

Public Employees Benefits Board

March 17, 2021

Public Employees Benefits Board

March 17, 2021

12:00 p.m. – 5:00 p.m.

Zoom Attendance Only

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

Table of Contents

Meeting Agenda	1-1
Member List.....	1-2
2021 Meeting Schedule	1-3
Board By-Laws	2-1
Approval of Meeting Minutes	3-1
May 28, 2020	
June 17, 2020	
Follow Up from January 27, 2021 Retreat	4-1
2021 Legislative Session.....	5-1
K-12 Non-Medicare Retiree Update	6-1
2021 FSA & DCAP Flexibility.....	7-1
Annual Benefits Planning Cycle.....	8-1
Eligibility & Enrollment Policy Development.....	9-1
Long-Term Disability (LTD) Insurance	10-1

TAB 1

Public Employees Benefits Board
March 17, 2021
12:00 p.m. – 5:00 p.m.

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

TO JOIN ZOOM MEETING – SEE INFORMATION BELOW

12:00 p.m.*	Welcome and Introductions		Sue Birch, Chair	
12:05 p.m.	Meeting Overview		Dave Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information/ Discussion
12:15 p.m.	Approval of: May 28, 2020 Minutes June 17, 2020 Minutes	TAB 3	Sue Birch, Chair	Action
12:20 p.m.	Follow Up from January 27, 2021 Retreat	TAB 4	Dave Iseminger, Director ERB Division	Information/ Discussion
12:25 p.m.	Executive Session		Tanya Deuel, ERB Finance Manager Financial Services Division Lauren Johnston, SEBB Program Procurement Manager, ERB Division	
1:30 p.m.	Break			
1:40 p.m.	2021 Legislative Session	TAB 5	Cade Walker, Special Executive Assistant, ERB Division	Information/ Discussion
2:00 p.m.	K-12 Non-Medicare Retiree Update	TAB 6	Molly Christie, Fiscal Information & Data Analyst, ERB Rates & Finance	Information/ Discussion
2:15 p.m.	Medical Flexible Spending Arrangement (FSA) & Dependent Care Assistance Program (DCAP) 2021 Leniency	TAB 7	Leanna Olive, Navia/Centers of Excellence (COE) Account Manager ERB Division	Information/ Discussion
2:30 p.m.	Annual Benefits Planning Cycle	TAB 8	John Partin, Manager Benefits Strategy & Design Section ERB Division	Information/ Discussion
2:50 p.m.	Break			
3:00 p.m.	Eligibility & Enrollment Policy Development	TAB 9	Stella Ng, Senior Policy Analyst Emily Duchaine, Regulatory Analyst Policy, Rules, & Compliance Section ERB Division	Information /Discussion

4:00 p.m.	Break			
4:10 p.m.	Long-Term Disability (LTD) Insurance	TAB 10	Kimberly Gazard, Contract Manager Portfolio Management & Monitoring Section, ERB Division	Information / Discussion
4:40 p.m.	Public Comment			
5:00 p.m.	Adjourn			

***All Times Approximate**

The Public Employees Benefits Board Retreat will meet Wednesday, March 17, 2021. Due to COVID-19 and out of an abundance of caution, all Board Members and attendees will attend this meeting virtually.

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

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

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

Direct e-mail to: board@hca.wa.gov.

Materials posted at: <http://www.pebb.hca.wa.gov/board/> by close of business on March 15, 2021.

Join Zoom Meeting

<https://zoom.us/j/95158276448?pwd=RGNYSDZQdStydWdMdXA4eVFYQW53QT09>

Meeting ID: 951 5827 6448

Passcode: 906453

One tap mobile

+12532158782,,95158276448# US (Tacoma)

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Dial by your location

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+1 301 715 8592 US (Washington DC)

Meeting ID: 951 5827 6448

Find your local number: <https://zoom.us/u/axVoUoN2s>

PEB Board Members

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

PEB Board Members

Name	Representing
Yvonne Tate 1407 169 th PL NE Bellevue WA 98008 V 425-417-4416 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 23 rd DR SE Bothell WA 98012 V 360-689-9275 PEBBoard@hca.wa.gov	Benefits Management/Cost Containment
Legal Counsel Michael Tunick, Assistant Attorney General 7141 Cleanwater Dr SW PO Box 40124 Olympia WA 98504-0124 V 360-586-6495 MichaelT4@atg.wa.gov	

*non-voting members

3/12/21



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

PEB BOARD MEETING SCHEDULE

2021 Public Employees Benefits (PEB) Board Meeting Schedule

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

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

March 17, 2021 - Noon – 5:00 p.m.

April 14, 2021 - Noon – 5:00 p.m.

May 12, 2021 - Noon – 5:00 p.m.

June 9, 2021 - Noon – 5:00 p.m.

June 30, 2021 - Noon – 5:00 p.m.

July 14, 2021 - Noon – 5:00 p.m.

July 21, 2021 - Noon – 5:00 p.m.

July 28, 2021 - Noon – 5:00 p.m.

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

6/12/20

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 21, 2020

TIME: 11:23 AM

WSR 20-15-132

TAB 2

PEB BOARD BY-LAWS

ARTICLE I

The Board and its Members

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

ARTICLE II

Board Officers and Duties

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

ARTICLE III
Board Committees

(RESERVED)

ARTICLE IV
Board Meetings

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

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

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

ARTICLE V
Meeting Procedures

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

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

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

Last Revised July 15, 2020

TAB 3

DRAFT

Public Employees Benefits Board Meeting
Meeting Minutes

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

Members Present:

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

PEB Board Counsel:

Michael Tunick, Assistant Attorney General

Call to Order

Sue Birch, Chair, called the meeting to order at 12:04 p.m. Due to COVID-19 and the Governor's Proclamation 20-28, today we're meeting telephonically only. Sufficient members present to allow a quorum. Board self-introductions followed.

The Board met in Executive Session at 12:10 p.m., pursuant to RCW 42.30.110(I), to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026.

The public portion of the meeting resumed at 1:00 p.m.

Meeting Overview and Follow Up

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Agenda Item: UMP Additional Plan Proposal

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Elyette Weinstein: Thank you. That was helpful.

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

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

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

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

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

Elyette Weinstein: Thank you.

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

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

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

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

Tom MacRobert: Correct. Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sue Birch: Slide 16 - Resolution for vote.

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

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

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

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

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

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

Yvonne Tate: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dave Iseminger: Correct.

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

Sue Birch: For 2021?

Tim Barclay: Correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Voting to Approve: 3

Voting No: 4

Voting Yes: Yvonne Tate, Leanne Kunze, Sue Birch

Voting No: Harry Bossi, Elyette Weinstein, Tim Barclay, Tom MacRobert

Sue Birch: Resolution PEBB 2020-06 fails.

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

Agenda Item: UMP Vision Proposal

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

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

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

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

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

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

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

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

Sue Birch: Slide 7 - Resolution for vote.

Resolution PEBB 2020-07 – UMP Vision Benefits.

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

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

Voting to Approve: 7

Voting No: 0

Sue Birch: Resolution PEBB 2020-07 passes.

Agenda Item: Expanding PEBB Medicare Options Update

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ellen Wolfhagen: Thank you for pointing that out.

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

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

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

Agenda Item: Policy Resolutions

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

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

Sue Birch: Resolution PEBB 2020-04 Default Enrollment for An Eligible Employee Who Fails to Make A Timely Election

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

- Enrollment in employee-only medical coverage;
- Enrollment in employee-only dental coverage;
- Enrollment in basic life insurance;
- Enrollment in basic AD&D; and
- Enrollment in basic Long-Term Disability insurance.

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Resolution PEBB 2020-04 passes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dave Iseminger: Yes, you are correct.

Voting to Approve: 7

Voting No: 0

Sue Birch: Resolution PEBB 2020-05 passes.

Agenda Item: Annual Rate Process

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

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

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

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

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

Sue Birch: Resolution PEBB 2020-01 Rate Development Procedure

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

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

Voting to Approve: 7

Voting No: 0

Agenda Item: COVID-19: Potential Financial Impact

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Public Comment

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

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

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

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

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

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

Next Meeting

June 17, 2020
12:00 p.m. – 5:00 p.m.

Preview of June 17, 2020 PEB Board Meeting

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

Meeting Adjourned: 3:34 p.m.

DRAFT
Public Employees Benefits Board Meeting
Meeting Minutes

June 17, 2020
Health Care Authority
Meeting Held Telephonically
Olympia, Washington
12:00 p.m. – 4:00 p.m.

Members Present:

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

Members Absent:

Yvonne Tate

PEB Board Counsel:

Katy Hatfield, Assistant Attorney General

Call to Order

Sue Birch, Chair, called the meeting to order at 12:04 p.m. Due to COVID-19 and the Governor's Proclamation 20-28, today we're meeting telephonically only. Sufficient members present to allow a quorum. Board self-introductions followed.

The Board met in Executive Session at 12:10 p.m., pursuant to RCW 42.30.110(I), to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026.

The public portion of the meeting resumed at 1:00 p.m.

Meeting Overview and Follow Up

David Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of today's meeting and a follow up from the May 28, 2020 meeting.

Follow Up: HCA previously described some COVID-19 responses from our carriers regarding coverage within the plans related to emergency orders from the Office of the Insurance Commissioner. Since the last Board Meeting, Kaiser Northwest and Kaiser Washington informed us that the waiving of cost shares for treatment related to COVID-19 they had originally anticipated would be waived for a subset of this year will now be waived COVID-19 treatment through December 31, 2020. As a reminder, the Uniform Medical Plan currently has a similar policy that goes through June 30, 2020. HCA is currently evaluating the need to modify that date due to current circumstances.

