. The third column shows certain high-value drugs HCA is recommending be allowed under the notice. This is an iterative process. Some of the differences, for example, are blood pressure medications. HCA will continue to evaluate what other drugs can be added in the future.

Dave Iseminger: It's important to know that when it comes to the IRS and taxes, they are very particular and highly technical reasons that things are advantaged or disadvantaged within the tax code. This notice is a perfect example of the highly technical nature of IRS guidance. It is down to the mechanism of action that a drug is actually performing. For example, on Slide 9 you see ACE inhibitors, and you see lisinopril and hydrochlorothiazide, which are common blood pressure medications. You

don’t see other common high blood pressure medicines that you might be familiar with, like amlodipine or Losartan. That’s because those other drugs aren't ACE inhibitors.

We will continue to look at the technical nature of what exactly might qualify for pre-deductible status. And if there are other things, other blood pressure medicines that are able to fit in, we're hoping to be able to expand some of the things that count as pre-deductible for some of these common drugs that people take.

Christine Davis: Slide 12 – Proposed Resolution PEBB 2022-06 UMP CDHP Pharmacy Preventive Care.

2023 PEBB Medicare Rates and Proposed Resolutions

Sara Whitley, ERB Finance Unit Manager, Financial Services Division.
Molly Christie, Fiscal Information and Data Analyst, Financial Services Division.

Sara Whitley: Slide 2 – Enrollment Summary provides a quick summary of our Retiree Member Enrollment in the PEBB Medicare portfolio of offerings as of February 2022 following final open enrollment results from our 2022 Open Enrollment.

Slide 3 – Medicare Retiree Rates.

Slide 4 – Medicare Retiree Premiums.

Slide 5 – 2023 Annualized Premium Costs. Typically, we share a summary of the monthly retiree premiums by plan for a single subscriber. This year, we wanted to also provide a summary of the annualized monthly premium costs for all of our Medicare Plan offerings. The single subscriber UMP Classic annualized retiree premium is an outlier at more than $5,200 for the 2023 Plan Year. And annual premium costs for UMP Classic Medicare are just about three times more than the UnitedHealthcare PEBB Complete Plan, which was procured as the most similar and comparable option when compared to our UMP Classic Plan from a coverage and value perspective.

Dave Iseminger: This slide is a stark picture about the offerings. We often talk about premium as a monthly piece, but the reality is most people are looking at an annual premium. This slide reflects that annualized amount and how much more expensive from a premium standpoint UMP Classic Medicare is. It's an important concept you'll hear us say throughout today that just because UMP Classic costs more, it doesn't mean it has more value. When I say value, I'm talking very specifically about things like the deductible, the out-of-pocket maximum, the cost shares, and coinsurance.

When you compare those cost shares within the Kaiser Senior Advantage, the Kaiser Medicare Advantage, Original Medicare, and United PEBB Complete and Balanced, and even the Medical portion for the Premera Supplemental G Plan, you will see that the cost shares are the same or very similar to UMP Classic or even better. It's hard to explain what value, from a benefit standpoint, individuals are receiving for that extra increase in premium. Today, if we were to have a 2022 annualized premium chart, the difference between UMP Classic Medicare and some of the other plans would be about $2,500. With the 2023 rates, that jumps to almost $3,500.

We continue to see challenges with the UMP Classic premiums increasing at an outpaced rate for reasons Sara and Molly will share shortly. Value is only going to diminish more over time. The benefits are very similar or in some instances better, but that premium difference is growing.

Sara Whitley: Slide 6 – Medicare Bid Rates Over Time shows a different view. The graph shows Medicare bid rates, not premiums, which are full plan rates before the Medicare explicit subsidy is applied to calculate member premiums. We're providing a full 10-year look back, from 2013 through the current proposed 2023 Medicare premiums. The key takeaway and one that is really important within the scope of our discussion today is twofold. There is a very clear trendline for the UMP Classic Medicare rate. Rates have significantly increased over time, and the slope of that blue line has steadily pointed upward from 2013 through 2023.

While our other plans, the Medicare Advantage Plan, the Kaiser Washington and Kaiser Northwest Plans, are in the red and green lines below the blue line, those rates remain relatively stable. This trend is not only expected to continue into future years, but it has been a predicted trend in the plan for a number of years. It's not something that has gone unnoticed or unpredicted. If we go back in time to 2018, there was a large increase in the UMP Classic rate. It was clear that the increasing trend, and UMP's position in the Medicare market, were not going to reverse course at that time. This led the Legislature to draft a proviso requesting HCA to analyze options for stabilizing the Medicare portfolio.

From about 2018 through the end of 2019, there was extensive research done on what option would be the most effective alternative for retirees that would allow for premium relief in out-of-pocket costs, but also provide a high-value alternative for retirees in UMP Classic. This ultimately led to an 18 month-long procurement and implementation of the Medicare Advantage Plus Part D plans administered by UnitedHealthcare, which were implemented in 2021. If we fast forward to 2023, we're seeing another steep increase in this line graph. While there are other Medicare Advantage Plan premiums, including the MA-PD Plan at the bottom of the graph, are remaining stable. Molly will dig into the details around why we're seeing another large increase for 2023 and why, for the Medicare Advantage Plans this dynamic isn't taking place.

Elyette Weinstein: This was before my tenure on the Board. When the Legislature gave HCA its direction in 2018, did it also indicate an intent to close the UMP Plan?

Sara Whitley: No. We were instructed to research and look at alternatives for the UMP Classic Medicare Plan, particularly to provide more choices to retirees. In addition to the cost increases we were seeing in the plan, we received a lot of feedback from retirees themselves indicating they wanted more choice. It was a two-fold request.

Sue Birch: Sara, wasn't there something that the Congressional Budget Office put out recently, too, about the total federal health care spending consuming a larger portion of federal resources? Didn't they move that date forward, that this isn't a trend unique to Washington, but is part of the national movement of what's happening with rising health care costs? Can't they adjust some of their predictions of when things are and what they need to do to keep putting downward pressure on cost containment?

Sara Whitley: I believe they did. We do want to reiterate that this isn't just a UMP Classic problem. The Coordination of Benefits plans and original Medicare plans are struggling against the Medicare market and the subsidies that are provided to the Medicare Advantage plans. Medicare Advantage plans provide a lot of value, and they are subsidized by CMS, which provides value to our retirees in stable premiums year over year.

Dave Iseminger: It is not just UMP Classic COB that has the structural disadvantage of not being able to access substantial subsidies the federal government and CMS provide to other plans. All original Medicare plans structurally don't qualify for those types of subsidies. Any original Coordination of Benefits plan is struggling with that structural difference of not being able to access those subsidies, which then makes the monthly premium much more attractive to members. It's why when the agency went out for the Medicare Advantage plus prescription drug procurement; we focused on having custom-tailored benefits for our employer group waiver plans because this is not a private individual Medicare Advantage Part D plan. This is an employer group-sponsored plan.

We specifically designed, asked, and worked with United to have a benefit design that would be familiar, welcomed, and appreciated by members who are in UMP Classic. That is not something that can happen on the individual market. It was purposeful to have a comprehensive benefit design that was still affordable given the structural subsidy disadvantage.

Molly Christie: Slide 7 – Medicare Subsidy and Premiums Over Time layers on an historical look back at one of our other Medicare offerings, the Kaiser Washington Medicare offering, to better illustrate the relationship. The takeaway with this slide is that the amount by which the retiree premium increases year over year is a function of the total bid rate and how it leverages the Medicare Explicit Subsidy.

Slide 8 – 2023 Increase to UMP Classic Medicare Premium. The pharmacy trend has continued to increase in double digits, which we expect to continue to happen. The remaining 40% of the total plan spend is attributed to medical claims experience.

Slide 9 – Medicare Bid Rate Development Illustration.

Sue Birch: This slide is such a great visual representation that shows our commitment to trying to better understand the impact to the retiree and their portion of that premium.

Dave Iseminger: The point is to describe that structural disadvantage that a Coordination of Benefits plan, like the Uniform Medical Plan Classic, has because it cannot access the same level and extensive subsidies that the Medicare Part C and Part D plans can, or Medicare Advantage plans, the MediGap plans, or Medicare Advantage plus prescription drug plans. The Uniform Medical Plan Class Medicare can't be restructured to ever qualify for those subsidies. It is a structural disadvantage in the market based on how the federal subsidies administered by CMS are set up.

Elyette Weinstein: Do Plans F and G qualify for the C subsidy?

Molly Christie: No. They are a different type of plan. They are a private plan that doesn't directly provide benefits like specific medical or pharmacy benefits. They help cover the cost of Original Medicare.

Slide 10 – Proposed Fully Insured Medicare Resolutions.

Slide 11 – Proposed Resolution PEBB 2022-07 Medicare Premium – Explicit Subsidy.

Slide 12 – Proposed Resolution PEBB 2022-08 Medicare Premium – KPNW.

Slide 13 – Proposed Resolution PEBB 2022-09 Medicare Premium – KPWA.

Slide 14 – Proposed Resolution PEBB 2022-10 Medicare Premium – UHC MA-PD.

Slide 15 – Proposed Resolution PEBB 2022-11 Medicare Premium – Premera

Slide 16 - Proposed UMP Medicare Resolution.

Slide 17 – Preview of UMP Classic Medicare Recommendation.

Slide 18 – Recent Five-Year Strategic Journey.

Slide 19 – Challenges to Maintaining a Self-Insured COB Plan.

Slide 20 – Reasons for Closure Recommendation.

Slide 21 – Retiree Impacts.

Slide 22 – Proposed Resolution PEBB 2022-12 Uniform Medical Plan Classic Medicare Premium and Plan Closure.

Dave Iseminger: Sara highlighted the five-year strategic journey on how to address the premium increases for UMP Classic Medicare. Summer 2017 was the last time there was a significant one-year rate increase, similarly a 20% increase. I remember very vividly sitting in the Sue Crystal Conference Room at the Health Care Authority and hearing from many retirees about their concerns on a fixed income of the monthly dollar increase per enrollee that was happening at that time.

There was a very clear signal that there was a structural disadvantage to the Uniform Medical Plan Classic within the Medicare portfolio. That started our journey. The legislature provided actuarial funding. There was a budget provision and evaluation of options. The goal was to identify ways to have comprehensive affordable benefits available ongoing in the portfolio, knowing there would be an increasing structural disadvantage for premiums for UMP Classic. Ultimately, a procurement for Medicare Advantage plus prescription drug coverage occurred. Two plans were introduced at the beginning of 2021. The UnitedHealthcare PEBB Complete product design was built based off the foundation of UMP Classic coverage. It was not started from scratch. It was not modeled off an individual private Medicare Advantage Plus Part D prescription drug plan. It was modeled off of the Uniform Medical Plan Classic. It was purposeful to make sure there would be comprehensive benefits in the portfolio that were familiar to

PEBB retirees. Procuring of the MA-PD products was not a cause or symptom, it was part of the proactive solution identified to stabilize the portfolio and offerings that would be maintained as accessible by Medicare retirees.

Sue Birch: Board members, this is the time for discussion.

Board members discussed this topic at length. Audio minutes of their discussion can be found at: https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials.

Policy and Rules Development

Stella Ng, Policy and Rules Coordinator, ERB Division.

Slides 2-4 – RCW Resources.

Slide 5 – Introduction of Proposed Resolution.

Slide 6 – Proposed Resolution PEBB 2022-13 Allowing A One-time Plan Change for Certain Subscribers Enrolled in UMP Classic.

Slide 7 – Proposed Resolution PEBB 2022-13 Example #1.

Slide 8 - Proposed Resolution PEBB 2022-13 Example #2.

Slide 9 - Proposed Resolution PEBB 2022-13 Example #3.

Slide 10 – Next Steps.

Medicare Portfolio

Ellen Wolfhagen, Senior Account Manager, ERB Division.

Slide 2 – Medicare 101.

Slide 3 – PEBB Medicare Portfolio.

Tom MacRobert: Does Plan F contain a drug enrollment? I know Plan G does not.

Ellen Wolfhagen: No, Plan F does not include drug coverage, either. You would need to get an independent drug coverage.

Elyette Weinstein: On page 3, I see that for UHC, there are no enrollment restrictions or additional costs for retirees with pre-existing conditions. Does that apply to going from UnitedHealthcare to Plan G?

Ellen Wolfhagen: There would not be additional costs as a result of having a pre-existing condition. Within the PEBB portfolio during the annual open enrollment, it is possible for Medicare retirees to switch to any plan from any plan within the Medicare portfolio. One could switch from the Kaiser Plan to UMP, or from UMP to Premera, or Premera to United. It doesn't matter. There is no restriction on pre-existing conditions

that would limit your ability to enroll and there is no additional cost for having pre-existing conditions that would limit your ability to enroll.

Slide 4 – Simple Portfolio Comparison.

Ellen Wolfhagen: Medicare Supplement is Plan F, Plan G; Medicare Advantage KP is Kaiser, UHC is UnitedHealthcare; and Original Medicare is UMP.

Slide 5 – Medicare Portfolio Comparison provides a deeper dive into actual benefits.

Slide 6 - Portfolio Comparison – Supplemental Benefits. There is a mistake on this slide. The chiropractic care, acupuncture, and massage therapy for UMP Classic are actually incorrect. The 15% should be $15 copay and the limit is 24 visits for each of those. Premera Plan G is not on this slide because they do not cover any Supplemental benefits. On Kaiser WA Medicare Advantage for routine vision and hardware, the $300 is in red because it was proposed for this year.

Slide 7 – Medicare Pharmacy Comparison.

Slides 8-9 – Sample Most Expensive Drug Comparison. The formulary for UHC was designed specifically to match the formulary in UMP as much as possible. The first row of drugs are specialty drugs, not preferred brands. For UMP, there is no Specialty Tier so they are considered Preferred brands. Under UHC, the information in the box is incorrect. It should say Specialty, and the cost is $100 per month. Although the cost per month is $25 more per drug, overall, a year's worth of those drugs is $300 more a year. As noted before, the annual difference in premium is 10 times that, so there would be the ability to cover that increased monthly expenditure. There is a difference in the formularies in some drugs in UHC. In United, there are more drugs available within a class or Tier, which means there may not be a need for an exception the same way there is in UMP. UMP requires people to try different specific drugs before moving to another drug.

Slides 10-11 – Sample Most Commonly Used Drug Comparison.

Slide 12 - UMP and UHC Comparison Highlights. The green box has combined an increased chiropractic and acupuncture limit that is incorrect because UMP changed their limits. I will address that on June 30, as well as the massage. The last bullet in that box says “Enhanced Vision and Hearing Aid Hardware Benefit.” The hearing aid benefit is NOT enhanced on UHC. I will correct that for June 30, too.

Slide 13 – Kaiser Permanente Networks.

Slides 14-15 – United Network Providers.

Slide 16 – Premera Plan F / G Details. Board members had questions on specific coverage. Those conversations can be heard in the audio minutes at: https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials.

Public Comment

Six provided public comment. Their testimonies can be found in the audio recording for the June 9, 2022 meeting at https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials.

Next Meeting
June 30, 2022
9:00 a.m. – 2:00 p.m.

Preview of June 30, 2022 PEB Board Meeting
Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the June 9, 2022 Board Meeting.

Meeting adjourned at 1:59 p.m.

PEB Board Meeting Minutes

June 30, 2022

Washington State Health Care Authority

Draft

Public Employees Benefits Board Meeting Minutes

June 30, 2022
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 2:00 p.m.

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

Members Present via Phone

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

PEB Board Counsel

Michael Tunick, AAG

Call to Order

Sue Birch, Chair, called the meeting to order at 9:07 a.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting was telephonic only.

I want to acknowledge that the Commonwealth Funds 2022 Scorecard on State Health System Performance ranked Washington State the fourth highest health care performing system in the nation. I want to thank our Employees and Retirees Benefits Division because they are part of how we continue to be transformation leaders and how we continue to offer the greatest value, and to be bold about shaping health care policy and moving things in the right direction. Our successes are around access and affordability, prevention and treatment, avoidable hospital use and cost, healthy lives, income disparity, and racial and ethnic equity. In the western states, we are 2 of 6 and in the country, we are 4 of 51. ERB team, you are a big part of the HCA ship and for the past decade have been shaping the transformation journey.

Meeting Overview

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda, explained the meeting would begin with a scheduled Executive Session, described how public comment would be organized for the meeting given the high volume of attendees, and stated no vote was scheduled for the meeting on PEBB Resolution 2022-12.

Follow Up from June 9, 2022 Meeting

Dave Iseminger, Director, ERB Division. Questions from the June 9 meeting are either embedded in presentations today or responses still in progress. I do want to provide some follow up comments generally about PEBB Resolution 2022-12.

Board members know that the typical practice of the Board is to hear recommended policy resolutions at one meeting, and they are automatically scheduled for action at the next meeting. Between those meetings HCA receives feedback, questions, and insights, and sometimes that prompts changes in the resolution language, and other times it has prompted a delay in a vote so more information can be gathered and presented to the Board. That's a process used by both this Board and the SEB Board for all decisions, large and small.

Now, Resolution 2022-12, was without a doubt a *significant* policy proposal. And with such a significant proposal, automatically scheduling it for action at the next meeting has unnecessarily caused a lot of anger and fear. I want the Board and public to hear that this was never intended and for all the feelings invoked, we are truly sorry.

I'm sure Board members have been reviewing the letters and emails sent about the proposal, as have I. Many have questioned the motivation behind making the closure proposal, and I want to only briefly address this because, again there is *no vote* planned on that resolution today.

Succinctly put, the proposal focused on the fiduciary responsibilities related to running the PEBB Program. But as retirees have pointed out in the past several weeks, there are many other important considerations beyond simply fiduciary ones.

With the feedback received, we realize more time and communication is needed. Not to push a closure proposal, but instead to discuss and ensure there are plans that are available to meet all retiree's needs and also to provide important information about some of the unique protections and safeguards built into the plans offered to retirees, which make them very different from similarly named plans in the commercial market.

HCA wants to take a big step back, engage, listen, and also provide information to ensure a balance between affordability, provider access, and benefit design.

With that said, I also want to be clear that in addition to no vote occurring today, there is no timeline to revisit the closure proposal in the future. Not this Board season, which is planned to end in July. Not this September or fall. Not even during the 2023 Board season. HCA will engage and work with retirees and retiree stakeholder groups to both explain some significant challenges that make UMP Classic less competitive and subject to higher premium increases and listen to approaches to balance the needs of

the diverse retiree population. This will be hard work and they will not always be easy conversations – but rarely is important work that has such a big impact on our lives or the lives of our friends, colleagues, and families – remembering that we are all public servants here are HCA and we all personally know and care about many of the retirees, employees, school employees, and their dependents that we serve.

How the agency planned to organize public comment was then described.

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

Leanne Kunze Motion to Postpone Action on PEBB Resolution 2022-12
Leanne Kunze asked to codify postponing action regarding PEBB Resolution 2022-12. Leanne Kunze moved, and Elyette Weinstein seconded a motion to postpone action on PEBB Resolution 2022-12.

Sue Birch: Vote on Amendments to Resolution PEBB 2022-16
After considerable Board discussion on the verbiage of the new resolution, voting on the final amendments occurred.

Resolved that, the PEB Board postpone action on closure of the UMP Classic Medicare Plan until at least January 2024 to allow staff to interact in earnest with stakeholders.

Public and Board comment occurred.

Voting to Approve: 7
Voting No: 0

Sue Birch: Amendments to Resolution PEBB 2022-16 passes.

Vote - Resolution PEBB 2022-16
Resolved that, the PEB Board postpone action on closure of the UMP Classic Medicare Plan until at least January 2024 to allow staff to interact in earnest with stakeholders.

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2022-16 passes.

Uniform Medical Plan (UMP) RFR 2022 for Benefit Year 2023 Benefit Resolutions for Action
Christine Davis, UMP Account Manager, ERB Division.

Slide 2 – Resolutions for Board Action Today.

Slide 3 – HSA Qualified Consumer Directed Health Plan.

Slide 4 – Resolution PEBB 2022-05 IRS Minimum Deductible for Consumer Directed Health Plan.

Slide 5-6 – IRS Notice 2019-45.

Sue Birch: Vote - Resolution PEBB 2022-05 IRS Minimum Deductible for Consumer Directed Health Plan

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2022-05 passes.

Slide 7 – Resolution PEBB 022-06 UMP CDHP Pharmacy Preventive Care

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2022-06 passes.

Slide 8 – Proposed Resolution.

Slide 9 – UMP Accumulators.

Slide 10 – Proposed Resolution PEBB 2022-14 UMP Accumulators.

Medicare Portfolio Comparisons – This agenda item moved to July 14, 2022 Board Meeting due to time constraints and to expediate reaching general public comment

2023 PEBB Medicare Rate Resolutions and Proposed Resolutions
Sara Whitley, ERB Finance Unit Manager, Financial Services Division.

Slide 2 – Medicare Retiree Premiums.

Slide 3 – 2023 Annualized Premium Costs.

Slides 4-8 – Follow ups will be discussed at a future meeting due to time restraints.
Slide 9 – Fully Insured Medicare Resolutions.

Slide 10 – Resolution PEBB 2022-07 Medicare Premium.

Sue Birch: Vote - Resolution PEBB 2022-07 Medicare Premium

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2022-07 passes.

Slide 11 – Resolution PEBB 2022-08 Kaiser NW Medicare Premium.

Sue Birch: Vote - Resolution PEBB 2022-08 Kaiser NW Medicare Premium

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2022-08 passes.

Slide 12 – Resolution PEBB 2022-09 KPWA Medicare Premium.

Sue Birch: Vote - Resolution PEBB 2022-09 KPWA Medicare Premium

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2022-09 passes.

Sara Whitley: Slide 13 – Resolution PEBB 2022-10 UHC Medicare Premium adopts the United Healthcare Medicare Plan premiums, also listed on Slide 2. These premiums include the changes presented earlier this month related to a copay structure for prescription drugs and increases to the chiropractic and acupuncture visit limit to 24 visits and each applicable copay for each plan, which was included in Ellen's presentation today that was postponed for a future meeting.

Dave Iseminger: I think it's important if our administrative team can show the slide from Ellen's presentation that is intimately related to what Sara just said. It's Slide 33 in Ellen's presentation which is a benefit change brought to HCA since the June 9 meeting.

Earlier this month Board member Tom MacRobert asked that last year the Uniform Medical Plan had increased the chiropractic, acupuncture, and massage visits and wondered if there was a possibility that the UnitedHealthcare plans could similarly make adjustments. We approached UnitedHealthcare about this with an eye towards 2024, but UnitedHealthcare came back and said that, in fact, they could make adjustments

without making changes to any of the premiums that had been presented to the Board on June 9 and are subject to the vote Sara is teeing up now. What I wanted to highlight here is that UHC can match the UMP Classic Medicare treatment limits, and on the PEBB Complete Plan would have a $0 copay and on the PEBB Balance Plan would have a $15 copay.

If the Board adopts this resolution, there would be a separate treatment limit visit of 24 routine visits for chiropractic and a separate 24 for acupuncture in retaining those copays that exist within the plans today, a $0 copay within the Complete Plan and a $15 copay within Balance. Moving from a customized bundled setting like we're in today to the standard book of business, allows this to be absorbed within the premiums already brought and shown to the Board.

HCA felt this last-minute addition was important to bring before the Board for your consideration meeting, it's our obligation to bring this to the Board for your consideration. It is a benefit enhancement that doesn't come with a cost.

Sue Birch: Vote - Resolution PEBB 2022-10 UHC Medicare Premium

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2022-10 passes.

Slide 14 – Resolution PEBB 2022-11 Premera Medicare Premium.

Sue Birch: Vote - Resolution PEBB 2022-11 – Premera Medicare Premium

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2022-11 passes.

Dave Iseminger: Instead of reviewing Slides 15-17, and in the spirit of getting to public comment faster, and due to prior action taken by the Board codifying my original comments that there is no intention of bringing a concept of closing the UMP Classic Medicare Plan to the Board in the foreseeable future, I want to move to Slide 18. The only reason this page is in the Briefing Book is for the Board to be able to compare the language that isn't being asked for versus the language that is being asked for.

Slide 19 – Resolution PEBB 2022-15 Uniform Medical Plan Classic Medicare Premium. So, let's go to Slide 19.

Sue Birch: Vote - Resolution PEBB 2022-15 – Uniform Medical Plan Classic Medicare Premium

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2022-15 passes.

Public Comment

There were 44 people who provided public testimony, related to PEBB Resolution 2022-12 and the importance of UMP Classic Medicare being a plan choice for retirees. Their testimonies can be found in the audio recording for the June 30, 2022 meeting at: https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials

Next Meeting

July 14, 2022
9:00 a.m. – 2:00 p.m.

Preview of July 14, 2022 PEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the July 14, 2022 Board Meeting.

Meeting adjourned at 2:01 p.m.

PEB Board Meeting Minutes

July 14, 2022

Washington State Health Care Authority

Draft

Public Employees Benefits Board Meeting Minutes

July 14, 2022
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 1:00 p.m.

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

Members Present via Phone

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

Members Absent

Monica McLemore

PEB Board Counsel

Michael Tunick, AAG

Call to Order

Sue Birch, Chair, called the meeting to order at 9:03 a.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting was telephonic only.

Meeting Overview

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

Sue Birch: I want to share that Dave Iseminger has been selected for a prestigious National Fellowship on Health Policy. He's not leaving. He will be getting some very unique mentoring with a select group of folks. He is representing the state of Washington with the Milbank Fund and equal numbers of legislative elected staff and appointed or administrative staff that formed this group. I have known about this for years. I actually met many of the Washington State legislators when I, myself, got this

appointment years ago. Dave, you earned this, and we are so proud. People don't realize that Dave brings things before the IRS. He gets Boeing, Microsoft, and others moving forward. He's really cutting edge, and it's a huge distinction, Dave, that you won this Fellowship. He'll be released off-site several days next year, so you make us proud! You keep doing this great pioneering work and keep challenging the medical complex. Dave, thanks to you for all you do. You're a wonderful emerging health policy leader.

Approval of June 30, 2021 Meeting Minutes

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

Follow Up from June 30, 2022 Meeting

Dave Iseminger, Director, ERB Division. I have two pieces to follow up on. As Chair Birch mentioned, we do have the closed captioning feature now available. I appreciate that this was brought to our attention at the last meeting. Our technology team helped to ensure it was available for Board meetings, which included last Thursday's SEB Board Meeting. We are up and running on the closed captioning function.

I also wanted to address a specific question asked about a parliamentary procedure. A member of the public made an inquiry about the Chair and the Chair's voting privileges. In this instance, state law actually confers on this Board who votes and who does not vote, and based on state law, the Chair has full voting rights on this Board. (RCW 41.05.055)

Uniform Medical Plan (UMP) 2023 Benefit Resolution

Christine Davis, UMP Account Manager, ERB Division.

Slide 2 – Resolution for Board Action Today.

Slide 3 – UMP Accumulators.

Slide 4 – Resolution PEBB 2022-14 UMP Accumulators.

Sue Birch: Vote on Resolution PEBB 2022-14 UMP Accumulators

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

Voting to Approve: 6
Voting No: 0

Sue Birch: Resolution PEBB 2022-14 passes.

2023 PEBB Non-Medicare Rates Overview

Tanya Deuel, ERB Finance Manager, Financial Services Division.

Slide 2 – Employee Premiums.

Slide 3 – Calculating the State Index Rate. This slide is a reminder of how the employer contribution is calculated for active employees. This methodology is established as part of the Collective Bargaining Agreement and states that the state will contribute 85% of the weighted average projected health care costs. Three sample Plan Bid Rates are shown.

Slide 4 – Determining Employee Premiums – Sample illustration.

Slide 5 – Determining Employee Premiums by Tier – Sample Illustration.

Slide 6 – Employee & Employer Premium Contributions. This slide shows the actual employee premiums proposed for the calendar year 2023. There is a change for Kaiser Washington regarding the first fill benefit. At the June 9 Board meeting, Beth Heston verbally walked through the proposed First Fill change for Kaiser Washington. The formal slide from that presentation as part of the Appendix.

Slide 7 – Employee Premium Contributions.

Slide 8 – Employee Contributions by Tier.

Sue Birch: Can you please clarify with UMP Classic, why we aren't seeing the same impact as we saw with our retirees? Can you clarify any other subsidies we might receive as a state?

Tanya Deuel: I have two slides coming up that talk about the differences between the two risk pools. There are distinct differences between the non-Medicare risk pool, the Medicare risk pool, and the subsidies received in the Medicare risk pool.

Slide 9 – Historical PEBB Rates. This is the first of the two new slides which shows the total plan bid rates, the combination of the employee and the employer contributions, for Kaiser Northwest Classic, Kaiser Washington Classic, Kaiser Washington Value, UMP Classic, as well as the dotted line, which is the State Index Rate. These plans were selected because they most closely align in terms of deductible and out-of-pocket maximums. The overall change in bid rate is increasing for all plans.

Slide 10 – State Index Rate Impact on Employee Contributions. This is the second of the two new slides.

David Iseminger: If you go to Slide 9 and look at the slope of the line from 2022 to 2023, they're all going up, but the UMP blue line is slightly steeper than the other lines. Because UMP drives the average -- and it drives the average as it has the vast majority of enrollment – when the slope of the other carrier line is lower relative to the UMP, you'll end up in this phenomenon like we are this year, where UMP goes up from a dollar standpoint while other carriers go down. This is because it's the *relative* increase to UMP and UMP is driving the average. It's that very slight, subtle, steeper slope of the blue line compared to the other lines is not something you have seen historically. That's why it's manifesting the way it is in the previews this year, but the overall trajectory of the plans has been generally the same.

Elyette Weinstein: I'm just not clear as to why this is happening. Why is the curve steeper for UMP versus the other plans?

Tanya Deuel: Each plan is developed completely separately. They take their own base experience, their own trend assumptions, and predict what they're going to need for Plan Year 2023 to cover costs. The difference between the fully insured carriers and the Uniform Medical Plan is they have a structural difference on targeting how much revenue they need to cover the costs for the plan year. Kaiser Washington and Northwest versus UMP, all three carriers have different baseline assumptions within their plans and are somewhat different. There is a different risk associated with each of the plans, so the revenue needed to cover the costs is different between each of the plans.

Elyette Weinstein: I'll never totally get it, but I think that's about as good as it's going to get.

David Iseminger: It's all very subtle on Slide 9, but year over year there, some years the blue line is less steep relative to the others, and then this year it's higher. In an individual year there is some steepness that is higher or lower relative to other plans. But, overall, in the five-year outlook, it's generally the same trajectory.

Tanya Deuel: There are small nuances that each plan has within their underlying assumptions that do make them maybe slightly higher in one year versus another plan or slightly lower in another year versus another plan.

Slide 11 – Non-Medicare Retiree Rates.

Slide 12 – Non-Medicare Retiree Rates by Tier

Slide 13 – PEBB Risk Pools. These slides on why there are differences between the non-Medicare risk pool and the Medicare risk pool.
Final
Slide 14 – Medicare vs. Non-Medicare Retirees.

Sue Birch: Tanya and Dave, we have a lot of subsidies going on in the health care space to shore up a very expensive system. The Exchange gets subsidies. Is there any chance that we might see any federal movement for any more subsidization or change in these subsidizations of how writ large, no matter what type of insurance coverage you have, we subsidize this very expensive situation of health care offerings?

David Iseminger: A lot of that comes down to an act of Congress. We are putting information together because I'm anticipating that both stakeholders, legislators, and many others would want to know exactly what the federal law is that would need to be amended. We may bring that at a future Board meeting in a slide presentation so when we say CMS subsidies can't come to this type of plan, where exactly is that in the United States Code? That's where it gets back to it is not discretion under CMS, it's actually the embodiment of Federal statutes when it comes to CMS's ability to subsidize a plan like the Uniform Medical Plan and the Medicare risk pool.

The state has its own subsidy that is provided in the Medicare risk pool and set biannually in the budget. That is a funding question for our state as to what level that subsidy will be at any given point in the future. The important theme of both of those insights is there is legislative action through budgets or statutory changes at the heart of changing the structure that HCA works within today.

Tanya Deuel: Slide 15 – Other Benefits.

Slide 16 – Dental Premiums.

Tom MacRobert: Looking at these premiums, does that mean we've dropped the idea of an incentive program?

Tanya Deuel: No. These are for Plan Year 2023. Anything that would impact the Uniform Dental Plan would be in a future rate, not in these rates presented.

Slide 17 – Life and AD&D, and Long-Term Disability (LTD) Premiums.

Slide 18 – Proposed Resolutions.

Slide 19 – Proposed Resolution PEBB 2022-17 KPNW Non-Medicare Premium.

Slide 20 – Proposed Resolution PEBB 2022-18 KPWA Non-Medicare Premium.

Slide 21 – Proposed Resolution PEBB 2022-19 UMP Non-Medicare Premium.