Agenda Item: Robert's Rules of Order Parliamentary Procedure Training

Katy Hatfield, Assistant Attorney General, provided training for the Board on Robert's Rules of Order. In general, parliamentary procedure is a body of rules for conducting a meeting and making decisions as a group. For PEB Board Meetings, the PEB Board's By-laws require all rules of order not provided in the By-laws "shall be determined in accordance with the most current edition of Robert's Rules of Order."

PEB Board By-Laws Update

Dave Iseminger, Director, ERB Division, reviewed proposed updates to the PEB Board By-Laws.

Slide 2 – Why Update the By-Laws? The Board structure changed on January 1, 2020, when the final stages of some of the original legislation of creating the SEBB Program was passed by the Legislature in 2017. Our current By-Laws are now in conflict with some of the legal statutory authority.

The By-Laws have not been revised in at least six years and there have since been technological advancements and modernization of the Open Public Meetings Act that make our By-Laws out of alignment with what is required in state law. And there are some technical updates we are proposing.

Slide 3 – PEB Board Action Required. To change Board By-laws, it requires a two-thirds majority vote of the Board. A vote on these proposed updates will take place at the July 15, 2020 Board Meeting.

Slide 4 – Appendix. By-Laws redline version of strikeout and replace.

Slide 5 – PEB Board By-Laws, Article I – The Board and Its Members. The recommendations in Article I are to align with statutory language that's now in both 41.050.55, which describes the composition of the Board, and RCW 41.050.65, which describes the roles, responsibilities, duties, and authority of the Board.

Article I – 1 Board Function. Added words from statute. The primary responsibilities and authorities of the Board are related to designing and approving insurance benefits and establishing eligibility criteria. The current By-Laws did not reference the eligibility responsibilities of the Board. Additionally, because school district employees no longer have the option to join PEBB Benefits, verbiage is added to describe the population served by this program. Retirees weren't mentioned even though it's roughly a third of the program. We also removed the references to school district employees that are no longer under the authority of this Board.

Slides 5 & 6 - Article I – 4 Non-Voting Members. Due to the new SEB Board and SEBB Program, there is now one non-voting member appointed by the Governor instead of two. The non-voting K-12 active employee representative no longer exists due to K-12 active employees moving from the PEBB Program to the SEBB Program. The Legislature amended the PEB Board statute to remove that non-voting member. Although the Legislature re-amended the statute to let Educational Service District employees stay with PEBB for a couple of years, they did not revisit the Board composition. This proposed update cleans up those references that no longer exist in statute. The rest of the items in Article I are technical changes.

Slide 7 – Board Officers and Duties. No Changes.

Slide 8 – Board Meetings. Article IV – 2 Regular and Special Board Meetings. The first proposed change removes the requirement for the Board to adopt the schedule of meetings that are filed with the Code Reviser's Office. The meeting schedule for the next year is presented to the Board the last two meetings of the season for their information. The schedule is prepared to align with rulemaking filing and is not a requirement of the Open Public Meetings act, so HCA's recommendation is to strike that reference.

Slide 9 – Board Meetings. Article IV – 5 Meeting Minutes and Agenda. This subsection relates to the minutes and the Open Public Meetings Act. Under the Board's existing By-Laws, there's a requirement to make the agenda available ten days prior to the meeting, unless otherwise required by the Open Public Meetings Act (OPMA). The Legislature amended the Open Public Meetings Act in 2014 to acknowledge that the internet exists and the OPMA requirement now is, if using the internet or your website, to post the agenda no less than 24 hours before the meeting. HCA is recommending the By-Laws align with the OPMA.

The remaining piece addresses minutes. The Board minutes produced are pretty verbose due to the content of these meetings and the importance to members who are impacted by these benefits. The minutes are also a public record of what transpires during a Board meeting and are occasionally referenced years later. The By-Laws reference retaining documents, video, or audio recordings for up to six months. In truth, there are retention laws, as part of the Public Records Act that require longer retention than was reflected in the By-Laws. And rather than have a constant revision of By-Laws coming back to you, our advice and recommendation is to just follow the Public Records Act retention requirements, which the Secretary of State's Office monitors. Over time, our meetings have become more complicated and the minutes are almost verbatim due to the content and discussions at our meetings. The By-Laws say the minutes will be acted upon at the next Board meeting. HCA's recommendation is to change the requirement to "a subsequent" meeting. In June and July, there are up to four Board meetings in each month making it almost impossible to get that work done.

Slide 10 – No Changes.

Slide 11 – Meeting Procedures. Article V. This slide has technical clean up recommendations.

Slide 12 – Meeting Procedures. Article V – 7 – Manner of Voting. The additional verbiage relates to proxy votes not being permitted among Board Members but there's an acknowledgement that a proxy vote does not occur if the Chair's duties have been delegated from Director Birch to a Designated Chair of the meeting. This is true whether it's in the By-Laws or not. Under 41.05.021, the Director has inherent authority to delegate their duties and powers that are vested in law, which includes the Chairship of the PEB Board. We wanted to make sure it was clear that if there is a Chair Pro-Tem designated by Director Birch to chair a particular meeting, that delegation happens under their inherent statutory authority as the director, includes the vote, and it's not a violation of the proxy vote description that exists within Article V.

Slide 13 – Meeting Procedures. Article V – 10 – State Ethics Law and Recusal. A recusal process was added to this subsection. It helps a Board Member to determine if there are any points at which an individual Board Member may find it necessary to recuse themselves under the Ethics or Public Service Act. It's one of the required trainings for Board Members.

State Budget Forecast & Budget Reduction Options

Megan Atkinson, Chief Financial Officer, Financial Services Division

Dave Iseminger, Director, ERB Division

Dave and I are going to have a conversation with you about the state budget forecast and budget reduction options HCA submitted to the Office of Financial Management (OFM) a few weeks ago.

Slide 2 – Big Picture State Budget Background. I want to discuss setting the context for the state budget background. This has significantly changed in the last 24 hours. The most recently enacted state operating budget, which is for the current 2019-2021 biennium, totals about \$50 billion in General Fund State. Health Care Authority expenditures are about \$30 billion of the total, about \$6 billion of the General Fund State (GFS). That's a bit of a misnomer because of our total expenditures because so much comes from our PEBB and SEBB Benefit Funds. While those funds themselves are not considered General Fund State, GFS contributes to those funds. For example, in our PEBB Program, the employer contributes a significant portion of the cost of the program. The majority of employers are state of Washington agencies and the majority of them are using GFS. Even though we might be making an expenditure from our PEBB Fund, which for purposes of our budget is considered a non-General Fund State Fund, the source of that money that gets to PEBB, about 42% - 45%, is GFS. There is a significant amount spent at the state level and HCA is a good chunk of that. And then within HCA, especially as you're looking at the PEBB and SEBB Programs, we have several billion dollars' worth of expenditures in both programs. The majority of that is health care purchasing – our self-insured premiums, third-party administrator, managed care premiums, and a small slice for program administration.

Slide 3 – COVID-19 Economic Impacts. For budget context, we need to consider the impact of the COVID pandemic, the resulting economic contraction, and how that ripples through not just the state's economy, but into state agency budgets. The COVID pandemic has had a significant impact on the world's economy, the nation's economy, and our state's economy. The first two bullets on this slide are a bit out of date because the last bullet indicates the next update from the Economic and Revenue Forecast Council is expected on June 17, which is today.

The Economic and Revenue Forecast Council met this morning and the new revenue update for the next few years is a decrease of about \$9 billion for just the General Fund State portion of the state's budget. That's a reduction in revenue estimates of about \$4.5 billion in the current biennium and another \$4.3 billion in the next 2021-23 biennium. The numbers are about the same amount of adjustment in both biennia, but we're halfway through the current biennium. The reduction of \$4.5 billion in the 2019-21 biennium will hit the fiscal year 2021 budget, with several billion-dollar reduction in the following biennium. That is a significant amount of state revenue contraction. All agencies, Health Care Authority included, have already been directed to take steps to reduce and curtail expenditures. That environment will impact the agency moving forward over the next few years.

Dave Iseminger: Just to drive home your point, there's \$4.5 billion in less revenue expected over basically the next 12 months that has to be accounted for in the current biennial budget ending June 30, 2021.

Megan Atkinson: Essentially that is correct. While the economic contraction that represents that \$4.5 billion is longer than a fiscal year because the economic contraction really started in March, there is not the ability for the Legislature to alter anything because they had already gone home by then. Fiscal year 2020 budgets for the agencies were set prior to the COVID pandemic, prior to the economic contraction. The budgetary impact of the contraction has to be addressed in only one fiscal year, even though the contraction happened over a longer period.

Slide 4 – Select Statewide Actions. Agencies were directed to freeze hiring, personnel service contracts, and equipment purchases and to start a voluntary separation and retirement incentive program. This morning the Governor provided additional direction to state agencies regarding employee furloughs and cancelled cost of living increases.

Dave Iseminger: This morning it was announced that state employees will begin a furlough process, eight hours per week starting no later than June 28, and then for the duration of the weeks that begins June 28 through July 25, in addition to once per month for August through November. State agencies were also directed to allow and work with any employees wanting to voluntarily take additional furloughs.

Beyond furloughs, it was announced a planned 3% salary adjustment for Washington Management Service (WMS) or exempt positions who make \$53,000 annually or more would not go into effect on July 1. Anyone who makes under that, in those positions, as well as the classified Washington General Service positions will continue to have the 3% salary adjustment that was planned. That is this morning's news about how we are addressing some of the current biennial year fiscal realities we're now facing.