Slide 22 – Next Steps.

Medicare Portfolio Comparisons

Ellen Wolfhagen, Senior Account Manager, ERB Division.

Slide 2 – Overview.

Slide 3 – PEBB Medicare Portfolio.

Elyette Weinstein: What's confusing for me is when you talk about medical coverage only? I'm assuming that doesn't mean chiro, that doesn't mean massage, and naturopath. What I see as medical is not necessarily what Supplement Plan C's medical is. Is that true?

Ellen Wolfhagen: For the most part. The difference is there is some Medicare coverage for chiropractic. It depends if Plan F and Plan G covered those services that Medicare covers under Part B coverage. If Part G generally covers a specific kind of chiropractic for spinal manipulation, then it would be covered. Generally speaking, when we talk about Medicare Medical, we're talking about primary care specialists and hospital care.

John Comerford: I want to get clarification on Plan F. In the private sector, if you're eligible for Plan F on January 1, 2020, you can still enroll in it. It's not open to new Medicare participants after that date. Is that true also with the state?

Ellen Wolfhagen: Yes, that is true. You had to have been enrolled already or Medicare entitled prior to January 1, 2020, which in our case means you had enrolled prior.

Tom MacRobert: Perhaps you can address this. People have asked me if the reason Plan F ended and was replaced with Plan G because Plan G is not as rich a plan as Plan F? The Federal government got rid of Plan F to save money? Could you address that?

Ellen Wolfhagen: Tom, the coverage is exactly the same in Plan G and Plan F. The difference is in Plan G, the member has to pay their Part B deductible. Plan F was a little bit richer because the plan paid the Part B deductible, and now the member has to pay that, but the coverage is exactly the same.

Slide 4 – Original Medicare & the PEBB Portfolio.

Slide 5 – PEBB Medicare Portfolio.

Slide 6 - Comparing Individual Market Plans and Group-sponsored Plans.

Slide 7 – Key Differences: Commercial AARP UHC Plans and PEBB's Group-sponsored UHC MA-PD Plans.

David Iseminger: I want to drive home one point - this slide is comparing the PEBB UnitedHealthcare underwritten PPO MA-PD Plan with AARP offered MA-PD plans. We're trying to show as close to comparison as possible, knowing that questions have understandably been asked because most people are familiar with individual market plans. Employer-sponsored plans are something a lot of people don't have access to and aren't familiar with because it's simply not as prevalent in the market as the individual market.

We wanted to show those direct comparisons from the UnitedHealthcare has underwritten products that people may be very familiar with on the private individual market compared to what was negotiated and is offered under the PEBB Program. The Appendix on Ellen's presentation has a detailed comparison chart of all the UnitedHealthcare Plans under AARP, including their HMO plans. This was designed as a snapshot to highlight at the high level some of those key benefit coverage and plan structure differences of similar products as can be as comparative as possible.

Ellen Wolfhagen: The benefits noted in the Appendix are the 2022 benefits. We've made some plan changes for 2023 in the chiropractic and acupuncture visit limits and the drug tier copay, so if you see a difference, that's why.

Elyette Weinstein: I understand the purpose of this chart. Getting feedback from several RPEC members, they would like to see a chart that compared the commercial

plans to the UMP Plan with respect to drug coverage as well, because they wonder why nobody is talking about UMP. That would be helpful for our membership.

David Iseminger: Absolutely, Elyette. Ellen is going to be with us for many, many Board meetings to come. There is just a lot of information to share. This was designed answer the many questions we had about UnitedHealthcare.

John Comerford: It would be worthwhile looking at the commercial premium versus the state subsidized PEBB Group premium.

David Iseminger: John, I will highlight for everyone that in the Appendix, Slide 47, the premiums are noted as part of the more detailed table for the United AARP Plans and the PEBB Complete and Balanced UnitedHealthcare Plan. We can do the broader piece at a future meeting.

Tom MacRobert: You've addressed this in a conversation, but on television, you often see in commercial market plans, plans with no monthly dues whatsoever. I've had people ask why haven't they been considered as being a market choice for PEBB members? I don't have an answer to that, but perhaps it would be beneficial to put one of those plans up for comparison to UnitedHealthcare, Complete, or Balanced.

David Iseminger: I'll point everyone to Slide 47 in the Appendix. In the first column there is an example of a $0 premium plan. The way many of those plans are designed, there's no premium upfront. Then you have those higher out-of-pocket maximums, so it's higher copays. The plans with no premium typically have very high points of service costs. There are two examples of $0 premium plans with that chart that can compare as a start.

Ellen Wolfhagen: If I may point out, it's the first column on Slide 47 and the last column before the SEBB Complete Plan that are those above $0 premium plans. One has a $6,500 out-of-pocket max, the other has a $5,500 in-network out-of-pocket max with a $10,000 out-of-pocket max - these are medical maxes. You compare that to the second line on Slide 7 where our out-of-pocket maximum for medical for PEBB Complete is $500, and $2,000 for PEBB Balance.

Slide 8 – Additional Key Differences.

Slide 9 – More Key Differences.

Slide 10 - Prior Authorization, Claims, and Appeals: UMP and UHC Plan Insights.

Slide 11 – UMP Medical Prior Authorization Process.

Slide 12 – UMP Medical Prior Authorizations.

Slide 13 – UMP Pharmacy Prior Authorization Appeal Process.

Slide 14 – 2021 UMP Pharmacy (Moda) Prior Authorization Appeals.

Slide 15 – UHC Prior Authorization Process.

Slide 16 – Medicare Rules on Timely Prior Authorization and Appeals Decisions.

Elyette Weinstein: Who enforces that?

Ellen Wolfhagen: Elyette, if I could clarify on Slide 17.

Slide 17 – 2021 UHC Medical Appeals.

Ellen Wolfhagen: 2021 had a total of 22 appeals out of 3,000 enrollees, about 1% or less. Of those, the initial decision was overturned, most often because information came in after the deadline. CMS enforces the deadline. United has to issue the initial decision within 72 hours if it's expedited, or the 30 days. If they don't have enough information to make the decision, they're going to deny it. As soon as more information comes in, they can overturn that decision. A number of these are provider situations where, for example, the provider put in the wrong code. These get settled out and some is based on having a new plan with some bugs that get worked out with providers interacting with United.

Slide 18 – 2021 UHC Pharmacy Prior Authorization Appeals.

Slide 19 – Provider Network Insights.

Slide 20 – Who Determines the Network?

Slides 21-22 – UHC Providers.

David Iseminger: This question has come up several times. Can a non-contracted provider accept the plan and treat some patients but not other patients? The answer is no. The provider accepts this for all of their patients or none of their patients. There is not distinction on a patient-by-patient basis.

Ellen Wolfhagen: Slide 23 – UMP Retiree Subscriber WA Locations.

Slide 24 – Current PEBB Medicare Plans' Availability.

Slide 25 – Provider Directories.

Slide 26 – PEBB Program Medicare Offering Benefit Designs.

Slide 27 – UMP and KPNW Senior Advantage.

Slide 28 - UMP and KPNW Senior Advantage – Pharmacy.

Slide 29 – UMP and KPWA Medicare Advantage.

Slide 30 – UMP and KPWA Medicare Advantage – Pharmacy.

Slide 31 – UMP and UHC PEBB Complete.

Slide 32 – UMP and 2023 UHC PEBB Balance.

Slide 33 – UMP and 2023 UHC PEBB Plans – Pharmacy.

Slide 34 – UMP and Premera Plan G.

Slide 35 – Follow Up: Outpatient Rehabilitation Therapies.

Slide 36 – Follow Up: Chiropractic & Acupuncture Therapies (Medicare covered).

Slide 37 - Follow Up: Massage and Naturopathic Services (non-Medicare covered).

Slide 38 – Retiree Engagement.

Slide 39 – Informed Decision Making.

Slide 40 – Recent/Upcoming Retire Engagements.

Slide 41 – Future Opportunities.

Slides 42-43 – Goals of Retiree Engagements.

Slide 44 – Board Follow Up.

Slide 45 – Questions? Contact Information. I am available for any PEBB Program member to contact me. A lot of members have reached out to me. When I make presentations, I always provide my email. HCA is also reaching out to additional stakeholder groups, which is an easier way for us to reach a lot of people at one time. Dave said HCA will be hosting a variety of different engagements in different formats so people can attend in a way they are comfortable. At the end of 2023, certainly as part of the retreat in 2024, we will be talking about what we have heard. I will be bringing that back to the Board.

Medical Clinical Insights
Emily Transue, MD, Medical Director, CQCT Division.
Luke Dearden, PharmD, BCPS, Clinical Pharmacist, CQCT Division.

Emily Transue: Slide 2 – Continuity of Care.

Slides 3-6 – Continuity of Providers.

Slide 7 – Continuity of Care Utilization Management / Prior Authorization (PA).

Luke Dearden: Slide 8 – What is a Formulary?

Slide 9-10 – Value Formulary Follow Up.

Slide 11 – Benefits of UMP's Value Formulary.

Slide 12-14 – Continuation of Therapy: When Changing from UMP to a UHC Plan.

David Iseminger: Some people in the public might be wondering why we're still focused on describing things related to the UnitedHealthcare Plans from a UMP enrollment switch. We're trying to answer as many of the questions that came up over the last 45 days. We want to provide information that might not be well understood or that we haven't been able to get before members for full appreciation of some of the differences between the plan portfolio. We're focused on trying to answer those types of questions. I just realized the context in which the presentation was originally created on the June 30 is not the same context we're in today, because there is no proposal under consideration related to UMP Classic Medicare.

The second piece is on the last bullet on Slide 12. I anticipate the question will be asked, “What if the step therapy in UMP during the Value Formulary involved drugs A and B, but this step therapy at United involves drugs C and D. C and D aren't the same as A and B. Do you got to go through step therapy again?” The conversation with United was, "No." I wanted to provide that additional context.

Luke Dearden: Slide 15 – Utilization by Member.

David Iseminger: I want to share with the Board that this part of the presentation was created for June 30 and designed in response to the question in June where HCA was asked to produce a formulary comparison of every drug between UMP and UHC. As Luke highlighted, there are thousands of drugs in the formulary, but I did want to give the context as to where this part of the presentation came from.

Slide 16 – Utilization by Prescription Count.

Slide 17 – Generic Drugs – Top 10 Used (30-day Fill).

Slide 18 – Brand Drugs – Top 10 Used (30-day Fill).

Slide 19 – Specialty Drugs – Top 10 Used (30-day Fill).

David Iseminger: Luke, can you share anything about the number of members who take multiple specialty drugs? A good example of a person taking one specialty drug, it relates to about $300 more per year compared to say the premium. Is there anything about the volume of individuals or retirees who take multiple specialty drugs?

Luke Dearden: When I looked at that information closer to the end of June, there were about 50 Medicare members from what I could tell who are taking more than one specialty medication simultaneously. There was one member taking four specialty medications simultaneously. That was the maximum. If you factor in just that number, they'd be paying approximately $1,200 more per year on their specialty medication through United, which would still actually be quite a savings when you factor in the premium difference.

Slide 20 – Finding Drugs for Each Plan.

Public Comment
There were 6 people who provided public testimony. Their testimonies can be found in the audio recording for the July 14, 2022 Meeting at:
https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials

Next Meeting
July 20, 2022
9:00 a.m. – 2:00 p.m.

Preview of July 20, 2022 PEB Board Meeting
Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the July 20, 2022 Board Meeting.

Meeting adjourned at 12:56 p.m.

PEB Board Meeting Minutes

July 20, 2022

Washington State Health Care Authority

Draft

Public Employees Benefits Board Meeting Minutes

July 20, 2022
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 11:00 a.m.

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

Members Present via Phone

Sue Birch, Chair
Harry Bossi
Elyette Weinstein
Monica McLemore
Tom MacRobert
Leanne Kunze
John Comerford

Members Absent

Scott Nicholson

PEB Board Counsel

Michael Tunick, AAG

Call to Order

Sue Birch, Chair, called the meeting to order at 9:01 a.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting was telephonic only.

Meeting Overview

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

Approval of July 14, 2021 Meeting Minutes

Tom MacRobert moved, and Monica McLemore seconded a motion to approve. Minutes were approved as written by unanimous vote.

Approval of July 21, 2021 Meeting Minutes

Harry Bossi moved, and Leanne Kunze seconded a motion to approve. Minutes were approved as amended.

Approval of January 26, 2022 Meeting Minutes

Leanne Kunze moved, and Tom MacRobert seconded a motion to approve. Minutes were approved as written. Monica McLemore abstained since she was absent from meeting.

Follow Up from July 14, 2022 Meeting

Dave Iseminger, Director, ERB Division. There were a variety of questions and ideas that came up at last Thursday's meeting, which was just six days ago. The vast majority of questions are things we'll be working on for next Board season, in particular, there were questions raised about Plan F and Plan G, the enrollment process for Plan F vs Plan G, and the differences.

Elyette Weinstein: In the past week, I have developed another question. I was reading Social Security and Medicare bulletins, and they said that Plan G, I think you pay the deductible for Plan B when you're in Plan G. The bulletin says that if you're born before a certain date, you don't have to pay the deductible. Ellen explained to me that this was a PEBB requirement, which is fine. Unfortunately, I wasn't here when this decision was made. Could you explain a little bit about why PEBB makes this requirement when the Federal government doesn't? The history behind it.

David Iseminger: We will wrap that into a sub-question. I think John asked about enrollment limitations at the last meeting. We'll bucket it with that at the same time.

2023 Premium Resolutions Non-Medicare

Tanya Deuel, ERB Finance Manager, Financial Services Division.

Slide 2 – Premium Resolution PEBB 2022-17 KPNW Non-Medicare Premium

Sue Birch: Vote on Premium Resolution PEBB 2022-17 KPNW Non-Medicare Premium

Harry Bossi moved, and Elyette Weinstein seconded a motion to approve.

Voting to Approve: 6
Voting No: 0

Sue Birch: Premium Resolution PEBB 2022-17 passes.

Slide 3 – Premium Resolution PEBB 2022-18 KPWA Non-Medicare Premium.

Sue Birch: Vote on Premium Resolution PEBB 2022-18 KPWA Non-Medicare Premium

Tom MacRobert moved, and Monica McLemore seconded a motion to approve.

Voting to Approve: 6
Voting No: 0

Sue Birch: Premium Resolution PEBB 2022-18 passes.

Slide 4 – Premium Resolution PEBB 2022-19 UMP Non-Medicare Premium.

Sue Birch: Vote on Premium Resolution PEBB 2022-19 UMP Non-Medicare Premium
Leanne Kunze moved, and Elyette Weinstein seconded a motion to approve.

Voting to Approve: 6
Voting No: 0

Sue Birch: Premium Resolution PEBB 2022-19 passes.

Medicare Portfolio Insights
Ellen Wolfhagen, Senior Account Manager, ERB Division.

Slide 2 – Overview.

Slide 3 – Overlap between UMP and UHC PEBB Plans.

Slide 4 – UMP and UHC Providers.

David Iseminger: I have seen a lot of provider disruption reports in the last five years as Director, and this is one that has some of the most profound overlap. I was really surprised. In my experience looking at provider overlap and provider disruption reports, this one did have significantly high overlap. Typically, when we see provider disruption reports it is not in the high 90 percentile of overlap. It's important to highlight what Ellen said last week to reinforce that is unique in this particular space. There are some providers who have not signed a network contract, but they still accept the plan, treat patients, and bill UnitedHealthcare, even without a network contract.

There is no cost share difference to the member by seeing that provider whether they are in- or out-of-network, but one of the big differences is they don't show up in a provider online directory. I believe there is around 4% to 5% of the providers in that scenario and they truly are not "a network provider." Because they are treating and billing United, they look and feel like a network provider contract. That's why Ellen's statement was to directly contact the plan because over the phone they can confirm more of those situations.

Ellen Wolfhagen: Slide 5 – Pharmacy Network. I want to remind folks about changes for 2023 on the UHC pharmacy benefit. UnitedHealthcare is moving to copays rather than coinsurance. Copays for Tier 1 Generic are $5; for preferred brand names $45; $100 for nonpreferred brand names; and $100 for specialty drugs. Specialty drugs are limited to a 30-day supply. However, another benefit of UHC in 2023 is the cost for a 90-day supply is only two times the 30-day supply copay. So $10 for Tier 1, $90 for Tier

2, and $200 for Tier 3. Because specialty drugs are limited to a 30-day supply, it's still $100 and would only be a 30-day supply.

Elyette Weinstein: Is this slide US-wide data and not just the state of Washington?

Ellen Wolfhagen: Yes, this is nationwide data.

Slide 6 – Premium and Out-of-pocket Questions.

Slide 7 – State Pension System Benefits: PERS.

Slide 8 – State Pension System Benefits: TRS (Teacher's Retirement System).

Slide 9 – State Pension System Benefits: SERS (School Employees' Retirement System).

Slide 10 – Premium versus Out-of-pocket.

2023 PEB Board Meeting Schedule

Dave Iseminger, Director, ERB Division. This is the regular meeting schedule for the 2023 Board season that was filed with the Code Revisor. There are a variety of different rules under the Open Public Meetings Act related to meetings and these are the regularly scheduled meetings set for the entire Board season.

Going forward, will continue to support, at a minimum, hybrid meetings. The public and the Board members will always have the choice of in person or virtual.

Public Comment

There were 5 people who provided public testimony. Their testimonies can be found in the audio recording for the July 20, 2022 Meeting at:
https://www.hca.wa.gov/about-hca/public-employees-benefits-board-pebb-program/meetings-and-materials

Next Meeting

February 2, 2023
9:00 a.m. – 4:00 p.m.

Final Comments

Dave Iseminger, Director, Employees and Retirees Benefits Division. It's several months away, but a lot of requests for things to be discussed at the Retreat have been identified. I want to say that over the next couple of months, HCA and staff pivot to Open Enrollment. With your adoption of the premiums, we are full steam ahead, and the turnarounds are quick. We'll shortly be thinking about print production deadlines. Things move very rapidly at the Health Care Authority, which is why Board season traditionally ends at the end of July, whenever possible.

The other important work we'll be doing, not just for the next five months, but we'll come back at the Retreat to talk about how things are going with our engagement strategy regarding our Medicare portfolio, our retirees, and our various stakeholders. I say engagement because we have a lot of different stakeholders we need to engage with.

It's RPEC, WEA-Retiree, the Washington State School Administrator Association, higher education institutions, etc. I just wanted to be clear why I'm calling it an engagement strategy because there are so many varieties of stakeholders involved with different preferences for how we're going to engage with them. Sometimes we'll be listening more than engaging, sometimes it will be more dialogue. Other times, more presentations. But when we come back to the Board Retreat, we'll talk about how that engagement is going!

I want to shift to the last comment for this Board season for me. We likely have changes to a few Board members as we have a cycled appointment process. Every year, there's the potential for some Board members to transition from the Board. I want to acknowledge in case this is the last meeting, it's likely we will lose both Scott Nicholson, who unfortunately couldn't be here today, and Leanne Kunze. I want to thank them both for their service to the PEBB Program over the last two or three years depending on their particular timeline and take a moment to appreciate them and the work they've done with the Board and on behalf of members -- in case this is their last Board meeting.

Sue Birch: I would echo my gratitude. Leanne, I know you're online with us. You have been a tireless champion. You've been so reasonable, willing, and also so enthusiastic about our work. Thank you, thank you, thank you from myself, the Board, and all the staff here at HCA. I'm certain we'll be contacting Scott, too, as he goes through his transition from state employment, to express our gratitude directly. I sincerely mean this when I thank the full Board for their attention to detail, their enthusiasm, their eagerness, and their curiosity.

I don't think people ever in their wildest dreams thought that health care would turn into such a medical industrial complex. If you are wondering what I mean by that, again, I implore you to listen in to the Health Care Cost Transparency Board today from 2:00 to 4:00 p.m., where there will be all sorts of deep dives into probably the biggest part of health care spending, the hospital industry. And that Board will systematically be reviewing things like Executive Compensation Packages, which are published publicly. We are getting so much more information in detail about true costs of care. We simply are being outpaced by our other global partners. So, Board members, thank you for being on this path of oversight and responsibility for all our public employees. And, Dave, and your team, thank you. You do an amazing job guiding us through all this.

Meeting adjourned at 10:21 a.m.

TAB 4

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

February 2, 2023
Board Retreat Follow Up

David Iseminger
ERB Director
Employees and Retirees Benefits Division
March 9, 2023

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Board Member Communications

Clarification of the Term "Action"

Under Open Public Meeting Act

- What defines the Board "taking action" under the Open Public Meetings Act (OPMA)?
  - Specifically, is information sharing via individual emails and subsequent member to member cascading considered "action"?
- Insights will be shared by AAG Michael Tunick

  https://www.atg.wa.gov/open-government-training

Preferred Provider Status

Plan Development of Provider Reimbursement

Plans typically develop provider fee schedules

- Based on Medicare Resource-Based Relative Value Scales (RBRVS) methodology
- Result in networks sufficient to meet OIC network adequacy requirements
- Result in networks that meet the care needs of enrolled members

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Plan Development of Preferred Provider Networks

Preferred Provider determinations generally consider multiple factors:

- Provider quality metrics
- Cost effectiveness
- Comparative, risk-adjusted utilization patterns
- Member satisfaction survey results
- Network adequacy standards

Questions?

David Iseminger
ERB Director
Employees and Retirees Benefits Division
David.Iseminger@hca.wa.gov

TAB 5

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

PEB Board By-laws Amendment

David Iseminger, Director
Employees and Retirees Benefits Division
March 9, 2023

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

PEB BOARD BY-LAWS
PROPOSED AMENDMENT TO
ARTICLE V
Meeting Procedures
4. Public Testimony

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. Opportunity for public testimony at Board meetings shall also be made available immediately before the Board's vote on a resolution. At the direction of the Chair, opportunities for public testimony may also be made available at other times during Board meetings. ~~may also occur in conjunction with a public hearing or during the Board's consideration of a specific agenda item.~~ The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

By-laws Amendment Process

- Article VI (1): The PEB Board By-laws may be amended upon a two-thirds (2/3) majority vote of the Board
- With seven voting Board members, five votes required to pass a by-laws amendment

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

PEB BOARD BY-LAWS
ARTICLE V
Meeting Procedures
4. Public Testimony

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the PEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. Opportunity for public testimony at Board meetings shall also be made available immediately before the Board's vote on a resolution. At the direction of the Chair, opportunities for public testimony may also be made available at other times during Board meetings. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Questions?

David Iseminger, Director
Employees and Retirees Benefits Division
David.Iseminger@hca.wa.gov

TAB 6

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Legislative Update

Cade Walker
Policy, Rules, and Compliance Section Manager
Employees and Retirees Benefits Division
March 9, 2023

Number of 2023 Bills Analyzed by ERB Division

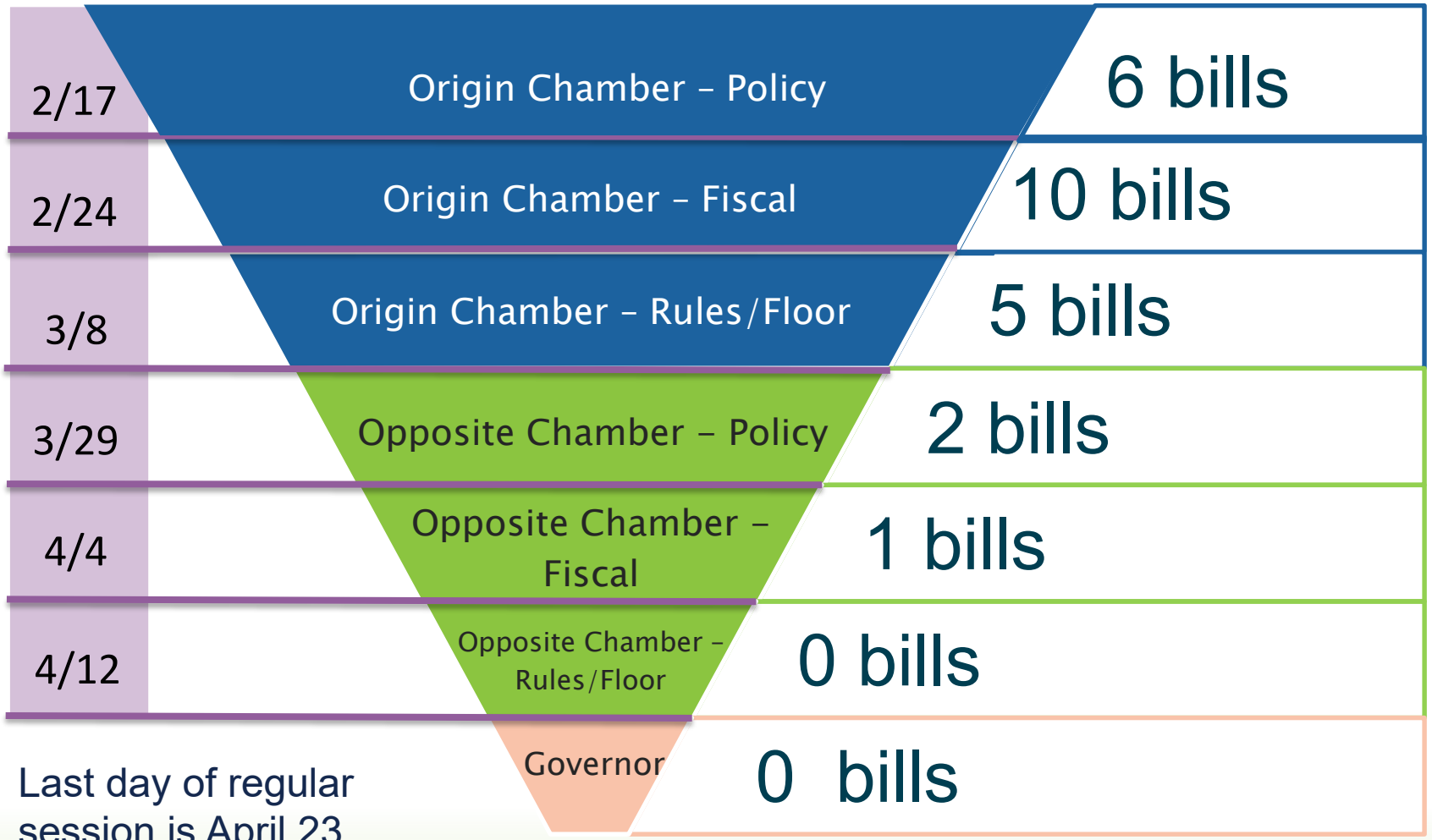
	ERB Lead	ERB Support	
High Priority	23	13	36
Low Priority	15	80	95
	38	93	131

Fiscal Notes	25	32	

Completed as of 2/17/23

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

2023 Legislative Session – ERB High Lead Bills



Last day of regular session is April 23

Requested Legislation

- SB 5700: Primarily all statutory clean up and removing outdated sections or language
- SB 5421: Creates a public records act exemption for all enrollment information collected by the PEBB and SEBB Programs

Topical Areas of Introduced Legislation

SEBB

- SB 5275 SEBB Benefits Access
- ~~HB 1246 Health Benefits SEBB Eligibility~~

Retirees

- HB 1008/~~SB 5420~~ Plan 2 Members Insurance
- ~~SB 5169 Medicare Health Care Plans in PEBB~~
- SB 5490 PEBB Deferred Retiree Coverage
- HB 1804/SB 5696 PEBB Subdivision Retirees
- ~~SB 5625 Public Employee Retirees Ombuds~~

Topical Areas of Introduced Legislation (*cont.*)

Medical Services Cost Sharing

- ~~HB 1115~~/SB 5242 Abortion Cost Sharing
- HB 1151/~~SB 5204~~ Fertility Services Coverage
- HB 1222 Hearing Instruments Coverage
- HB 1261 & SB 5396 Breast Exam Cost Sharing

Topical Areas of Introduced Legislation (*cont.*)

Pharmacy

- ~~HB 1253~~/SB 5213 Pharmacy Benefit Managers
- HB 1269 Rx Drug Affordability Board
- ~~HB 1465/SB 5445 Prescription Cost-Sharing~~
- SB 5729 Insulin Cost-Sharing Cap
- ~~HB 1725 Insulin Access Under 21~~

Topical Areas of Introduced Legislation (*cont.*)

Other

- New or Expanded Licensures: lactation consultants, medical assistants, anesthesiologist assistants, music therapists, physician assistants, optometry, naturopathic physicians.
- ~~HB 1495/SB 5373 ARNP & PA Reimbursement~~
- HB 1208/SB 5319 Pet Insurance Regulation
- HB 1357 Modernizing Prior Authorizations
- SB 5241 Health Care Marketplace

Questions?

Cade Walker

Policy, Rules, and Compliance Section Manager

Employees and Retirees Benefits Division

Cade.Walker@hca.wa.gov

TAB 7

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

PEBB Program Financial Insights

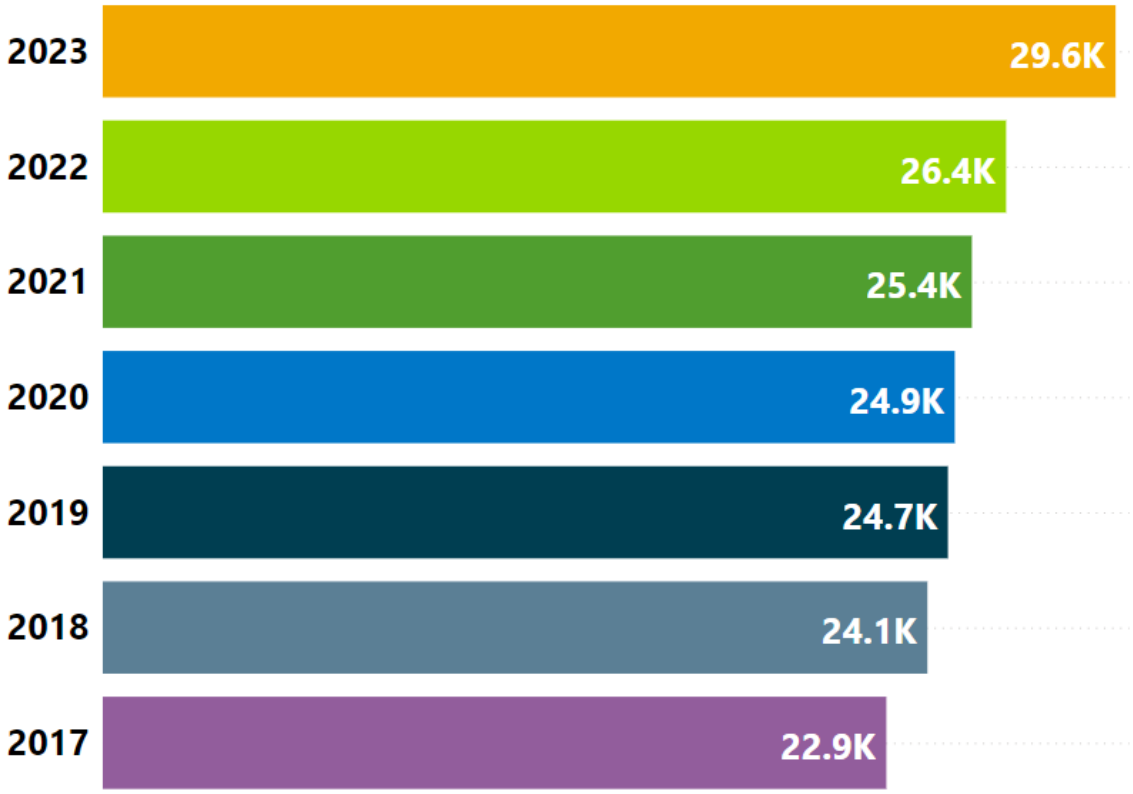
Molly Christie
Fiscal Information Data Analyst
Financial Services Division
March 9, 2023

Annual Total Non-Medicare Cost

(subscriber, spouse & children)

Average total annual **medical and pharmacy cost** for a Tier 4 family on **UMP** Classic* is **less than the national average** for a hypothetical family of 4**

Health care costs for PEBB Program members are **projected to increase in 2023** due to higher medical claims experience in line with historical (pre-COVID) trend