Megan Atkinson: Slide 5 – Spring 2020 Budget Option Directions. As state agencies develop their budgets, Office of Financial Management (OFM) annually provides budget instructions, budget guidance. This year, because of the economic contraction and revenue shortfalls that were coming, in mid-May OFM identified savings targets for each agency. HCA was provided a savings target of \$462 million in General Fund State expenditures for fiscal year 2021, this fiscal year starting July 1. All agencies received this 15% General Fund State reduction target. Again, because the PEBB and SEBB Programs are not directly funded by General Fund State, we didn't receive a specific

target as a result of that. We know they are essentially funded by General Fund State, appropriated to either the school districts for SEBB or state agencies for PEBB. That money is then paid into the Health Care Authority. HCA put forward budget reduction options, like all agencies in mid-May, which are published on the OFM website.

Currently, state agencies are working on putting together decision packages for consideration for inclusion in the Governor's budget that will be released in late December. That budget starts the budget debate with the Legislature in the 2021 legislative session. The budget instructions released by OFM this week directed agencies to submit an agency budget request to OFM, due mid-September, with a 15% reduction from our current maintenance level.

I'll explain "maintenance level." In Washington State Government, we budget in tiers, a carry forward level, maintenance level, and finally policy level. There are technical guidelines that describe what's in carry forward level, what's in maintenance level, and what's in policy level. Carry forward level is the foundation. It is what you're doing this biennium carried forward with no significant changes into the next year. There will be some technical adjustments made at carry forward, like truing up numbers. For example, a pilot program started in March, with only a few months of operation in one year, but is going to be 12 months of operation in the following year, you would make a technical adjustment at the carry forward level.

After the carry forward level, is the maintenance level, the budget amount needed for current law. For example, funding bills already enacted, legislative decisions made, current policy, current programs. Maintaining operations of the state with no policy changes.

The final tier is the policy level, which is new policies, new programs, changes to the current base.

Taking a 15% reduction from maintenance level reduces the base, to shrink what we're already doing. That is our direction from OFM.

John Comerford: I'm curious that if we have to make cuts for this fiscal year, starting July 1, will the next budget be based on those cuts as well? The maintenance budget? Or are they based on what we have going on right now without those cuts?

Megan Atkinson: The next budget enacted after the 2021 legislative session will take into consideration all the cuts or reductions state agencies have made until then and likely direct additional program and reduction changes, which is my guess.

Slide 6 – HCA's Budget Options Submission. HCA provided reduction options for all parts of the agency's business, all health care programs, including the PEBB and SEBB Programs. OFM has been publishing agency submissions since June 8. The identified savings options are not recommendations or requests from the agency, but simply reductions that can be made. They do not reflect the agency's prioritization or recommendations of where we will offer up reductions in our agency submittal later this fall.

Slide 7 – HCA’s Budget Options Submission (*cont.*). HCA’s goal is to preserve health care services for Washington residents. We will be expected to help address the revenue shortfall. HCA and OFM will continue to work together to refine the proposed budget reductions for the Governor’s and Legislature’s consideration.

Dave Iseminger: Slide 8 – HCA’s Budget Options Submission (*cont.*). There are a lot of competing and overlapping authorities. Different parts of the benefits portfolio are discussed in Collective Bargaining Agreements, some enshrined in state law, others are policy or benefit design positions delegated to and acted upon by this Board. It can be quite the tangled web to identify who can do what, when, where, and in what order, based on what timeline. The bottom line is, it gets complicated quickly for there to be many options on the table that the PEBB or SEBB Programs can immediately act on because the benefit design is set on a calendar year, which is frameshifted six months from the fiscal year. The fiscal year we're talking about, in the biennium we're talking about with a \$4.5 billion revenue shortfall, begins on July 1, 2020, which starts in a couple weeks and ends on June 30, 2021. The calendar year benefits that apply to that fiscal year cover only January through June 2021. There is this delayed ability for there to be an economic impact on the state budget when it comes to the PEBB and SEBB portfolios due to that frameshift of calendar year benefits that begin later in a fiscal year or biennial budget.

Layered on top of that is that benefits go live on January 1. As you know, open enrollment is in the fall and you back that up to adequate communication timelines, getting information to members, and printing communications. We quickly run back the calendar and we are at that time of year where changes for implementation in 2021 must have decision making done now.

Slide 9 – PEBB & SEBB Program Submission Topics. I’ll review submission topics at a high-level overview for benefits with the full table as submitted and published on OFM’s website in the second part of the Appendix. The first bucket of potential options is not a formal proposal. We simply costed out options that we were able to cost out and describe their implementation timelines. One is changing or eliminating the Wellness Program, which has Collective Bargaining implications. There is no unilateral authority for either the Board or the Legislature to act on this in the current environment.

The medical FSA employer contribution could be changed. This is part of the Collective Bargaining Agreement that was implemented earlier this year for plan year 2020 that provides \$250 FSA deposit for represented employees who make under \$50,004 annually as of a certain snapshot of time when salaries are reviewed. Neither the Board nor the Legislature, at the current time, can alter this.

HCA presented the UMP Select additional plan offering to the Board for action last month. This is a topic that has a timeline that could be acted on.

HCA could restructure the Long-Term Disability benefit. There's been a journey and a conversation about the LTD benefit over the past couple of years. An initial proposal will come before the Board in July for your consideration. This action is within the Board's authority, or the Legislature's.

Another option is to delay implementation of the next Centers of Excellence bundle. Currently we have a total joint replacement for hips and knees bundle and a spine care bundle that has helped reduce variability in cost and had good outcomes in preventing costly readmissions within the system. HCA did a request for information (RFI) related to a potential third bundle around bariatric surgery. That bundle could be delayed. It would be an expenditure that isn't made.

The last option in the benefits bucket is reducing the Health Savings Account (HSA) employer contribution. Currently, the HSA contribution in PEBB is \$700 for a single subscriber and \$1,400 for any sort of additional dependent coverage. This is listed as PEBB only. I will note that between the PEBB and SEBB Programs, the current employer contributions are different. What we put in the budget options sheet was what would happen if they were aligned, such that the PEBB Program's HSA employer contribution was reduced to match the SEBB contribution, which is \$375 and \$750 for the family setting. No contribution level is mentioned in the Collective Bargaining Agreement. The Board and the Legislature have the authority to act on this topic.

Slide 10 – PEBB & SEBB Program Submission Topics (*cont.*). This slide addresses options in the eligibility and state funding buckets. There are initial eligibility rules for how an individual is determined to be benefits eligible in the PEBB and SEBB Programs. In the PEBB Program, and there's nothing comparable in the SEBB Program, is a maintenance eligibility rule that once you are benefits eligible, you maintain benefits in any month in which you are in eight hours of pay status.

Our submission describes a world where that eight-hour rule is increased to say 16 hours – a projection of the number of individuals who may lose coverage, and the amount employers would no longer spend if they are not covering those individuals anymore. I do recognize, and this is a good example of all of these, any of these changes could impact member behavior. If you raise the maintenance rule, individuals might pick up more shifts. All of these proposals are based on a fixed point with some assumptions. And then of course, behavior will change, depending on what the rules are. This eligibility rule is enshrined in statute so it would require an act of the Legislature to implement.

The first piece under state funding is changing the employer and employee contribution split, or the formula for the calculation that's used. This is directly part of and the heart of the Collective Bargaining Agreement. In the PEBB Program, it is an 85%/15% split with a tiered weighted average based on enrollment. SEBB has a different formula. The formulas could be changed but would require an action within the Collective Bargaining Agreement and is not something the Legislature or the Board could take action on independently.

There is the option to introduce the retiree Medicare Advantage-Prescription Drug plans (MA-PD), which is the proposal we've been presenting to you in various iterations for the last at least two years. This was not designed to save money. It was designed to help with the general solvency and sustainability of the retiree portfolio in general. In describing budget options and potential savings, we costed out enrollment assumptions if these plans were introduced that would ultimately describe savings. Savings are realized because in an MA-PD Plan, the carrier is able to access more funds from CMS and accessing of those additional subsidy funds by the carriers then results in lower

retiree premiums. The way the subsidy works is that it's a flat amount, right now \$183 or 50% of the premium, whichever is less. As we introduce the MA-PD rates and the other Medicare rates, you will see the MA-PD rates being presented to you would exercise that 50% clause. The state would not have a subsidy that is the full \$183 for MA-PD enrollees. That difference between \$183 and the 50% represents the potential savings and reductions of the total amount of spend without actually changing the subsidy itself.

Finally, the state could change the retiree subsidy. The Legislature has changed the subsidy level for Medicare retirees many times over the years. We're currently at \$183 or 50% of the premium, whichever is less. That was the way it was for the past year. Before that it was \$168 and before that it was in the \$150s. The Legislature has changed that number over time. The Legislature could again change that number in the future. This is an area where the Board also has independent authority. Every year HCA brings you a resolution for action because the budget provision says it can be no more than \$183 or 50% of the premium. Over the years, HCA has interpreted that this Board has the authority to set a lower contribution. Those are the two mechanisms that could change that explicit subsidy level.

Slide 11 – PEBB & SEBB Program Submission Topics (*cont.*). This slide lists administrative topics. First, we could account for administrative fee reductions that are being returned by the carriers. We highlighted in prior meetings that the Uniform Dental Plan acknowledged, with the proclamation that closed and limited services in the dental field to just emergency services, there were multiple months with compressed access to dental services. Delta Dental, the third-party administrator for the Uniform Dental Plan, is returning some of the administrative fee reflecting that reduced service level, thus reduced claims administration and other TPA services they provide. Those can be accounted for within the budget models.