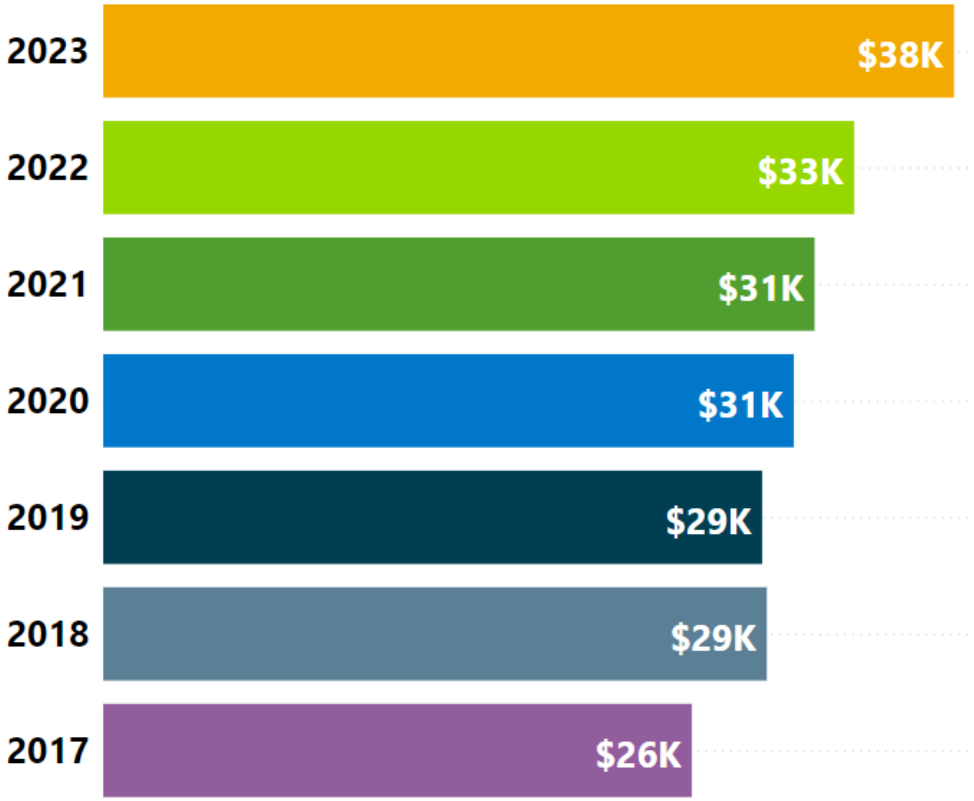
*Values are an approximation based on bid rates and the AV calculator for UMP Classic, Tier 4 (subscriber, spouse, dependent[s])

**Based on the 2022 Milliman Medical Index

Annual Total Medicare Cost
(Subscriber and Spouse)

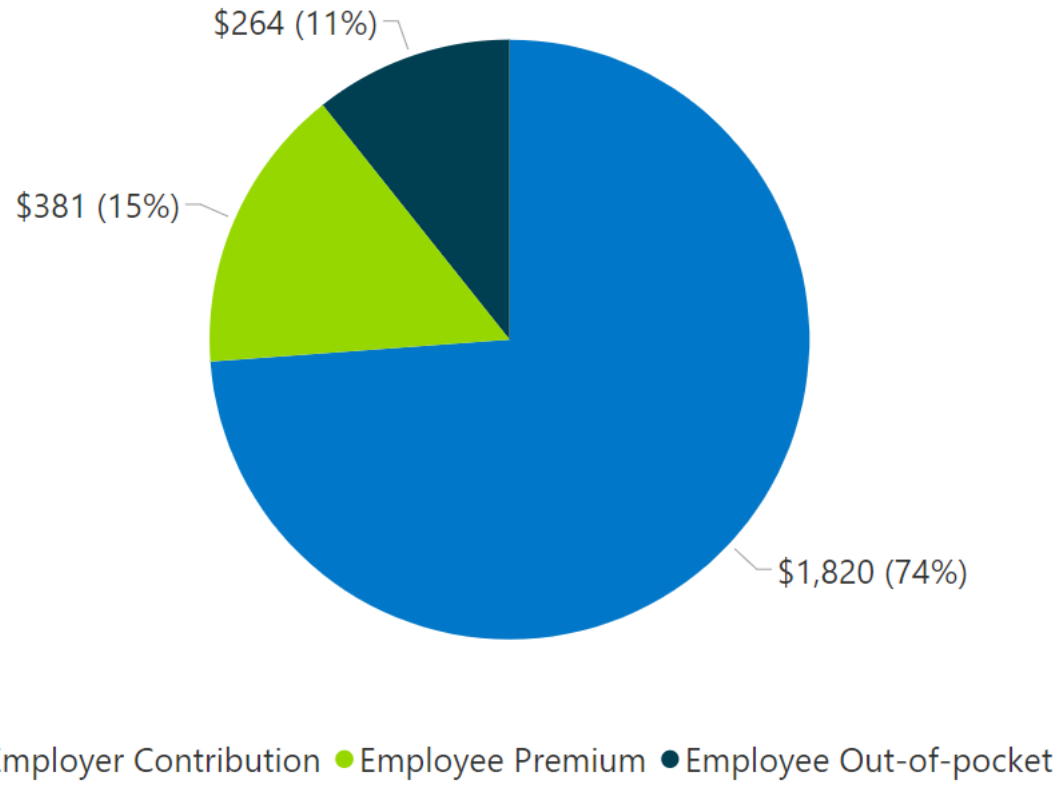
Chart shows average total annual **medical and pharmacy cost** for a Tier 2 family on **UMP Classic Medicare** (subscriber and spouse)

Health care costs for PEBB Program retirees are **projected to increase in 2023** due to pharmacy trend and higher medical claims experience



*Values are an approximation based on bid rates, historical estimated average pharmacy out-of-pocket PMPM spend and Medicare COB primary payments for medical benefits

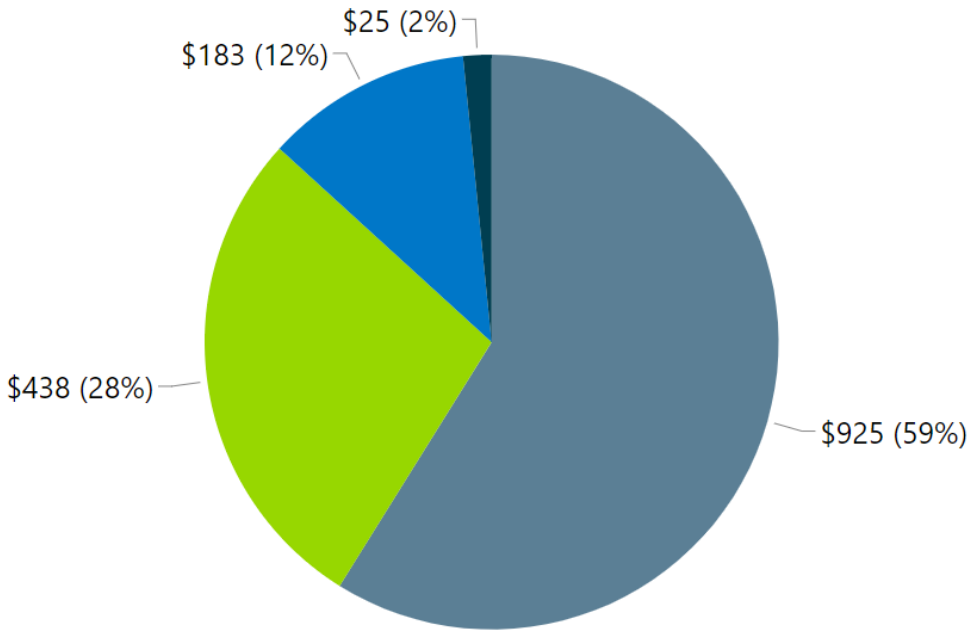
2023 Employee Monthly Medical Contribution Breakdown



Washington contributes significantly more toward total medical benefits (~74%) for a Tier 4 family enrolled in UMP Classic **than** an average family of 4 in **the national benchmark** employer-sponsored plan (~58%)

- Employee out-of-pocket includes coinsurance/copays and deductibles
- Values are an approximation based on 2023 bid rates and the AV calculator for UMP Classic, Tier 4 (subscriber, spouse, dependent[s])

2023 Medicare Retiree Monthly Medical Contribution Breakdown

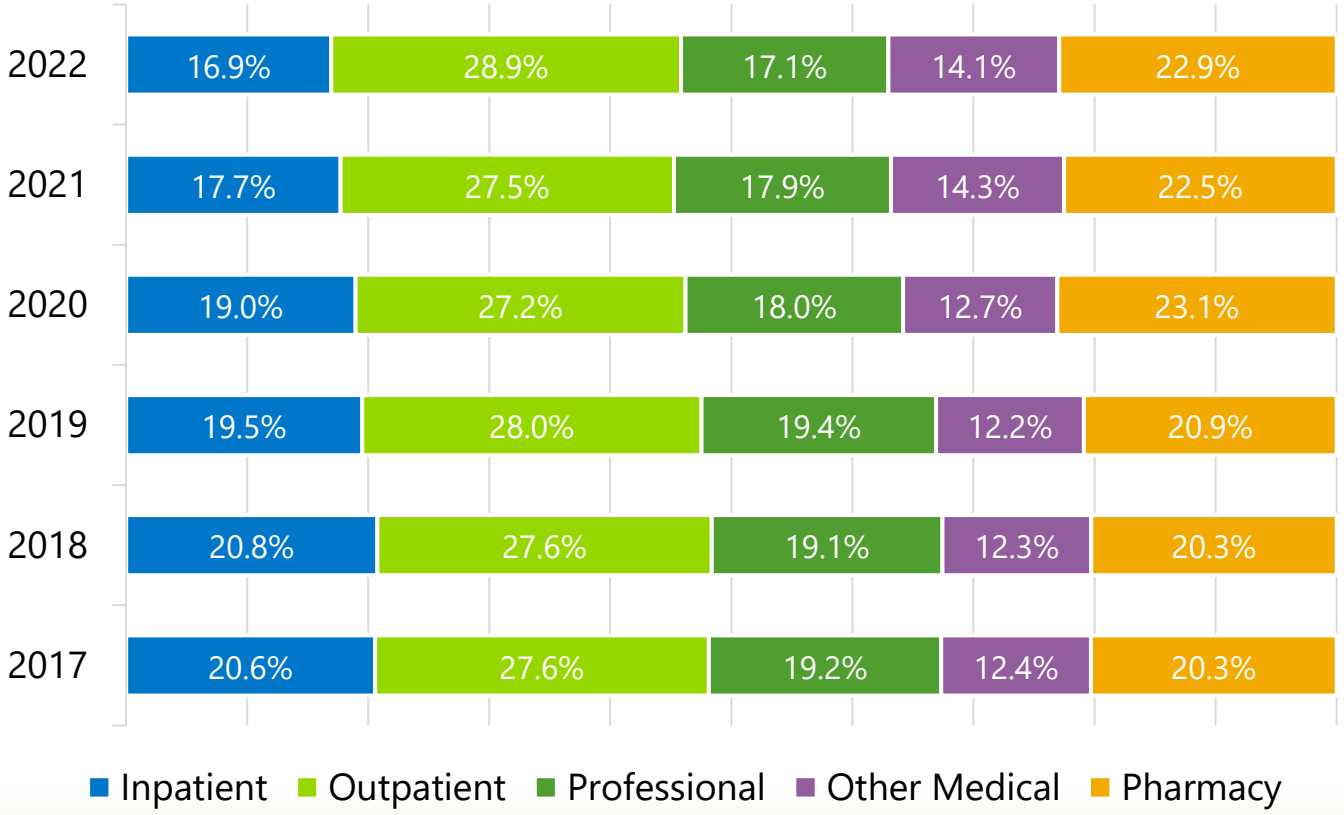


Medicare retirees spend **more on premiums but less on out-of-pocket costs** than employees, because Medicare pays primary on Medicare-covered medical benefits

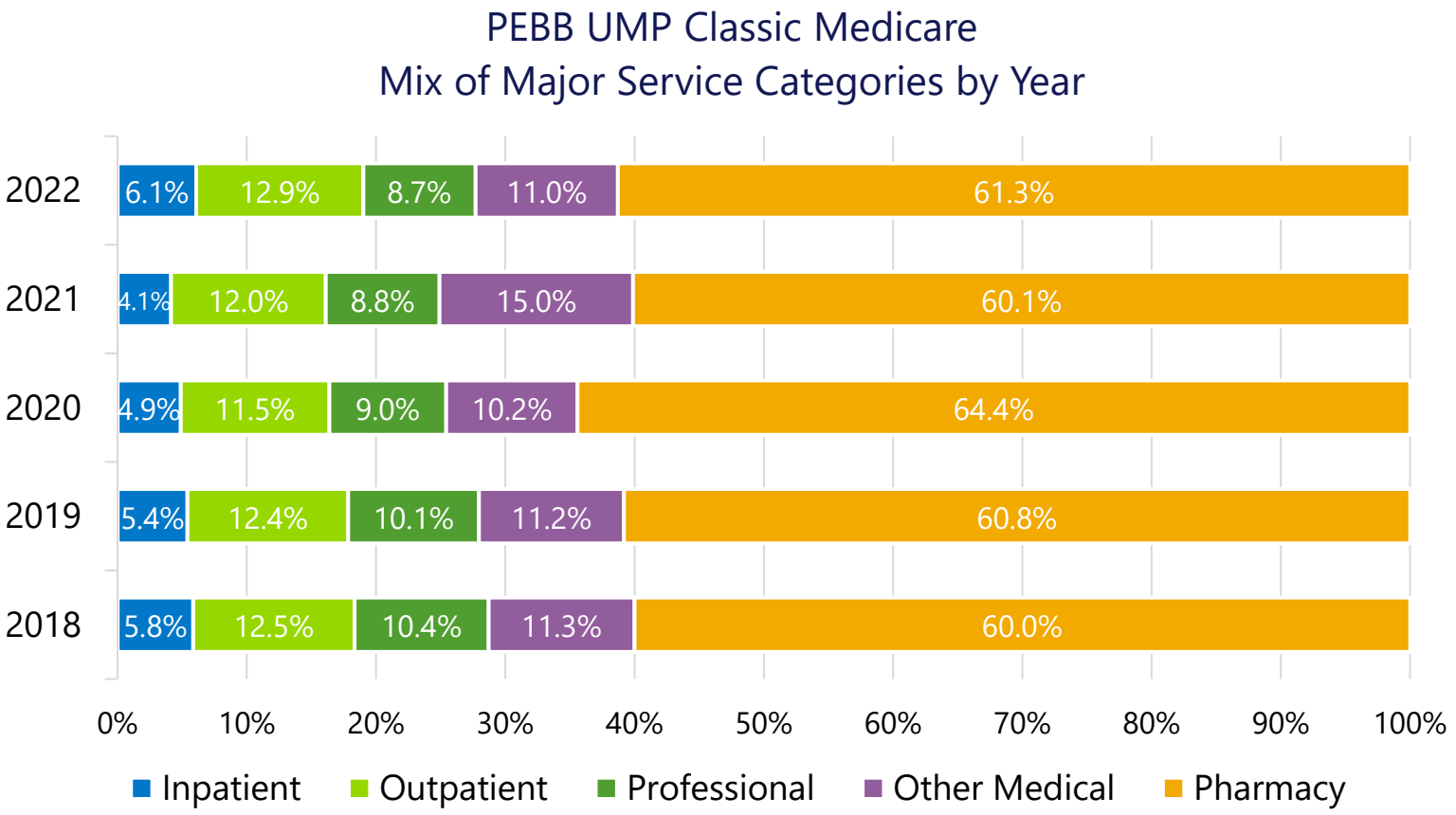
*Values are an approximation based on bid rates, historical estimated average pharmacy out-of-pocket PMPM spend and Medicare COB primary payments for medical benefits