Earlier this year, a legislative change set for implementation on January 1, 2022 prohibiting dual enrollment in benefits between the PEBB and SEBB Programs is an option. For many years, there's been a policy within the PEBB Program that you cannot be dual enrolled in medical or dental within the program. But the Legislature took action to say no dual enrollment across the program. We've identified there are more simplified ways to implement that policy. If there were additional statutory changes and the process was simplified, HCA would be able to return some of the one-time project money allocated to implementing that piece.

HCA could also reduce FTEs. We have a proposal of two or three FTEs between the programs that could ultimately be reduced. There are one-time actuarial budget variants within the SEBB Program we think could be returned.

These topics just shared are the initial piece. We were asked as an agency to begin this exercise in mid-March and it was turned in on June 1. It is an iterative process and we'll continue to think about reductions. In fact, it has since been brought to our attention that the spousal and tobacco surcharges could be changed from their current levels. The spousal surcharge is set at \$50 per month and the tobacco surcharge set at \$25 per month. The budget language says those surcharges should be at least those amounts. Both this Board and the Legislature could change those amounts.

Elyette Weinstein: I want to make sure I understand. When I look at page ten, all the things under state funding are things the Board can do, am I correct?

Dave Iseminger: That is not correct, Elyette. Neither the Board nor the Legislature can influence the employer/employee contribution split or formula. It is in the Collective Bargaining Agreement, so it would have to go through the collective bargaining process. The MA-PD plans are completely within either the Board's or the Legislature's authority. HCA has a recommendation for the Board later today to consider for action in July. The Board can act independently, which is being recommended by the agency. Changing the Medicare explicit subsidy level and K-12 remittance are something both the Board and the Legislature have the authority to do.

Elyette Weinstein: Thank you.

Dave Iseminger: Slide 12 – PEBB Program FY21 Timeline. I want to reinforce this calendar year versus fiscal year shift and the fact that if there's anything that could influence FY21, it's really CY21 benefits, which has a six to seven month on-ramp, and we are about six to seven months from that position. Any action that can be taken by the Board or Legislature, for the vast majority of impacts, would need to be acted upon now.

There are a few things that could be implemented closer to open enrollment and if there is a special session later this calendar year, we would assess any specific proposal with where we are in open enrollment or in the production of open enrollment materials. For example, if it was decided the Board wanted to restructure the LTD benefit in August, there's absolutely no way that could be done by January 1, 2021. If the Legislature wants to, in the budget provision, change the amount of the tobacco surcharge or the spousal surcharge, depending on where we are in the extra communications to implement that it requires changing a number in the system, and changing a number in the communications. That type of change could be done. When it comes to wholesale benefit design changes, plans, etc., the time for action to impact FY21 and CY21 benefits is now through the end of this month.

Slide 13 – PEB Board Authority FY21 Options. This slide reinforces the types of things on which this Board could take action to implement and impact FY21. There are four things on this list, two of which have been recommended. First is the introduction of Medicare Advantage Part D plans (MA-PD), which leverage and access CMS funding, which has lower retiree premiums, ultimately requiring less subsidy contribution, while still maintaining that 50% commitment to the long-standing Legislative piece.

The second is the proposal to introduce UMP Select as an additional plan offering. I'm asking the Board for a little grace because I recognize the Board voted on this topic at the last meeting, but there is fiscal information that wasn't available on May 28 and we think it's prudent and important to provide that information and context to the Board. HCA received questions since the May 28 Board Meeting. Our OFM budget offices, other parts of the Governor's office, as well as legislative staff, listen to Board meetings and pay attention to the proposals before the Board and how the Board acts. They asked questions about the timeline for implementing UMP Select in light of the Board's action on May 28. When questions arose, we had to reassess.

At the time, close to Memorial Day, there were still possibilities in Olympia of a special session, but now that we are nearing the end of June, that seems unlikely. But in the crucible of the last few days of May since the Board Meeting, we had to assess the timeline and determined with Regence and our finance team that if, in fact, any decision was made by anybody with the authority to make that decision to implement UMP Select, it could be implemented if the decision was made no later than June 30. Knowing the June 30 deadline and knowing there was additional fiscal information that might be relevant to that conversation, we wanted to bring this to you and to also describe it as a possible budget savings option within the submission that went to OFM at the beginning of this month.

The other two actions this Board could take this year would be to reduce the HSA employer contribution level or change the Medicare explicit subsidy level. Those aren't options we can recommend at this time but wanted to describe them for thoroughness.

A fifth option even more recently identified is the tobacco and spousal surcharges that could be adjusted.

Slide 14 – HCA's Current Recommendations. The introduction of MA-PD plans and UMP Select are HCA's recommendation to the Board. The hallmarks of these ideas are introducing plan options that don't replace existing options as they are supplemental offerings. There's no requirement that forces any member to elect any individual plan. It relies on individual choice and evaluation of their personal financial circumstances, and deciding what is in their own interest, and the various kitchen table fiscal issues each family is facing. At the same time, with the implementation of either of these plans, whether it be MA-PD plans and/or UMP Select, based on those individual choices, there would be some state budget relief and downward pressure on the state index rate.

I also want to highlight that the more and more programs and plans are aligned between the PEBB and SEBB Programs, there are greater efficiencies. Every difference between the programs has costs associated with it. There are multiple conversations that happen with our carriers about every nuance and difference, and what requires additional administrative fees. We have additional quality checks within our communications and finance teams for any difference, big or small. So, especially with regards to UMP Select and copying it from SEBB, this would eliminate those conversations on those PEBB and SEBB Program differences. A lot of the differences between PEBB and SEBB are attributable to time and administrative aspects of maintaining differences between the portfolios.

Slide 15 – Why These Two Recommendations Now? Neither recommendation was created in the crucible of a fiscal state crisis of \$9 billion. They were created for a variety of policy reasons, but now that we have more and more information about the fiscal direction of the state, the directives from OFM about state expenditures, and what agencies are to work on to address those new fiscal realities, they are an equally pressing factor and something we think is important context to ensure the Board is aware. Both recommendations have implementations that could be done by January 2021. This is the best opportunity for the Board to make influences on the 2021 fiscal year before the Legislature next comes to town.

I want to be very clear on this point that just because the Board does take action on a proposal, it does not foreclose or prevent additional action by the Legislature. It would be a way for the Board to send its message of where it prioritized, or made decisions, to provide budget relief.

Slide 16 – MA-PD Offering. There have been multiple presentations on the MA-PD offering and there will be several more. We are presenting rates today and scheduling action for the July 15 Board Meeting. This has been a multiyear process. We've gone through procurements, executed a contract with United contingent upon Board action. We stand ready to implement the Board's action in July.

With MA-PD, there is an additional ability to access CMS funds that the self-insured UMP cannot, to the tune of an additional 50% to 55% of the plan cost being picked up by federal funds. Leveraging that amount of money from CMS directly impacts retiree premiums without reducing benefits. The benefit design for the MA-PD plans that we've gone over was drawn on and built upon the Uniform Medical Plan Classic benefit that so many retirees are in already. The way it saves money to the state is not reducing the commitment on the explicit subsidy. The commitment has always been a flat dollar amount or 50% of the premium. The fact that these leveraged CMS funds pull the retiree contribution down so far also ends up impacting the overall total expenditure of the state's explicit Medicare subsidy. That was a very high-level overview. There's more to come on that in this meeting from Finance and Ellen Wolfhagen, as well as the next Board meeting.

Slide 17 - UMP Select Offering. HCA previously recommended the Board approve UMP Select and Board action voted not to authorize UMP Select at the May 28 meeting. I previewed earlier the request from legislative staff on the timeline to be able to implement UMP Select, which is June 30. Today being June 17 and with additional fiscal information, HCA wanted to bring that information back to the Board for consideration. I can understand the Board probably felt this was a rushed proposal. I realized two of our Board Members had their very first meeting as the April COVID Emergency Board Meeting. Some Board Members have been on this journey longer than others. The crucible of COVID has given us all a strange sense of time. I always wanted this to be a longer discussion. COVID didn't allow that. I want to assure the Board the plan design was created with actuarial involvement in time for the SEBB Program launch on January 1, 2020.

You've heard us talk about the Uniform Medical Plan third-party administrator contract that was awarded to Regence effective January 1, 2020 and there was an IT build happening in 2019. The SEB Board authorized an additional UMP plan. Regence built their technology structure to accommodate an additional plan because, at that time, there was already discussions about the potential consolidation of the two programs. Regence indicated if the work was done now, it wouldn't cost more later so Regence built the structure so implementation would be on an expedited timeline for introducing a new plan.

I've alluded to overlapping authorities in the PEBB Program and we vet these proposals and ideas with other parts of the authorizing environment. This is the plan design the Employees and Retirees Benefits (ERB) Division and Regence are familiar with, as it is drawn upon the experience of launching a plan in the SEBB Program.

Slide 18 – UMP Select Compared to Current Uniform Medical Plans. There are policy reasons, advantages, and disadvantages to all existing Uniform Medical Plans. There are long-term financial benefits to the UMP Consumer Driven Health Plan, especially for lower utilizers of health care who leverage the additional employer contribution of \$700. They can come out financially ahead year over year. We have thousands of state employees who have been in the high deductible health plan and have several thousand dollars in their HSAs that can be used as an emergency medical fund. There are advantages to that plan for some people. It's not the perfect plan for everybody. Just like UMP Classic is not the perfect plan for everybody.

Since the May 28 meeting, HCA started working internally to identify additional opportunities to communicate advantages of the CDHP plan for the right type of individuals, how to come up with some personas and illustrative scenarios of why people might be drawn to and have advantages within the different plans. For example, Tanya's life is X, Y, and Z and her utilization with healthcare is A, B, C. With those factors, she looks at these two plans and she might break this way on this plan. But Sara, whose experiences are different, she'd break the other way and why.

Slide 19 – Projected Program Budget Savings. This slide is a roll up from the Appendix of the chart submitted to OFM and is on their website now. If UMP were to introduce UMP Select, there is a 5% plan switching assumption drawn from the historical experience of the introduction of the UMP CDHP, and then the separate introduction of UMP Plus. In both of those years, the first enrollment was around 5%. If that switching happened, it's estimated to be about \$5 million per fiscal year of potential expenditures that wouldn't happen otherwise within the PEBB Fund.

Similarly, there are MA-PD plan assumptions that could be made. HCA described two different enrollment scenarios taking advantage of the lower 50% premium as being the trigger for the subsidy in those instances, looking at the year-over-year chart, enrollment grows in different amounts. The hallmark of it is the \$5 million ballpark. Each proposal, independently, is roughly \$5 million for discussion purposes. In a multibillion-dollar program, \$5 million may feel like a small amount, but examples of \$5 million for PEBB Program expenses is two-thirds of the staff salary and benefits of the ERB Division. Another example is the IT one-time project expenditures for implementing the PEBB modernization project to revamp PEBB My Account to have less reliance on paper enrollment, as well as the one-time project budget for implementing PEBB/SEBB dual enrollment, the IT budget for those projects is about \$5 million. A benefit example is in the Uniform Dental Plan in 2019, there was between \$5 - \$6 million dollars in orthodontia expenditures.

Leanne Kunze: When you're talking about the \$5 million and how that would somewhat have an impact if you were to compare it on HCA. Do you have any other comparisons of your examples outside of PEBB where you could explain how \$5 million would or could impact?

Dave Iseminger: I started going through budget options of other agencies to get a flavor of things other agencies were proposing. I personally wondered what \$5 million meant to other parts of government. When I looked it up, if my recollection is correct, the annual budget for entities like JLARC, PERC, the Public Employment Relations

Commission, or even the PDC, is each roughly \$5 million dollars. Because I'm a lawyer, I was curious what the Supreme Court's budget is and \$5 million is half of the annual budget of the State Supreme Court. Those are some illustrative examples. Is that responsive to your question?

Leanne Kunze: It is. Thank you.

Dave Iseminger: Slide 20 – Closing Considerations. I want to reinforce that HCA understands the Board's action at the May 28 meeting, but felt it was important to share additional information about both recommendations because MA-PD is pending before the Board. For UMP Select, the additional information on the implementation timeline gives the Board, or the Legislature, an additional opportunity to add a plan. It's challenging to think about the economic circumstances we're in and the impact it has. The next couple of years will be financially difficult, so at the very least, we wanted to make sure the Board was aware of the current fiscal realities as we know them. They continue to evolve literally every day.

Leanne Kunze: Can we go back to the slide where you are putting forth the various things that could be decided, whether by this Board, or if this Board were not to act, that could possibly fall into the hands of the Legislature to be making these decisions.

Dave Iseminger: That's Slide 13 – FY21 options.

Leanne Kunze: I want to confirm that I'm understanding correctly. My understanding was the MA-PD, when I first looked at it I was concerned, because it appeared to take away subsidy, but then I'm understanding that the CMS portion actually lowers the premium and it offers an additional choice for our retirees. Is that correct?

Tanya Deuel: Yes, that is correct. We will walk through those premiums shortly.

Elyette Weinstein: When we go over that, I would like to know how the premiums are lower, but the subsidy is not. I don't understand the mechanics of that, and maybe when Tanya goes over this, she can explain it with an example to simplify it for this newbie. I'm also interested in Leanne's question.

Dave Iseminger: Let's give Tanya a chance to try it now.

Tanya Deuel: Elyette, the bid rate is the total cost of a Medicare plan, then the state contributes a subsidy of \$183 or 50% of the premium, whichever is less. With a plan like UMP who has a higher total bid rate than the United plan, the amount of subsidy given towards the premium is less, but the total member out of pocket is still significantly less on the United plan because of the overall cost of the total premium.

Dave Iseminger: I'll give you an illustrative plan example with completely made up numbers for easy rounding. Let's say the total bid rate and cost for UMP Classic Medicare is \$500, such that the subsidy, 50% of \$500 is \$250. Since the choice of the subsidy is \$183 or 50% of the premium, whichever is less, when you compare 50% of the premium, that would be \$250 compared to \$183. You have to pick the smaller number, the subsidy that person experiences is \$500 minus \$183 because it can't be a 50% reduction. In that scenario, the person would pay \$317.

Then let's take a different plan and we'll call it an MA-PD plan that could leverage additional CMS money. By using the CMS money, their bid rate is \$300. When you apply the subsidy calculation, 50% of \$300 is \$150 or \$183, which is the full subsidy. The rule is "whichever of the two numbers is less," so in this instance, \$150 is the amount the state pays in that individual circumstance. Since the bid rate was \$300, the subsidy is \$150, the member pays \$150 (\$300 - \$150 = \$150). That is where the commitment on the subsidy isn't lowered, yet the total cost in the aggregate of the entire population would be less because anybody who enrolled in the MA-PD Plan would receive the benefit of 50% of the premium. And it's because the bid rate from the carrier is lower. The reason it's lower for the MA-PD Plans from United is they can access CMS funds that the Uniform Medical Plan can't.

Elyette Weinstein: Why is that?

Sara Whitley: Medicare Advantage plans fall under Medicare Part C, which are managed care Medicare offerings. Many years ago, CMS allowed as part of Medicare Part C private insurance carriers to contract with CMS to administer the benefits. As part of that contract, they're afforded different aspects of the Medicare Advantage Plan which are the federal subsidies, the manufactured drug discounts, different things that attempt to drive down the cost of providing care to Medicare enrollees. That was a function of the increasing cost of health care in our Medicare environment year over year. UMP, our self-insured plan, is original Medicare coordination of benefits offering. It's not a Medicare Advantage offering. HCA is not contracted with CMS. We administer the benefit as a self-insured plan. They're two very different offerings. They function very differently in the Medicare space. The Medicare Advantage plan enables us to contract with United, who contracts with CMS to provide this benefit offering to our enrollees.

Elyette Weinstein: And the state cannot contract with CMS.

Dave Iseminger: Correct, and remember, UMP is self-insured and that's why.

Elyette Weinstein: Okay. Okay, thank you.

Leanne Kunze: I have a follow-up question on the same slide. With the UMP Select, additional plan, I noticed the two asterisks on the top two points. And what I'm understanding is that if we don't act, the Legislature could, and they could do those things plus more. They could mandate versus us being able to change this.

Dave Iseminger: That is true. In fact, I can give you an example of when that happened in the PEBB Program's history with the UMP CDHP. The Board was directed to study the CDHP. The Board studied it and did not act to implement the plan. Then, in 2011 the Legislature changed the word "study" to "offer," and required the Board to authorize the plan in all future open enrollments. The Legislature did not get into the specific benefit design, but that power does reside with them. It could be as prescriptive or not prescriptive within their own benefits authority. That is an example of the Legislature taking action.

Leanne Kunze: So, things like reducing the HSA contribution not being recommended, changing the Medicare explicit subsidy level, also not recommended. Do you believe

that if the Board took action on those first two recommended items that it would send the message to the Legislature to leave those other things alone?

Dave Iseminger: That's a tough one, Leanne. As I said earlier, Board action now does not foreclose subsequent legislative action. The advantage of the Board acting now is you have influence on areas. The challenge is we don't know specific budget targets for the program. What we know is there's a 15% reduction target in all agency budgets for this biennium and next biennium, and the General Fund State. Like Megan said, approximately 45% of PEBB ends up being attributed back to General Fund State. We don't have a specific target here. Yet the PEBB and SEBB Programs combined, represent somewhere around 9% to 10% of the state budget itself. If the Legislature decides on a number that needs to be hit, any actions taken by the Board, HCA could remind them of Board action taken in the summer of 2020 accounts for our projection of about \$10 million. Those were reductions taken from current expenditure authority that would be at least an acknowledgement of those cuts. It's a way the Board can have influence over a pendulum crashing into the program and targeting where some of those cuts could happen.

I definitely don't want anyone to walk away thinking that if the Board acts on either, or both of these recommendations, it completely forecloses other legislative action because I absolutely could not promise that in any way, shape, or form. It just gives direction. It's the Board's way to direct where different cuts could happen in a scenario where it's extremely likely there will be cuts somewhere within the portfolio given the magnitude of the cut. It's also possible if the Board doesn't act at all, the Legislature could say we're going to solve the budget crisis without touching PEBB and SEBB. Given the size of the budget challenges, I'm not a risk taker, I suspect something will be done within the program.

Leanne Kunze: Right, and so do I. That's why I'm so concerned that this is our last chance to actually have some directive, and some say before the end of June when we would not be able to realize the budget savings. And I understand \$5 million doesn't close the gap, but \$5 million here, \$5 million there, like you said it's like half of some departments, more than half of other departments. I'm really concerned about that. I guess what I'm saying, I would like for the Board to reconsider the addition of the UMP Select. I'm assuming we're going to be taking a vote on both of these things. I don't know if that's something the group would be willing on entertaining a motion to adopt the two asterisked recommendations at this time. And happy to have caveats attached saying it's not an endorsement of the type of plan, because honestly, high deductible plans are not something HCA, the state of Washington, or either side of any labor table would want.