Non-Medicare Cost Drivers

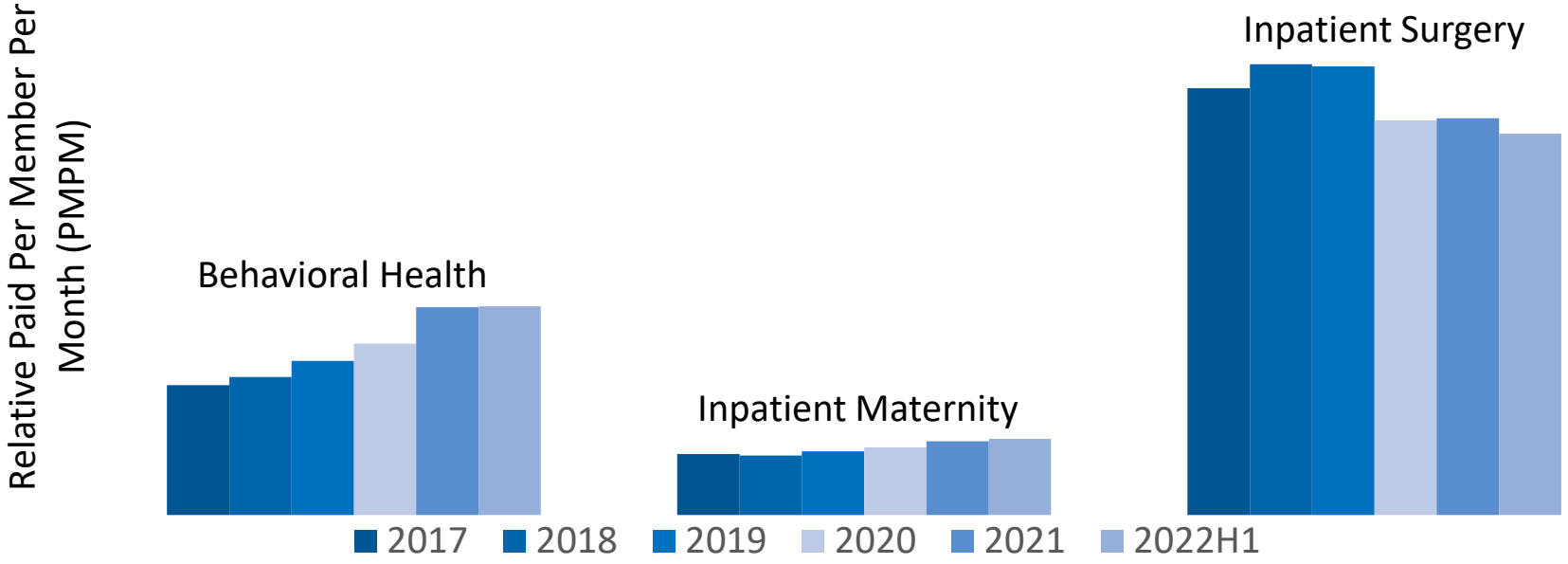
PEBB UMP Classic Non-Medicare
Mix of Major Service Categories by Year



Medicare Cost Drivers

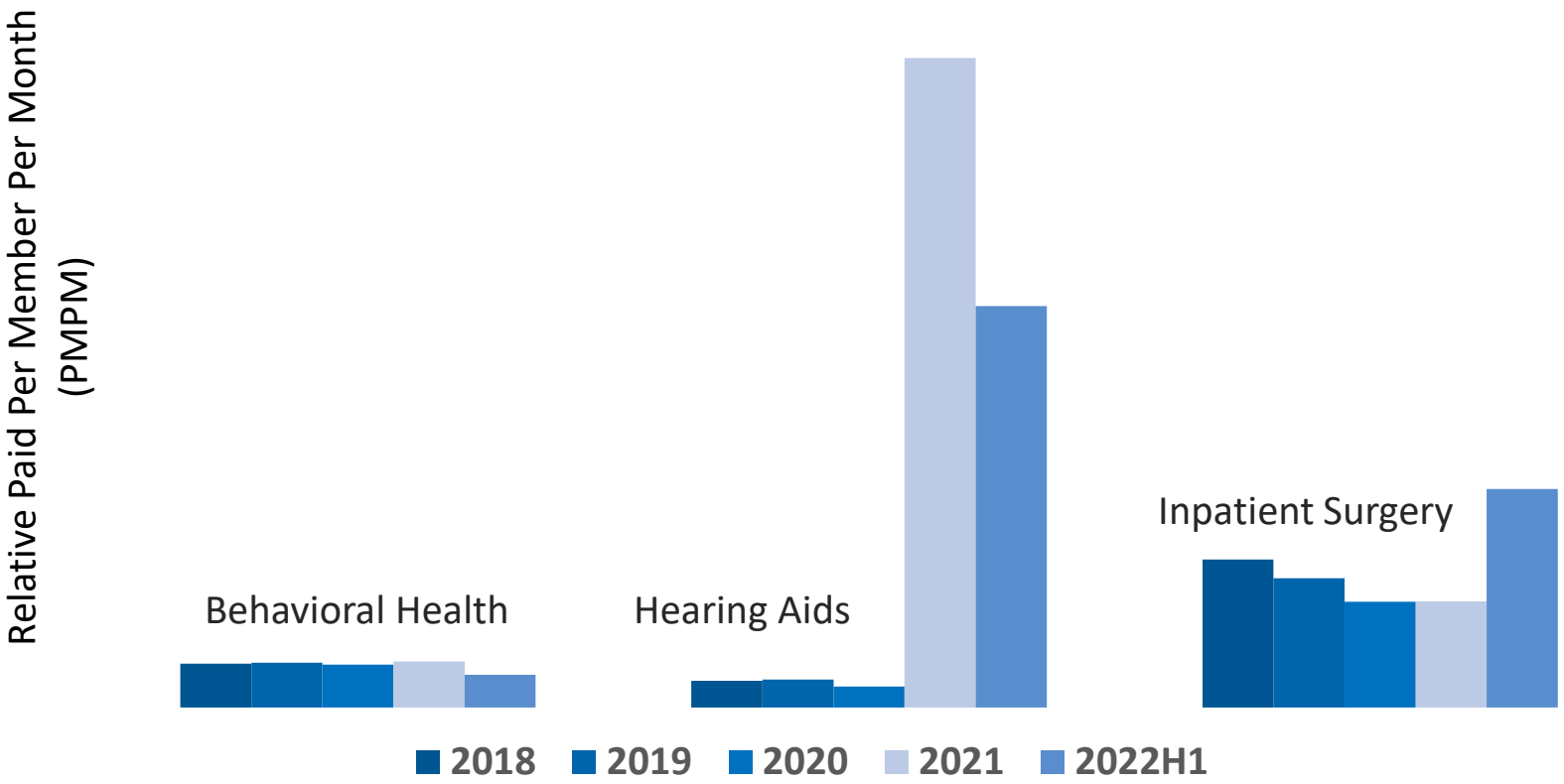


Non-Medicare Notable Service Trends



*2022H1 represents claims incurred and paid through June 2022

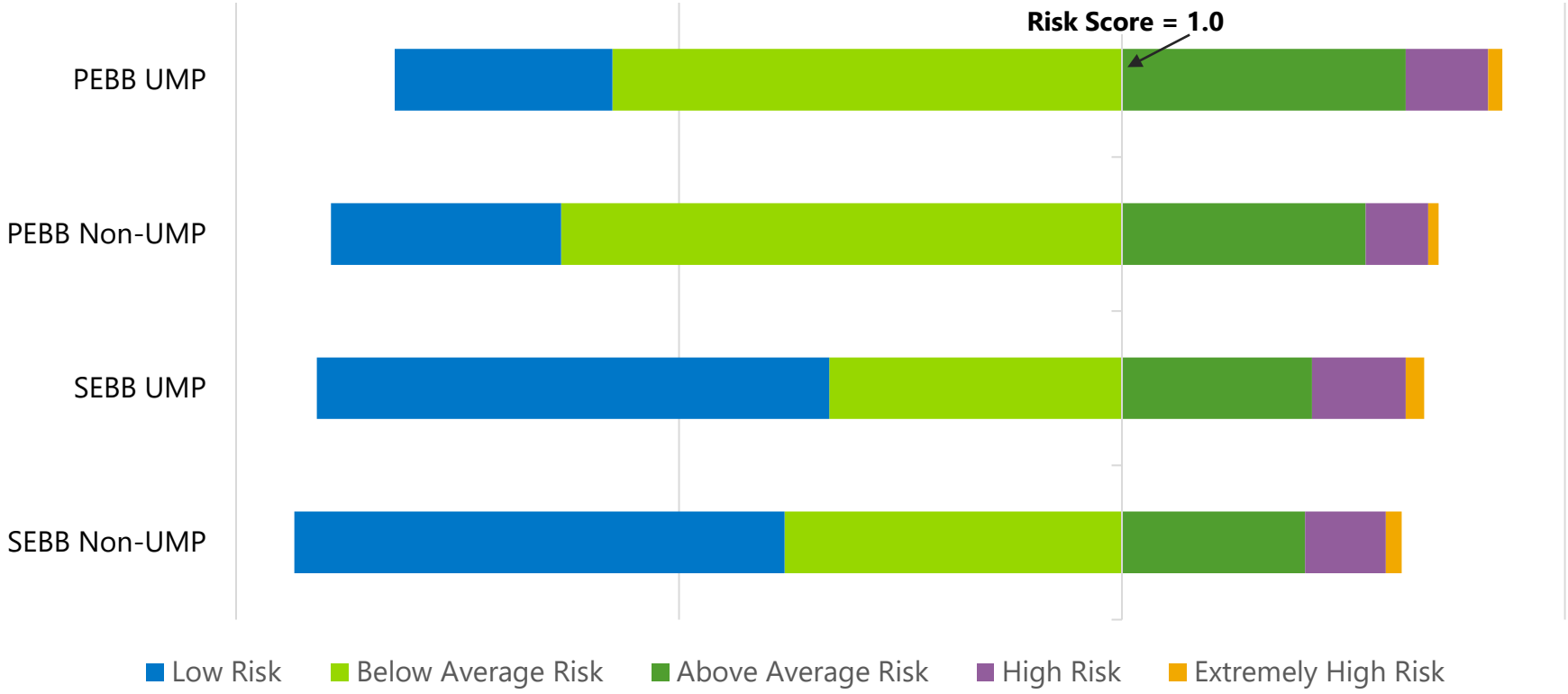
Medicare Notable Service Trends



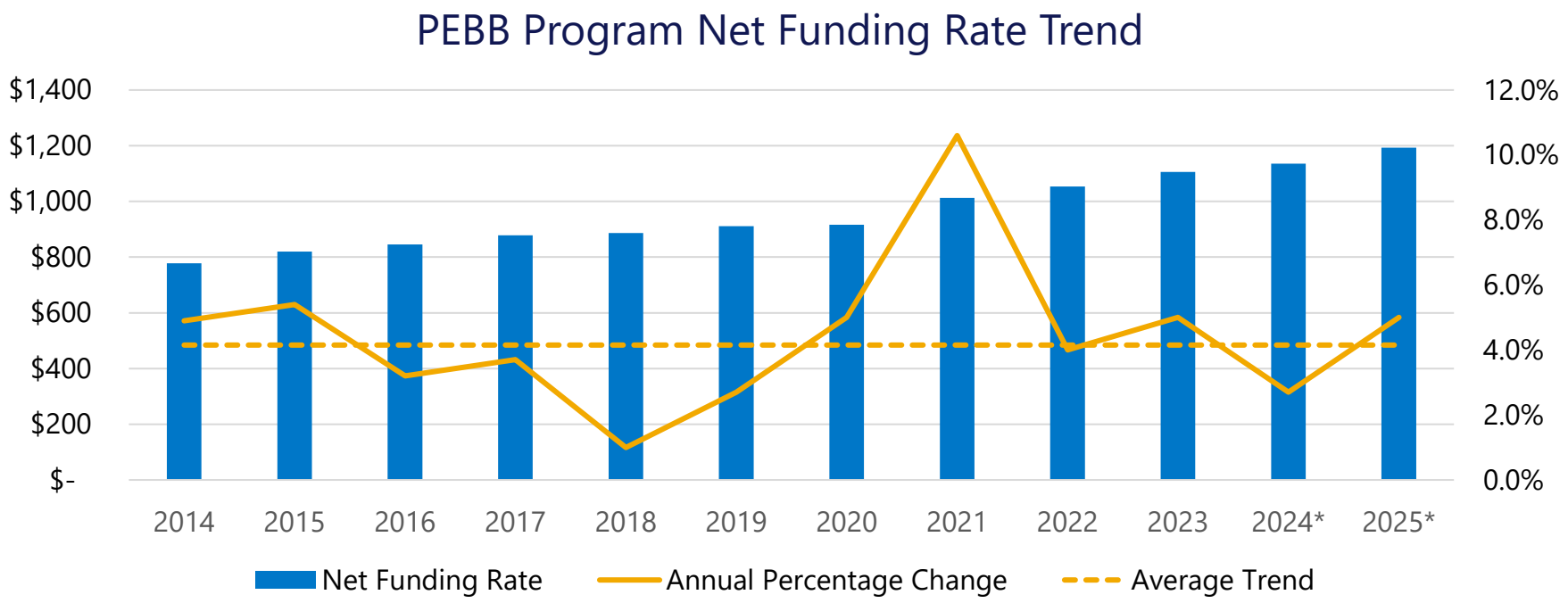
*2022H1 represents claims incurred and paid through June 2022

Non-Medicare Risk Profile

Risk Score Bands – PEBB Non-Medicare 2023 Procurement / SEBB 2021 Concurrent



PEBB Program Total Spending Trend



Questions?

Molly Christie, Fiscal Information Data Analyst

Financial Services Division

Molly.Christie@hca.wa.gov

TAB 8

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Hearing Instruments Benefits Overview

Sara Whitley
ERB Finance Unit Manager
Financial Services Division
March 9, 2023

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Benefit Comparison for Portfolio

Non-Medicare

	Kaiser Foundation Health Plan of the Northwest	
	Classic	**CDHP**
Hearing Instruments	$0, one aid per ear every 60 months**	
Routine annual hearing exam	$35	$30**

	Kaiser Foundation Health Plan of Washington			
	Classic	**Soundchoice**	**Value**	**CDHP**
Hearing Instruments	$0, one aid per ear every consecutive 60 months**			
Routine annual hearing exam	$15/$30^	$0/15%	$30/$50	10%**

	Uniform Medical Plan (UMP)			
	Classic	**Plus**	**Select**	**CDHP**
Hearing Instruments	$0, one aid per ear every 5 years**			
Routine annual hearing exam	$0	$0	$0	15%**

^Specialist copay

**Subject to deductible in UMP, KPWA and KPNW CDHP; Not subject to deductible in all other plans

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Benefit Comparison for Portfolio

Medicare

	Kaiser Foundation Health Plan of the Northwest
	Senior Advantage
Hearing Instruments	Retiree pays any amount over $1,400 per ear every 60 months
Routine annual hearing exam	$35

	Kaiser Foundation Health Plan of Washington	
	Original Medicare	**Medicare Advantage**
Hearing Instruments	Retiree pays any amount over $1,400 per ear every 60 months*	
Routine annual hearing exam	$15/$30^	$15/$30

	Uniform Medical Plan (UMP)
	Classic
Hearing Instruments	$0, one aid per ear every 5 years*
Routine annual hearing exam	$0

	UnitedHealthcare**	
	PEBB Balance	**PEBB Complete**
Hearing Instruments	Retiree pays any amount over $2,500 for hearing aids (combined for both ears) every 5 years.	
Routine annual hearing exam	$0	$0

*Not subject to deductible

^Specialist copay

**UnitedHealthcare Hearing vendor only

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Hearing Instruments

Evolution of the Benefit

Prior to 2021

$800 total allowance for hearing instruments every 3 years

→

SB 5179
Requires coverage of hearing instruments every 5 years for employees and dependents

→

2021 - Present

Member pays $0 per hearing instrument (per ear), every 5 years

SB 5179 Operationalization in UMP

- SB 5179 – Effective date of legislation was January 1, 2019, however:
  - Implementation was subject to appropriation, which was first included in the 2020 supplemental budget with an effective date for the 2021 plan year
- Unlimited benefit implemented in UMP due to concerns regarding insufficient in-network access and an inability to have a specific UMP allowed amount that would attract additional in-network providers

Induced Utilization in UMP

Hearing Instrument Benefit

Suppressed demand prior to 2021 led to ~300% increase in utilization beyond original projections

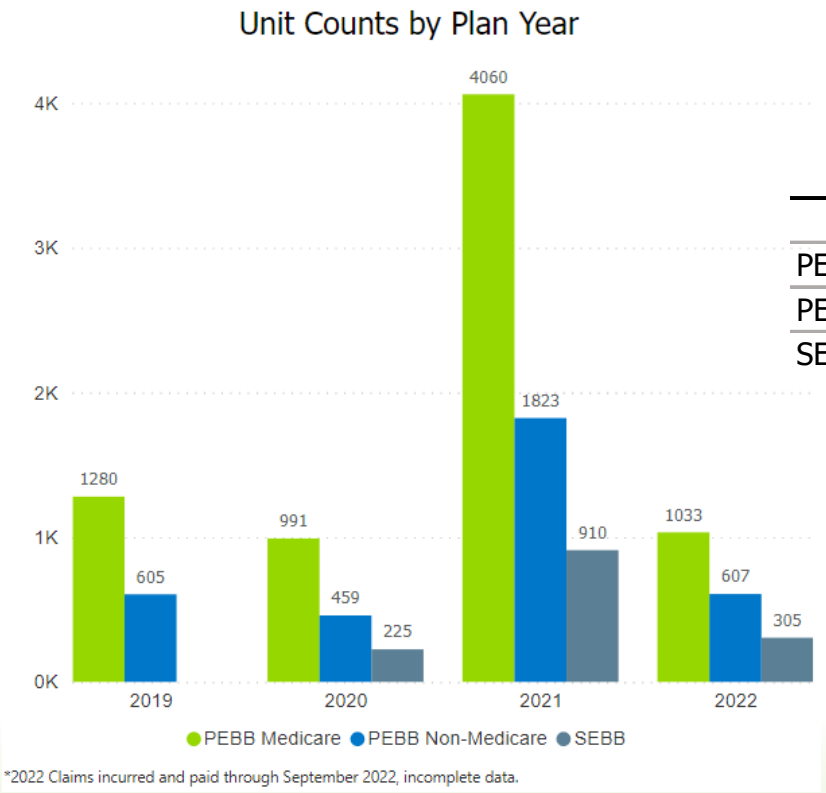
Payment of billed charges has led to double original projections of unit cost increases in UMP