It shouldn't be confused with an endorsement of a high deductible plan, or an endorsement of a Medicare Advantage plan, when that is not normally a position I think I would take. But I also think we need to be responsible as Board Members that we're in a fiscal crisis of our lifetime. I think it's critical that if we have the opportunity to achieve savings of \$5 million, then we need to adopt that before the end of June. And that leads up to today. It doesn't impact the UMP Classic. It's not replacing anything. It's adding a choice, and again, a choice I personally would not recommend. But with adding this choice, we have the ability to save and send a message to the Legislature that this Board understands the situation we're in. I'd like to reconsider that.

Tom MacRobert: I did want to make sure that I clearly understood that if we were to adopt the top two bulleted items that the Legislature could still come in and change the Medicare split subsidy on their own. Is that correct?

Dave Iseminger: That is correct, they could. I did want to provide one piece to clarify the timeline for different decisions. In a later presentation today, HCA is teeing up a vote on the first bullet on Slide 13 about MA-PD plans. We're introducing rates later in this meeting and teeing that up for a vote in mid-July. Because of the implementation plan timeline, that action doesn't need to be taken until the July meeting where it was originally slated for action.

At the May 28 Board Meeting, our belief on UMP Select was a decision had to be made that day to meet the implementation timeline. When legislative staff asked additional questions about the plan, it was determined the final opportunity to implement the proposal was June 30 so a decision on any reconsideration of UMP Select would need to be acted on by the end of this month and the MA-PD recommendation at the July 15 Board Meeting as originally planned.

Leanne Kunze: At this time, if I'm asking for reconsideration, it would be strictly for the UMP Select due to the fact that we don't have another meeting by the deadline for us to realize that \$5 million in savings, correct?

Dave Iseminger: I think that's a fair way to characterize it, Leanne. A copy of the resolution was added to the end of the Appendix in case this topic came up in order to facilitate an easier conversation.

Sue Birch: To clarify, I hear Leanne wanting to make a motion to consider offering UMP Select for 2021. Is that correct, Leanne?

Leanne Kunze: That is correct. I also want it to be noted in the record that it is not an endorsement of a high deductible plan. It is in support of offering an additional choice that does not impact UMP Classic, so we are able to realize the \$5 million moving into further budget discussions at a larger level.

Sue Birch: Resolution for Vote

Resolution PEBB 2020-06 – Self Insured Plan Offering

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

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

Leanne Kunze moved and John Comerford seconded the motion to reconsider

John Comerford: What is the downside of this motion?

Dave Iseminger: At the May 28 meeting, there was a robust discussion about pros and cons of plan design. I'll play devil's advocate. If members migrated to the Consumer Driven Health Plan (CDHP), especially with the plan design that exists today, it could be a benefit to members depending on their personal circumstances. There are pros and cons to every health plan. No one health plan in the existing portfolio, or the portfolio of the future if it includes this plan, is perfect for everybody. HCA will do our best to advertise and explain the advantages and disadvantages based on our members' personal circumstances as to what fits their scenario best. It's hard to quantify pro and con because it matters from your perspective. The introduction of the plan and the migration into UMP Select would provide stabilizing and/or downward pressure on the state index rate, which for some people is a pro, and other people is a con. It would put stabilizing or downward pressure on the state index rate which is the embodiment of the employer contribution in the PEBB Program.

John Comerford: In other words, you could increase the amount of the employer contribution.

Dave Iseminger: No. It would not increase the employer contribution. It would stabilize, or lead to lowering of the employer contribution, which then moves it to members. By definition, in a system where the employer contribution is on a tiered weighted average and all the existing UMP plans that are the driver of the state index rate have similar actuarial values of 88% - 89% (Classic, CDHP, and Plus), inherently the introduction of an 82% AV plan is below the average of the 88% - 89% AV plans. When you add in a number lower than the average, it can bring down that average. Is that helpful?

John Comerford: What about your employees and retirees? Does it have any negative impact on employees or retirees, making this available?

Dave Iseminger: UMP Select does not impact Medicare retirees and is not a plan offering for Medicare retirees. It is a plan for Non-Medicare retirees and state employees. The fiscal context described is the maintenance of the overall program. Cutting \$5 million would be an incremental piece of the cost of the program. Is that helpful context?

John Comerford: It is. Thank you very much.

Tom MacRobert: If I'm understanding it correctly, you are projecting, if we adopt these three separate plans, the two MA-PD, and the Select plan that we might see a migration of 5% from our existing members into those three new offerings, is that correct? So we're talking about maybe a total of 15% migration?

Dave Iseminger: No, Tom. The 5% migration described is just about UMP Select. We don't have a percentage described for MA-PD. In TAB 5, at the bottom of Slide 19 is a blue chart describing enrollment scenarios. Rather than say a 5% switching on MA-PD, we said if 1,500 retirees move to an MA-PD plan in year one, and by year two it doubles

to 3,000, the amount not spent in the subsidy if they have stayed in UMP Classic is \$400,000 in FY21, \$1.365 million in FY22, and \$2 million in FY23. A separate different mathematical scenario, if you have 5,000 people enroll in the MA-PD plan in year one that grew to 7,500 in year two, it looks like the figures in the rest of the table. We haven't described it in percentages for MA-PD, only in whole numbers of different enrollment scenarios.

Since we have not introduced something in the Medicare portfolio other than Plan G as a Plan F replacement, because it's very similar, there hasn't been a wholesale change in the retiree portfolio. We didn't want to go with a percentage presumption. We described it, if this was an enrollment scenario, what would it look like. It's not 15%, 5%-5%-5%. It's 5% enrollment assumption on UMP Select and then somewhere between 1,500 to 5,000 MA-PD covered lives in year one would equal this amount of potential savings. Is that helpful, Tom?

Tom MacRobert: Yes. Thank you.

Diane Sosne, SEIU Healthcare, 1199 Northwest. I wanted to offer for Board consideration, we raised concerns at the last meeting about putting in, with all due respect to the explanations given by PEBB staff and HCA staff about the UMP Select. There continues to be literature every day about when there are barriers like high deductibles that people have to meet, that it can deter people from getting needed care. And we're in an environment where that is more exacerbated than less. But I also wanted to offer this perspective, that the incredible financial challenges to the state, that I think nobody can know what is going to happen when the Legislature meets, either special session or next year, in terms of the health benefits program, there's a benefit to engaging with the Legislature on all the moving parts because making a decision now on one of the parts, as Dave, you said, doesn't preclude them making others. And I think it's more advantageous, on behalf of the covered beneficiaries, that we all look at what is on the table and don't get ahead of that because they could do this and a lot more whereas. I think, at that point, you can look at the different options and I think there's potentially more control. Thank you.

Tim Barclay: Bear with me. I have a few things I want to comment on. First, this premise that more choice is always good, I guess I would argue with that. I will give you two simple illustrations. With the Amazon business model, I can go on Amazon to buy something. I have lots of choice. I find it very difficult and oftentimes when I get something, I'm not happy with what I got. Or I can go to Costco where I have less choice, but where they've done it for me and made sure that they have quality at a fair price, and I'm rarely disappointed. I like the Costco model, from a Board perspective, much better, where we are sure all the plans offered represent good value within the portfolio so members are confident that no matter what they choose, they've made a good choice. I'm not going to go through all the arguments we did last time about why this plan is inferior to the CDHP and very similar. But it's clear from the actuarial value that Dave mentioned earlier this is an inferior product. I would prefer to be a Costco Board and not offer something I don't think people should take.

Secondly, I think we're fooling ourselves that if we take a \$5 million action today that somehow, we're preventing legislative action. The goals, the budget problems, are so much bigger. I mean, \$5 million is real money. Nobody's going to argue that. But it's

not the solution and it doesn't prevent legislative action. And if we're talking about sending messages to the Legislature, I'd much rather send a message that we'd like to do this in a smart way, and not do bad health care policy, and offer members bad options. I think the ball does fall back to the Legislature. I think that they need to address, what I think, is an outdated 1993 equivalency requirement for the UMP. I think to save real money, and to really get to the heart of the problem, we can't do it with axing administrative staff and offering bad plans to members. I think the Legislature needs to step up, address the 1993 equivalency requirement, and address it as it should be addressed if they want to save real money in the PEBB Program. So, I appreciate the budget problem, but I don't think a bad solution should be implemented just because it fits in the timeframe.

Leanne Kunze: The reason that I will be voting yes on this motion is not something that I take lightly. I agree with the comments that have been made about choice is not always good. I believe that it is imperative that we have a strong portfolio, and that we are putting forth good recommendations from our Board, and from PEBB, on plans for our members. I appreciate the Costco analogy. And I agree with comments about high deductible plans, and that people who are lower income have a higher tendency to look at a bottom line on the premium price versus the overall benefit of the plan. And I believe that falls to all of us to make sure members understand those decisions. I also think that falls on all of us to ensure we do everything we can to fight to protect the HSAs that are in place, especially for our lower income folks, and to find ways people can afford the plan they want versus the plan they can afford.

I would also say I don't believe adding this plan should be categorized as a solution. I do not believe that my motion would suggest that it's a solution. I see it as an opportunity to save \$5 million at a time when we are facing deficits like we've never experienced before. I also want to say that I agree with continuing to push the Legislature to do more, to be bold in their leadership, to ensure that we have a fair revenue system moving forward so we can weather these types of storms, should they ever happen in the future. And so, I ask you to join me in voting yes so that we are able to have this pass before the June 30 deadline where we would miss the opportunity of savings if we waited for the Legislature to mandate. Thank you.