No incentive for members or providers to avoid excessive cost options

Benefit Utilization Highlights

Key Drivers

Utilization

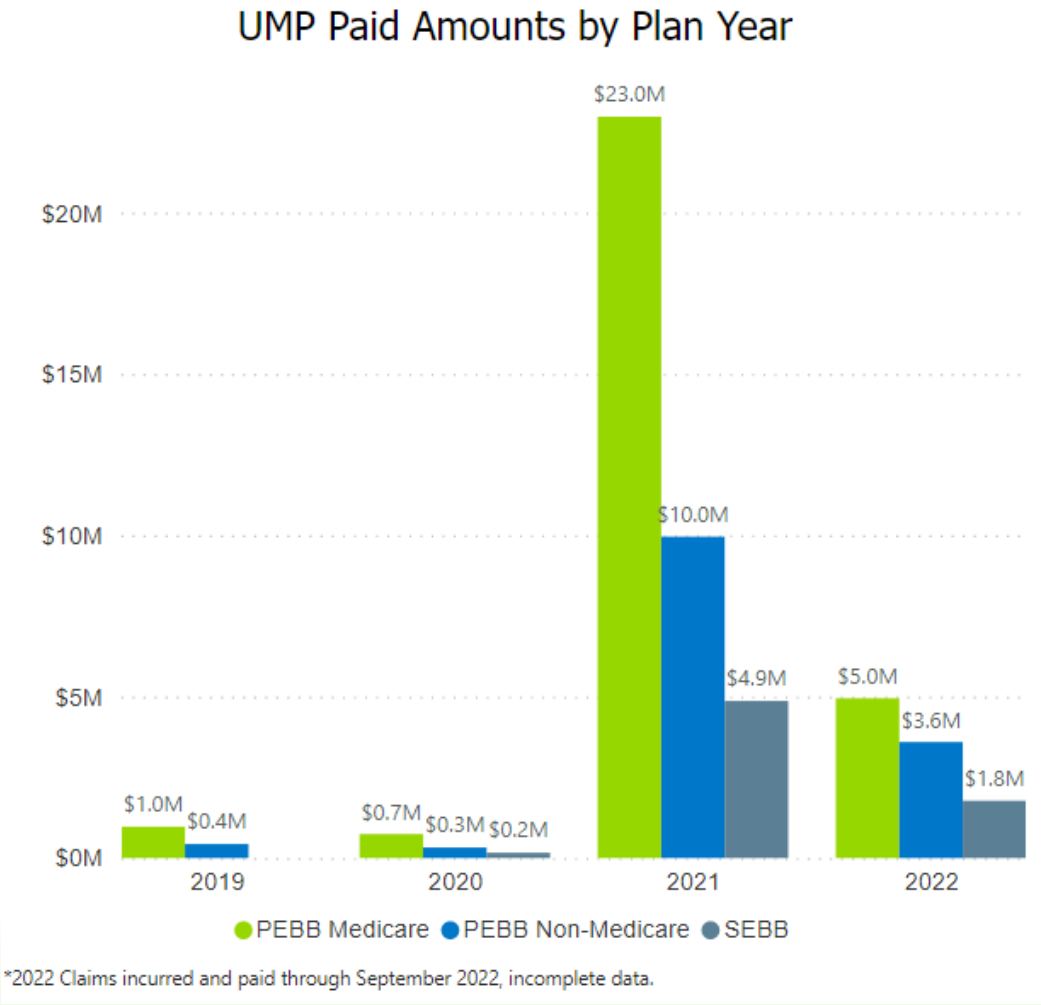


Unit Cost

Average UMP Paid per Distinct Member

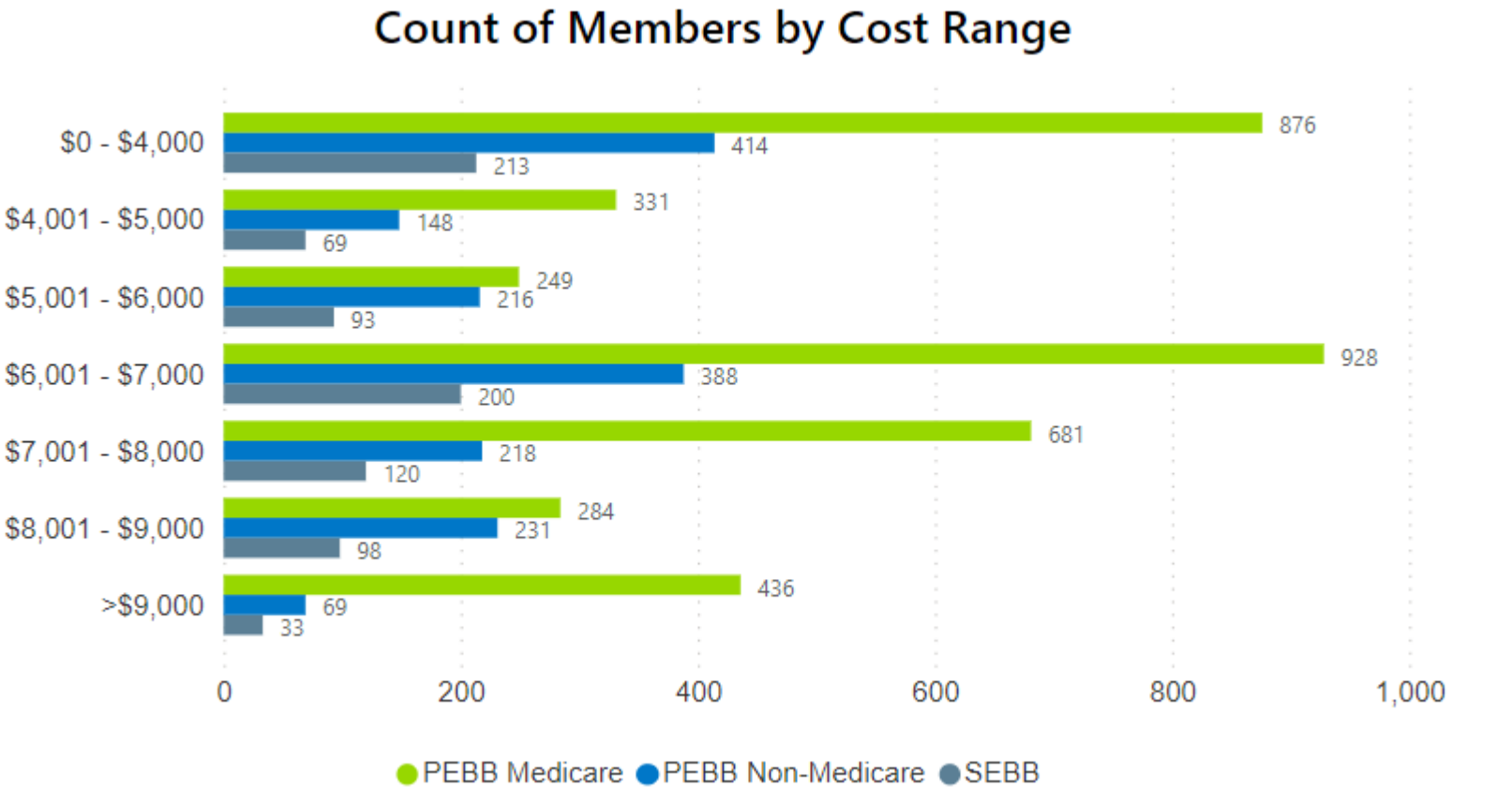
	2019	2020	2021	2022*
PEBB Medicare	$798	$800	$6,079	$5,635
PEBB Non-Medicare	$752	$749	$5,932	$7,380
SEBB		$768	$5,914	$7,306

Benefit Utilization Highlights (*cont.*)



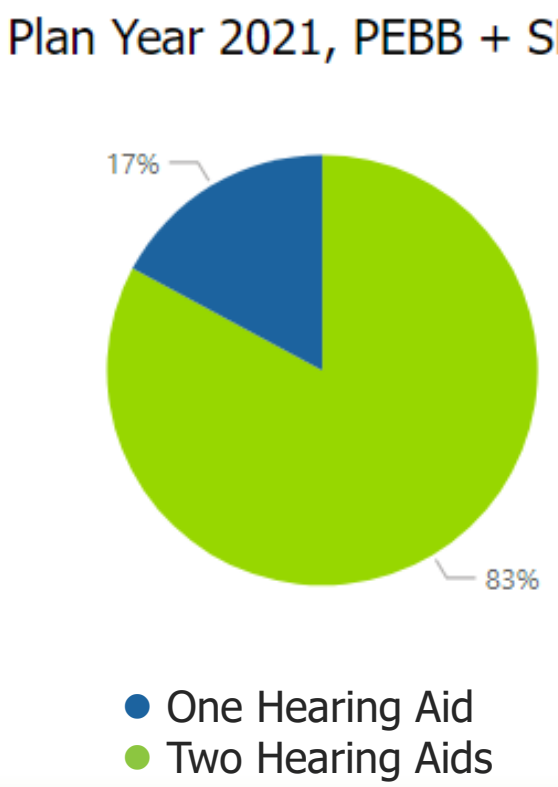
UMP Benefit Utilization Highlights (*cont.*)

Plan Year 2021



Benefit Utilization Highlights (*cont.*)

UMP Paid Amounts, Plan Year 2021



Average UMP Paid per Distinct Member

	2021
PEBB Medicare	$6,079
PEBB Non-Medicare	$5,932
SEBB	$5,914

Hearing Instruments

Opportunity for Purchasing Strategy Adjustment in UMP

- Current unlimited coverage in UMP has led to unanticipated levels of health care spend related to hearing instruments
- Opportunity for purchasing strategy adjustment in UMP that could place downward pressure on premiums for both the non-Medicare and Medicare UMP plans
- More information about options later this Board season

Questions?

Sara Whitley

ERB Finance Unit Manager

Financial Services Division

Sara.Whitley@hca.wa.gov

TAB 9

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Medicare Update

Ellen Wolfhagen
Senior Account Manager
Employees and Retirees Benefits Division
March 9, 2023

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Topics

- Open enrollment issue with UnitedHealthcare (UHC) files
- Update on comments submitted to Centers for Medicare & Medicaid Services (CMS)
- Update on Stakeholders' Medicare Coalition listening session pilot

Open Enrollment UHC File Issue

- In late January, UHC identified a system glitch on the UHC side which caused enrollment files to show the wrong effective date
- System glitch affected *all* UHC plans, not just PEBB plans
- UHC identified 283 PEBB Program members impacted

Open Enrollment UHC File Issue (*cont.*)

- Corrections were made to all records in early February
- Enrollment is retroactive to correct effective date
- UHC sent out letters to all impacted members on February 8th
- Letter included in appendix for reference

CMS Comments

- CMS issued proposed rules on December 14, 2022
- Rules aimed at strengthening Medicare Advantage (MA) plans' protections; aligning MA more with traditional Medicare and controlling marketing of MA plans
- Comment period closed on February 13

CMS Comments (*cont.*)

- HCA submitted comments on February 13 regarding:
  - Prior authorizations
  - Marketing and communications
  - Enrollee notification requirements for MA provider contract termination
  - Part D formulary changes
  - Provider directories
- Comments included in appendix for reference

Stakeholders' Coalition Listening Session

- Pilot listening session held on February 28
- 12 participants aligning with plan enrollment mix:
  - 5 with UMP Classic Medicare
  - 3 with Kaiser Medicare Advantage
  - 2 with UHC MA-PD
  - 2 with Premera Plan G
- Coalition identified participants

Stakeholders' Coalition Listening Session (*cont.*)

- 90-minute virtual session over Zoom
- Facilitated by Noel Villarreal from Ernst and Young, contractor to HCA
- Participants could include PEBB Program members or those who manage members' care

Stakeholders' Coalition Listening Session (*cont.*)

- Key questions posed to participants:
  - What do you like about your current PEBB plan?
  - What could be better about your plan?
  - What needs are not being met?
  - What other feedback?
  - Best way of HCA communicating with you?

Stakeholders' Coalition Listening Session (*cont.*)

- Listening session guide
  - Preparation for meeting
  - Discussion questions
  - Frequently asked questions
  - PEBB Medicare portfolio (plan information)
  - Glossary
- Guide included in appendix for reference

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Schedule of Listening Sessions

February						
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28				

March						
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

April						
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

May						
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Pilot Listening Session | Listening Sessions | Public Forums | PEB Board Meetings

* Listening sessions are virtual on Zoom, except for the following that will be in person: March 29 (Tumwater), April 11 (Cheney), April 12 (Yakima), May 16 (Bothell)

Initial Planning for Public Forums

- One per month (March 22, April 26, May 24)
- Virtual format over Zoom
- Opportunity for up to 30 speakers
- 3-minute time slots for speakers

Questions?

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

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Appendix

UnitedHealthcare Updated Enrollment Letter

<Primary Logo>
<Plan Correspondence Address 1>

<Member Full Name>
<Member Address 1>
<Member Address 2>
<Member Address 3>
<Member City State Zip>

Questions?
We're here to help.
Toll-Free <PHONE_NUMBER>
TTY <TTY_NUMBER>
<OPERATING_HOURS>
<OPERATING_HOURS>

[<Plan Name>]

<Date>

Member ID: <Membership ID>

Dear <Member First Name>,

We're writing with some important information about your <PLAN NAME> plan.

Due to an error in our system that we've fixed, we enrolled you in your new plan earlier than the date you requested. The correct start date for your plan is <PLAN_EFF_DATE>. We apologize for any confusion or inconvenience this may cause.

What does this mean for me?

Your <PLAN NAME> plan benefits are not affected, and you can continue to use the member ID card we sent you. We've also sent the corrected enrollment information to Medicare to update.

It may take Medicare a few weeks to update their system. During this time, you may receive plan materials from your previous insurance carrier. Please reach out to your previous carrier if you have any questions about services you received before <PLAN_EFF_DATE>.

Questions? We're here to help.

If you have any other questions, please call Customer Service toll-free at <**number**>, TTY 711, <Hours of Operation>.

Thank you for being a UnitedHealthcare member.

Sincerely,

The UnitedHealthcare Team

[Do we have the right address for you?
If not, please let us know so we can keep you informed about your plan.]

The company does not discriminate on the basis of race, color, national origin, sex, age, or disability in health programs and activities.

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文(Chinese)，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Comments Submitted to Centers for Medicare & Medicaid Services (CMS)

STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

February 13, 2023

Dear Chiquita Brooks-LaSure, CMS Adminstrator:

Thank you for the opportunity to provide comments regarding Centers for Medicare & Medicaid Services (CMS) proposed rules.

The state of Washington offers several employer-group sponsored Medicare Advantage (MA) and Medicare Advantage with Prescription Drug (MA-PD) plans to over 100,000 public sector retirees through the Washington State Health Care Authority (HCA). HCA is a state agency administering both Medicaid and centralized statewide public and school employee, and retiree, programs. Although in an employer-group sponsored plan setting like ours, there is more plan customization, less restrictions on plan switching, and potential for oversight of an insurance carrier by the employer. The predominance of concerns about individual market plans in the MA/MA-PD space, and the collateral impact on our state-offered plans, makes reforms and improvements to the entire system necessary.

HCA supports CMS's intent to strengthen the regulatory oversight of these plans and make improvements to better serve all retirees in Washington state, and across the nation. Within the extensive proposed rulemaking, we draw attention to a few areas of our strong support based on our recent experiences:

1. Prior authorization

   While cost-effective utilization management is a cornerstone of MA/MA-PD plans, we support the strengthening of prior authorization rules such that MA/MA-PD organizations may not limit coverage through internal policies and procedures that result in denials where traditional Medicare would cover and pay for the item or service. This parity between traditional Medicare and MA/MA-PD would go far to address beneficiary concerns that MA/MA-PD plans provide a lesser quality of care than does traditional Medicare.