Harry Bossi: I don't want to repeat what's already been said, but to me, this is not an improvement, period. It's a watering down of strong plans that we already have. A good portfolio. Just adding another plan, I mean, could add three more. But it'll just continue to water down the base. I see there, ultimately some potential adversity in strong plans that have healthy people, if you move all the healthy people to those that don't have as many needs, then ultimately can create some adverse selection problems. I also have concerns about the ability to effectively implement this plan given what we're hearing today about furloughs. The ability to have staff to put together complete plans, to reach out, to be able to provide some touch, if you will, to employees so they understand the various plans and what this one might mean for them. There's lots of reasons I don't think this is a good solution at this time. Thank you.

Tom MacRobert: I have some very serious concerns and very serious reservations about adding this Select plan. But I do also understand the reasons why it's being pushed forward. I am very, very concerned about maintaining that 85%/15% split. I

think there's a possibility that could change were we to fail to take action, so that's as of today.

Voting to Approve: 4

Voting No: 2

Voting to Approve: Leanne Kunze, Tom MacRobert, Elyette Weinstein, Sue Birch

Voting No: Tim Barclay, Harry Bossi

Sue Birch: Resolution PEBB 2020-06 passes.

PEBB Program 2021 Annual Procurement

Beth Heston, PEBB Procurement Manager and Kaiser Senior Account Manager.

Slide 2 – Procurement Work Plan. HCA goes through this process every year, driven primarily by the need to renew the plans, benefit changes, or proposals that come to us through different stakeholders. This year was our first year of handling two annual procurements at the same time because of the SEBB Program renewal that went on simultaneously. Currently we are still in negotiations. The first public presentation of the Non-Medicare rates will be mid-July, with the final benefits and rates presented the end of July.

Slide 3 – Hearing Benefit Changes. There is a change to the hearing aid benefit. Per legislative action on Engrossed Substitute Senate Bill 5179, HCA is directed to add a benefit that provides one hearing instrument per ear every five years to members with no cost share and there is no balance billing by providers. The hearing benefit is not a blanket change for all carriers in our portfolio. There are nuances that I'll explain. The benefit changes are effective January 1, 2021.

Slide 4 – Uniform Medical Plan (UMP) 2021 Benefit Changes. The first benefit change in UMP is the hearing instrument mandate. The nuance for UMP is the hearing instrument is covered after the deductible is paid in the CDHP to continue to qualify as an HSA. All other plans pay without requiring the member to meet the deductible.

The vision changes approved at the May 28 Board Meeting will also go into effect January 2021 and there will be changes to the UMP Plus Puget Sound High-Value Network service areas.

Slide 5 – 2021 UMP Benefit Changes (*cont.*). The changes to the UMP Plus Puget Sound High-Value Network (PSHVN) are marked by an expansion for 2021 into Chelan County and Douglas County. PSHVN will partner with Confluence Health in Chelan or Douglas County, and the Everett Clinic will join no later than January 1.

There is no change to service areas in UMP Plus UW Medicine Accountable Care Network.

Slide 6 – Network Partners – PSHVN. Some of the partners for 2021 are: Virginia Mason; Rainier Health Network, which includes CHI Franciscan, Pediatrics Northwest, Highline Medical; Physician Care Alliance (Polyclinic); Seattle Children's Hospital;

Signal Health (e.g., Yakima Valley Memorial); Confluence Health in Chelan and Douglas Counties; and The Everett Clinic.

Slide 7 – Network Partners – UW Medicine ACN. Partners for 2021 in the UW Medicine Accountable Care Network are: UW Medicine; Multicare; Cascade Valley Hospitals and Clinics; Seattle Cancer Care Alliance; Seattle Children’s Hospital; and Skagit Regional Health, which includes Skagit Valley/Cascade Valley Hospitals.

Slide 8 – UMP Plus – 2021 Counties Served. This slide is a visual representation of the counties to be covered by UMP Plus.

Dave Iseminger: Any time there is a service area expansion is good news. It has taken a lot of work by Puget Sound High-Value Network, a commitment from Confluence, work by the staff here at the Health Care Authority to make it happen. I want to acknowledge the amount of work that went into adding additional service area counties.

Beth Heston: Slide 9 – 2021 Benefit Changes. Kaiser is adding the hearing instrument mandate to all their plans, and again after the deductible on CDHP so that we maintain that HSA qualified health plan status.

Kaiser Foundation Health Plan of the Northwest also is changing the cost for an office visit to the Senior Advantage Plan, which has to do with a switch in the amount of co-pay for primary and specialty providers. Office visits will change to \$25 for primary and \$35 for specialty. This year it's \$30 for both.

Slide 10 – 2021 Benefit Changes (*cont.*). In addition to the hearing instrument mandate, Kaiser Foundation Health Plan of Washington has changes to member cost shares and the number of visits for some benefits. Medicare Advantage changes are: office visits will be \$15 for primary and \$30 for specialty (currently both are \$20); acupuncture and chiropractic visits will increase to 12 (from 8 and 10). Original Medicare will change the number of chiropractic visits 12 for uniformity. Acupuncture is already at 12 visits.

Dave Iseminger: Although these are modest changes on slide 10 related to Kaiser Health Plan of Washington, Kaiser Washington and Kaiser Northwest do have additional proposals and ideas for additional benefit design changes and are agreeable to evaluating them more systematically for consideration during the rate setting process for 2022 plan design. An example is that CMS has changed eligibility rules for access to Medicare Advantage plans by individuals who have end stage renal disease. With additional eligibility to Medicare Advantage plans, HCA will evaluate questions about potential adverse selection into or out of the PEBB population. As it stands, all the plan designs have the same coverage for dialysis proposed for 2021, so there shouldn't be adverse selection within the portfolio. But with the CMS eligibility change, HCA needs to have a broader conversation. Kaiser brought that to our attention.

Beth Heston: Slide 11 – No Benefit Changes. There are no benefit changes to Premera Plan G Medicare.

Slide 12 – No Benefit Changes (*cont.*). For the dental plans, there are no changes to: Uniform Dental Plan TPA Fee, DeltaCare Dental Plan, or Willamette Dental Group. All three are in a rate guarantee through December 31, 2022.

Expanding PEBB Medicare Options Update

Ellen Wolfhagen, Senior Account Manager, ERB Division. Slide 2 – Medicare Advantage Plus Prescription Drug (MA-PD) Recap. MA-PD plans include Medicare Part A and Part B, and Part D, which is prescription drugs.

Slide 3 – National MA-PD Coverage Recap. In the national plan, a member can see any provider who accepts Medicare and there's no differential in copays for in- or out-of-network.

Slide 4 – MA-PD – A Proposed Addition to Medicare Coverage. These plans are additions to our current portfolio offering. All of today's current plans will continue.

Slide 5 – Follow-Up Insights addresses questions that came up. Dental coverage is not part of this plan, but we will continue to have the dental offerings that are currently in the portfolio from both DeltaCare and Willamette. The MA-PD formulary is very similar to the UMP formulary, although some of the brand names may be different, but the functionality is the same. The MA-PD formulary is a little bit broader. In terms of customer service expectations, we have a report and standard on call center which includes the speed to answer calls, as well as resolving calls on the first try. We have reports on access to care and availability of services, which are separated by medical and pharmacy. HCA also tracks appeals and complaints. As part of the stars rating for the plan, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey will be done. There are monetary consequences for failure to meet the expectations.

Slide 6 – Proposed MA-PD Basic Medical. The table on this slide has an orange tab for the national PPO Plan 1, to be called PEBB Complete. The maximum out-of-pocket is \$500 compared to the \$2,000 maximum out-of-pocket for the national PPO Plan 2, to be called PEBB Balance, which is the green tab. The tradeoff for lower premiums on the PEBB Balance Plan is the higher medical maximum out-of-pocket. There is a cost for inpatient services and copays for primary care visits and specialty care visits.

Slide 7 – Proposed MA-PD Supplemental Benefits. On this table, in terms of the combined visits for chiropractic and acupuncture, although the total number of visits compared to UMP is fewer, 20 per and 26 available in UMP, depending on how they're used, there could be an increase for the member because the member could choose to use all 20 visits for chiropractic, which is currently limited to 10 in UMP, or they could use all 20 visits for acupuncture, which is currently limited to 16 in UMP. The other changes are an increased allowance for vision and hearing hardware.

Slide 8 – MA-PD Part D Coverage. The pharmacy benefit is exactly the same in each plan for PEBB Complete and PEBB Balance. The quoted costs are for a 30-day supply of drugs. Preferred insulin, although it is covered under Tier 2, has a specific copay which is not subject to the Tier 2 deductible, so that insulin is \$10 maximum or 5%.

Slide 9 – Comparison Highlights. The advantages are less out-of-pocket costs for retirees, based on an overall look at the MA-PD plan versus what's available now. There's an enriched benefit design, a national network of providers, and these plans include Part D coverage, which is not currently available under the portfolio.

Dave Iseminger: In Ellen's Appendix is a chart that does comparisons of the current portfolio with the two proposed plans. That was a specific request from the Board.

Tom MacRobert: Ellen, I'm going to give you the power to foresee into the future. And in January of 2021, you find out you're diagnosed with stage three colon cancer. Over the course of the year you face multiple surgeries, hospitalization for 40 days, radiation and chemotherapy, multiple doctor visits, multiple drug therapies, multiple medications. My question to you is very simple. Which plan would you rather be on, Uniform Medical, United Healthcare Complete, United Healthcare Balance?