2. Marketing and communications

   We support strengthening beneficiary protections and improving MA and Part D marketing. The ubiquitous TV and other media ads that flood the commercial market during the annual Medicare enrollment period add confusion for beneficiaries and make it difficult to distinguish between employer-group sponsored plans (which often offer additional protections for

beneficiaries as well as enhanced benefits) from plans on the commercial market.

3. Enrollee notification requirements for MA provider contract termination

   We support the proposed rules of establishing specific enrollee notification requirements for no-cause and for-cause provider contract terminations, as well as enrollee notification requirements when primary care and behavioral health provider contract terminations occur. This will provide retirees more time to make an informed decision about their medical care – a deeply personal and important decision.

4. Part D formulary changes

   Current regulations permits only the immediate substitution of newly released generics for brand name drugs. The proposed rule would also allow substitution with interchangeable biological products, new unbranded biological products, and new authorized generics. We see this as being a win for Part D beneficiaries.

5. Provider directories

   Under current regulations, MA/MA-PD organizations are prohibited from including providers for services not covered by traditional Medicare that are covered by the plan in online provider directories. When enrollees cannot identify providers for those services, it suggests limited or no access to these enhanced plan benefits, which are particularly prevalent in employer-group sponsored plans. This experience for an enrollee can be confusing and frustrating. We encourage CMS to consider adding flexibility for MA/MA-PD organizations to include providers of non-Medicare covered services that are covered by the plan within their online provider directories. We also support the proposed changes related to inclusion of providers' cultural and linguistic capabilities and the ability to identify certain providers waived to treat patients with medications for opioid use disorder (MOUD).

Should you have any additional questions or concerns, please contact me via email at sue.birch@hca.wa.gov or my assistant director for our public sector retiree offerings dave.iseminger@hca.wa.gov.

Sincerely,

Susan E. Birch, MBA, BSN, RN
Director

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Stakeholders' Medicare Coalition Listening Session Guide

PEBB Medicare Information & Listening Sessions

We want to hear from you!

Purpose

The Stakeholders' Medicare Coalition and the Health Care Authority (HCA) want to hear from PEBB members about how the portfolio of PEBB Medicare plans can serve you better. The listening sessions offer an opportunity, for members and active public employees supporting retirees, to share what they like and what could be better with the Medicare plans. We look forward to hearing about your experiences.

Preparation

Listening Session Agenda

- Welcome and opening comments (15 mins)
  - *Purpose of listening sessions*
  - *Why we are here*
  - *How will your feedback be used?*
  - *Zoom virtual participation (quick tutorial)*
- Facilitated Retiree Feedback Discussion (90 minutes)
  - *Discussion based on questions below*
- Closing

Meeting agreements

- Be respectful
- Be prepared to share (see Questions below and description of plans on page 3)
- Health care is very personal - please keep personal sharing in confidence
- No cell phones (please turn off cell phones)
- One person talking at a time

Discussion Questions

These are the initial starter questions for the listening sessions.

- Please **introduce yourself** (first name), **what Medicare plan are you or your family member on** now, **how long** have you been on this plan, and what is the **one thing you most like about it**?
- **What could be better** about your current plan?
- Are there any **needs that aren't being meet** (e.g., coverage, costs, comfort, convenience, provider choice, timeliness of care)?
- What **other feedback** would you like to share (e.g., needs, concerns, confusion about PEBB portfolio of plans or general comments)?
- **What other questions do you have?** *(We will not be answering the questions during the listening session. Note we want to capture questions to help improve our ongoing communication and outreach.)*
- **What are the best ways for HCA to communicate with you?** *(e.g., email, letters, videos, or website)*

Frequently Asked Questions

#	Question	Answer
1.	**Is the UMP Classic Medicare plan closing?**	*No. This plan will not be closing. There was some discussion of closing the plan at a PEB Board meeting during the summer of 2022, but that idea was not supported by the Board.*
2.	**Will my prescription drugs be covered with PEBB Medicare plans, and at what cost?**	*Each medical plan's formulary (list of covered prescription drugs) varies, however there is a lot of similarity in coverage. Cost-sharing for each drug varies by plan. If you enroll in Plan G, then you will need to obtain drug coverage elsewhere. Contact the medical plans directly or visit their websites for more information.*
3.	**Will I be able to see my provider with another medical plan?**	*Each medical plan's provider network varies, and some plans have no difference between in-network and out-of-network providers. While there are online directories available, contact the medical plans directly for the most complete information, as there are limitations as to what can be shown online.*
4.	**If I enroll in a PEBB Medicare Advantage plan, can I enroll in another PEBB plan later?**	*Yes, this is a benefit of PEBB membership and unlike in the commercial market, you can change to any PEBB Medicare plan for which you are eligible during the annual open enrollment for coverage effective the following year. You can also change your medical plan if you have a qualifying life event (e.g., marriage or moving).*
5.	**Why did UMP Classic Medicare premiums going up so much for 2023?**	*UMP Classic Medicare is a coordination of benefits (COB) plan that pays secondary after Medicare Part A and Part B and primary for pharmacy. COB plans cannot receive certain federal subsidies that all Part C (Medicare Advantage) and Part D (prescription drug) plans use to lower premiums.*
6.	**Where can I find a comparison of PEBB Medicare Plans?**	*HCA publishes and updates information about PEBB Medicare plans on their website at www.hca.w.gov. A PEBB Medicare Plan Comparison can be found by clicking on the following link.*
7.	**How do PEBB's MAPD plans compare to MAPD plans widely advertised during the fall and winter?**	*The PEBB Medicare Advantage Prescription Drug (MAPD) plans were specifically negotiated to have similar benefits to UMP Classic Medicare. These plans also offer additional benefits and no difference in copays between in-network and out-of-network services. The PEBB Medicare MAPD plans are not the same as other commercially advertised MAPD plans.*
8.	**What is the difference between PEBB retiree plans from individual market retiree plans?**	*The key differences between commercial AARP UHC plans and PEBB's group sponsored UHC MA-PD plans include:* • ***Plan network**: Individual market plans are mostly HMOs with closed networks; the PEBB MAPD plans are PPOs that work with any willing Medicare provider.* • ***Copay:** PEBB MAPD plans have no difference in copays between in-network and out-of-network providers.* • ***Maximum out-of-pocket pharmacy costs**: Some individual market plans have no drug coverage or no maximum limit an enrollee can pay. Under PEBB plans members only pay relevant Tier cost shares until the $2,000 limit has been reached.* • ***Donut Hole Coverage Gap:** The PEBB MAPD plans provide full coverage in the Donut hole. A member pays only applicable cost shares until the $2,000 limit has been reached.*
9.	**Which PEBB Medicare plans cover experimental and/or investigational therapies?**	*In general, experimental and investigational therapies are not covered by any plan (including UMP). There may be some exceptions. Please call the plans of interest regarding specific therapy or treatment coverage.*

PEBB Medicare Portfolio

	Original Medicare	Medicare Advantage		Medicare Supplement
Plans	**Uniform Medical Plan (UMP) Classic Medicare**	**Kaiser WA and Kaiser NW Medicare**	**UnitedHealthcare PEBB Balance and PEBB Complete**	**Premera Medicare Supplement Plans F & G**
Benefits	• Self-insured coordination of benefits (COB) plan • Original Medicare FFS pays primary on medical claims, UMP pays secondary • Creditable drug coverage, UMP pays primary on pharmacy claims	• Kaiser NW – Senior Advantage (MA) • Kaiser WA – Medicare Advantage (MA) and Original Medicare COB plans • Creditable drug coverage	• Employer group Medicare Advantage plus Prescription Drug (Part D) coverage (MA-PD) • National PPO network of providers, no difference in cost share for in-/out-of-network care • Lower premiums and out-of-pocket costs • No enrollment restrictions or additional costs for retirees with pre-existing conditions	• Supplemental (Medigap) plans for Medicare eligible enrollees (retired or disabled) • Helps enrollees fill the "gaps" in Original Medicare • Do not include drug coverage
Costs	2023 PEBB Plan Single Subscriber Premiums - Monthly			
	Classic $438.34	Kaiser NW/ Senior Adv. $176.13 Kaiser WA/ Adv. & Orig. $174.59	Complete $145.63 Balance $122.94	Plan F Retired $115.16 Plan F Disabled $196.69 Plan G Retired $98.53 Plan G Disabled $164.05
	2023 PEBB Plan Single Subscriber Premiums - Annual			
	Classic $5,260.08	Kaiser NW/ Senior Adv. $2,113.56 Kaiser WA/ Adv. & Orig. $2,095.08	Complete $1,747.56 Balance $1,475.56	Plan F Retired $1,381.92 Plan F Disabled $2,360.28 Plan G Retired $1,182.36 Plan G Disabled $1,968.60
Plan Options				
Nationwide Coverage	✓	×	✓	✓
Medical Deductible	✓	×	×	✓
Rx Deductible	✓	×	✓	N/A
Hearing Aids, Glasses/Contacts	✓	✓	✓	×
Chiropractic, Acupuncture, Massage Therapy	✓	✓	✓	Medicare approved only
Drug Coverage	✓	✓	✓	×
Gym Membership	×	✓	✓	×

Plan Phone Numbers

Kaiser NW Senior Advantage	1-800-813-2000
Kaiser WA Original Medicare and Medicare Advantage	1-888-901-4600
Premera Plan G	1-800-817-3049
UnitedHealthcare PEBB Balance and PEBB Complete	1-855-873-3268
Uniform Medical Plan Classic Medicare	1-888-849-3681

Resources

- For PEBB Medicare Inquiries, please send an email to **HCAPEBBMedicare@hca.wa.gov**
- HCA Website for PEBB retiree medical plans and benefits: **https://www.hca.wa.gov/employee-retiree-benefits/retirees/medical-plans-and-benefits**

Glossary

A general Medicare glossary is available online from Medicare.gov at **www.medicare.gov/glossary.**

Some key terms related to Washington PEBB Medicare plans are provided below.

Term	Definition
Appeal	An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of these: • Your request for a health care service, supply, item, or prescription drug that you think you should be able to get • Your request for payment for a health care service, supply, item, or prescription drug you already got • Your request to change the amount you must pay for a health care service, supply, item, or prescription drug. You can also appeal if Medicare or your plan stops providing or paying for all or part of a service, supply, item, or prescription drug you think you still need
Claim	A request for payment that you submit to Medicare or other health insurance when you get items and services that you think are covered.
Coinsurance	An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).
Coordination of Benefits	Coordination of benefits (COB) allows plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance plan has the primary payment responsibility and the extent to which the other plans will contribute when an individual is covered by more than one plan). *See ww.cms.gov for more details on Coordination of Benefits.*
Copayment	An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.
Deductible	An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles.
Formulary	A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.
Health Insurance Marketplace	A service that helps people shop for and enroll in affordable health insurance. The federal government operates the Marketplace, available at HealthCare.gov, for most states. Some states run their own Marketplaces.
Out-of-pocket Limit	The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges, or health care your plan doesn't cover. Some plans don't count all your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.
Network Provider	A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."
Non-participating providers	Providers who accept Medicare but do not agree to Medicare's approved amounts for services. These providers may charge up to 15% more than Medicare's approved amount. This means you are responsible additional charges.
Out-of-network provider	A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider.

TAB 10

Washington State Health Care Authority

PUBLIC EMPLOYEES BENEFITS BOARD

Policy and Rules Development

Stella Ng, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
March 9, 2023

RCW 41.05.065 (1) and (2)

(1) The public employees' benefits board shall study all matters connected with the provision of health care coverage, life insurance, liability insurance, accidental death and dismemberment insurance, and disability income insurance or any of, or a combination of, the enumerated types of insurance for employees and their dependents on the best basis possible with relation both to the welfare of the employees and to the state. However, liability insurance shall not be made available to dependents.

(2) The public employees' benefits board shall develop employee benefit plans that include comprehensive health care benefits for employees. In developing these plans, the public employees' benefits board shall consider the following elements:

(a) Methods of maximizing cost containment while ensuring access to quality health care;

(b) Development of provider arrangements that encourage cost containment and ensure access to quality care, including but not limited to prepaid delivery systems and prospective payment methods;

(c) Wellness incentives that focus on proven strategies, such as smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education;…

RCW 41.05.065(4)

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

RCW 41.05.080 (1) and (3)

(1) Under the qualifications, terms, conditions, and benefits set by the public employees' benefits board:

(a) Retired or disabled state employees, retired or disabled school employees, retired or disabled employees of county, municipal, or other political subdivisions, or retired or disabled employees of tribal governments covered by this chapter may continue their participation in insurance plans and contracts after retirement or disablement;

(b) Separated employees may continue their participation in insurance plans and contracts if participation is selected immediately upon separation from employment;

(c) Surviving spouses, surviving state registered domestic partners, and dependent children of emergency service personnel killed in the line of duty may participate in insurance plans and contracts.

(3) Rates charged to surviving spouses and surviving state registered domestic partners of emergency service personnel killed in the line of duty, retired or disabled employees, separated employees, spouses, or children who are eligible for parts A and B of medicare shall be calculated from a separate experience risk pool comprised only of individuals eligible for parts A and B of medicare; however, the premiums charged to medicare-eligible retirees and disabled employees shall be reduced by the amount of the subsidy provided under RCW 41.05.085.

Introduction of Proposed Resolutions

PEBB 2023-01	When a subscriber has a change in residence that affects medical plan availability
PEBB 2023-02	When a subscriber is involuntarily terminated by a MA or MA-PD plan

Proposed Resolution PEBB 2023-01
When a subscriber has a change in residence that affects medical plan availability

After a change in residence, the subscriber must elect a new medical plan if a subscriber's current medical plan is no longer available based on residence. If they do not elect a new medical plan within the time period allowed by special open enrollment rules, the subscriber will be enrolled in a PEBB medical plan as designated by the director or designee.

Proposed Resolution PEBB 2023-01 Example #1

Example: John lives in Snohomish County and enrolls in Kaiser Permanente WA Classic plan. In September 2024, John moves to Vancouver in Clark County. Because John no longer lives in a county where Kaiser Permanente WA Classic Plan is available, John **must** select a new medical plan.

- What happens if John fails to elect a new medical plan during the special open enrollment period when his current Kaiser Permanente WA Classic Plan is no longer available in the county where he lives? If John does not elect a new medical plan within the time period allowed by special open enrollment rules, he will be enrolled in a PEBB medical plan as designated by the director or designee.

Proposed Resolution PEBB 2023-01 Example #2

Example: Marcia lives in King County and enrolls in Kaiser WA Medicare Advantage plan. In September 2024, Marcia moves to Arizona. Because Marcia no longer lives in a county where Kaiser WA Medicare Advantage is available, Marcia **must** select a new medical plan.

- What happens if Marcia fails to elect a new medical plan during the special open enrollment period when her current Kaiser WA Medicare Advantage Plan is no longer available in the county where she lives? If Marcia does not elect a new medical plan within the time period allowed by special open enrollment rules, she will be enrolled in a PEBB medical plan as designated by the director or designee.
- Without this resolution, if Marcia did not change plans CMS will disenroll her from coverage after 6 months.

Proposed Resolution PEBB 2023-02 When a subscriber is involuntarily terminated by a MA or MA-PD plan

When a subscriber or their dependent must be disenrolled by a Medicare Advantage (MA) plan or Medicare Advantage-Prescription Drug (MA-PD) plan as required by federal law, the subscriber and their enrolled dependents will be enrolled in a PEBB medical plan as designated by the director or designee. The new medical plan coverage will begin the first day of the month following the date the MA or MA-PD plan is terminated.

Proposed Resolution PEBB 2023-02 Example

Example: Bob is enrolled in UHC PEBB Complete and has not been paying his Part D Income-Related Monthly Adjusted Amount (IRMAA). At the end of July 2024, CMS disenrolled Bob from the plan as required by federal law because he fails to pay his Part D IRMAA to the government.

- What happens next for Bob's coverage? Bob will be enrolled in a PEBB medical plan as designated by the director or designee, effective August 1, 2024

Next Steps

- Incorporate Board feedback in the proposed policies
- Submit feedback by March 20, 2023 to HCAPEBSEBBoardPolicyFeedback@hca.wa.gov
- Bring recommended proposed policy resolutions to the Board for action at the April 13th Board meeting

Questions?

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