Dave Iseminger: Tom, I'm going to ask Ellen to put together personas like I was describing for UMP Select because every plan might be right under different circumstances. Since we do have a follow up that can occur, with both actions scheduled in July, I'm going to ask her to be able to describe as a follow-up, personas where the choice to your question might be UMP Classic or the choice might be United. I'd like Ellen to dig into that to give some personas of who might make sense in different scenarios. Is that okay?

Tom MacRobert: All right, thank you, Dave.

2021 PEBB Medicare Rates

Sara Whitley, Fiscal Information & Data Analyst, Financial Services Division. Tanya and I will introduce our 2021 PEBB Medicare rates and bring back a follow-up item from our May 28 meeting.

Slide 2 – Medicare Portfolio Review. Current 2020 enrollment counts include both retirees and dependents. The majority of our retirees are enrolled in UMP Classic Medicare, Kaiser Washington plans, and Premera Supplement Plan F. There are two new plans proposed for 2021, PEBB Complete and PEBB Balanced offered via UnitedHealthcare.

Slide 3 – Follow Up from May 28 Meeting – Medicare Split Accounts. A question arose during the May 28 Board Meeting regarding a resolution on Medicare split accounts. A Medicare split account is when a Medicare-eligible retiree also has Non-Medicare eligible dependent or dependents also enrolled. The account is split because we have an eligible retiree who has Non-Medicare eligible enrollees appear on the same account, which is always described as a subscriber level. In this situation, Non-Medicare dependents are always enrolled in like plans in the same carrier group.

For example, Non-Medicare dependents of Medicare subscribers who select one of our Kaiser Medicare plans are enrolled into a Kaiser Non-Medicare offering. Non-Medicare dependents of Medicare subscribers who select UMP Classic are enrolled in the Non-Medicare UMP Classic offering. Non-Medicare dependents of Medicare subscribers who select Premera Supplement Plans F or G are enrolled into UMP Classic. Starting

in plan year 2021, Non-Medicare dependents of subscribers who select the United MA-PD plan are placed in UMP Classic.

We were also asked to provide insight into the estimated number of Medicare subscribers and Non-Medicare dependents currently enrolled in the PEBB retiree plan to size the potential impacts of those who may choose to switch into the United plan. This slide includes an estimated count of Medicare subscribers with Non-Medicare dependents organized by plan. The majority of split accounts occur in UMP Classic which makes sense because most of our Medicare enrollment is in the UMP Classic Medicare account offering. Assuming the majority of switching occurs from UMP Classic, Non-Medicare dependents would not realize any disruption. They would be placed into the Non-Medicare UMP Classic offering. Those who may switch out of a Kaiser plan, we have communications around what the rule is, and how those Non-Medicare dependents would be placed into the UMP Classic plan.

Tanya Deuel, ERB Finance Manager, Financial Services Division. Slide 4 – Medicare Retiree Rates. This slide lists the plan names alphabetically vertically down the left side of the table, with the Single Subscriber Premium, Medicare Explicit Subsidy, and Composite rates horizontally across. The composite rate is what I was referring to earlier when I was explaining how the Medicare explicit subsidy works in relation to the bid rate in the single subscriber employee premium. The Composite Rate is the total rate, the Medicare Explicit Subsidy is the value of the explicit subsidy for that specific plan. The 2021 Medicare explicit subsidy is set at \$183 or 50% of the premium, whichever is less, per enrollee for each of those plans. The equation is Composite – Medicare explicit subsidy = single subscriber premium.

UMP Classic Medicare and Premera Medicare Supplement Plan F Disabled have the full value of the \$183 Medicare explicit subsidy, and the rest are slightly less due to the 50% rule.

Slide 5 – Medicare Retiree Premiums. This slide compares 2020 member retiree premiums to 2021 member retiree premiums and the percentage of change from 2020 to 2021. The slide says subscriber premiums because we have not yet calculated the Non-Medicare rates and we don't usually publish the full suite of Medicare tiers until we have final Board votes on the Medicare and Non-Medicare rates due to the calculations involved. What you're seeing is just the single subscriber rate.

There are fairly consistent percentage changes with the exception of UMP Classic Medicare in Premera Plan F, which are a bit higher. Those two plans are receiving the full value of the Medicare explicit subsidy, which means any increase is borne by the Medicare retiree.

Slide 6 – Impact of Medicare Explicit Subsidy – UMP Classic Medicare. This slide is an illustration of the impact of the Medicare explicit subsidy on the UMP Classic Medicare rates. Across the top you'll see a dollar amount above the bar ranging on the far left from \$417 in plan year 2016 to \$519 in plan year 2021. That is the total composite rate. In the blue bar are the Medicare explicit subsidies. From plan year 2020 through Plan year 2021, those both stayed at \$183. The blue bar has remained flat yet the total bid rate has gone up, which means the gray bar has increased. The gray bar is the

member's share of the total premium. While the blue bar stays flat, the increase is all borne by the Medicare retirees.

Dave Iseminger: When I was reviewing Slide 5, I had an idea. I looked through some historical documents I had in my office to look for a better example of this. But if you look at the MA-PD Plan and you look at the complete rate \$150.61, I was curious about when UMP Classic cost that much per month from an employee perspective. I got as far back in my documents as I could get in the time I had and got to 2005. In 2005, the UMP Classic premium was \$183.20. Of course, over time the subsidy has changed, all sorts of things, but essentially what we're saying is this kind of level sets premiums on a very comparable, and in many ways richer, benefit at least 15 years ago. I thought that was an interesting facet. It gives you an insight of the magnitude of that premium differential. Basically, it's not 2020, it's 2005-ish.

Tanya Deuel: Slide 7 – Resolutions. To level set for the new Board Members, you will be asked to adopt the resolution for the carrier, not the individual plan. When we ask you to vote on the Medicare resolutions on July 15, you will be asked to vote per carrier, which adopts all of the plans within that carrier, and that means you're adopting the premiums and the benefit design underlying those premiums.

Elyette Weinstein: In the case of UMP, I'm so confused. Who's the carrier? Is it Regence or is it UMP Classic?

Tanya Deuel: UMP is the state's self-insured medical plan, which is administered by our third-party administrator, Regence. Regence helps process claims, has the provider contract and the network for which we pay an administrative fee. It's self-insured and the risk is borne by the state.

Dave Iseminger: Elyette, I think the heart of your question may be does HCA negotiate with Regence on the rate? The answer is no. Regence isn't in the room when we're doing the rate analysis because the state has the liability at the end of the day. It's HCA's finance team with our paid actuaries coming up with the UMP rate. Regence is not negotiating. It's the state setting the rates.

Elyette Weinstein: So there is no carrier, am I correct?

Dave Iseminger: Legally speaking, you are correct. That's also why the Insurance Commissioner's Office doesn't have regulatory authority over a self-insured plan because as the employer, the state is taking on the full risk. You have all the risks and rewards of the liability. There is no carrier per se.

Elyette Weinstein: Thank you.

John Comerford: Do you have a reinsurance carrier? Stop loss or anything like that?

Dave Iseminger: No, we do not.

Tanya Deuel: We have a premium stabilization reserve that we keep in our account and it's valued at 7% of the annual medical claims.

John Comerford: Have you looked at reinsurance or stop loss insurance?

Tanya Deuel: Not within the last few years that I've been here.

Dave Iseminger: We'll dig into some history and give you a better insight on that one, John, but not in recent history.

Elyette Weinstein: I'd like to know more about that if you get together. If you just tell me what you've decided, or discussed, it would be good background for me.

Dave Iseminger: It may be of part of a standard follow-up at a subsequent Board Meeting.

Tanya Deuel: Slide 8 – Proposed Resolution PEBB 2020-08 Medicare Premium. This proposed resolution would essentially make the Medicare explicit subsidy at that cap that was set by the Legislature, \$183 or 50% of the premium, whichever is less. However, if the Board would like to look at reducing that from \$183, this is where that would be done.

Slide 9 – Proposed Resolution PEBB 2020-09 – Medicare Premium is the Board endorsing the Kaiser Foundation Health Plan of the Northwest Medicare plan premiums.

Slide 10 – Proposed Resolution PEBB 2020-10 – Medicare Premium is the Board endorsing the Kaiser Foundation Health Plan of Washington Medicare plan premiums.

Slide 11 – Proposed Resolution PEBB 2020-11 – Medicare Premium is the Board endorsing the Uniform Medical Plan (UMP) Medicare plan premiums.

Slide 12 – Proposed Resolution PEBB 2020-12 – Medicare Premium is the Board authorizing the UnitedHealthcare Medicare Advantage plus Prescription Drug (MA-PD) plan premiums as presented at the June 17, 2020 Board Meeting.

Slide 13 – Proposed Resolution PEBB 2020-13 – Medicare Premium is the Board endorsing the Premera Medicare Supplement plan premiums.

Slide 14 – Next Steps. The Board will take action on the Medicare plan premium resolutions at the July 15 Board Meeting.

2020 Annual Rule Making

Rob Parkman, Policy and Rules Coordinator, ERB Division. Slide 2 – Rule Making Timeline. This slide is the timeline for completing the rule adoption process. In June HCA will file the CR-102 with the Code Reviser's Office, which is our proposed rule making.

In July we will conduct a public hearing on our proposed amendments and new rules and then file the CR-103 with the Code Reviser's Office, which are our final rules to be implemented effective January 1, 2021.

Slide 3 – Focus of Rule Making. This year's focus is divided into four areas: administration and benefits management, which adds clarity to rules; regulatory

alignment, which makes changes to implement state legislation and to comply with federal requirements; amendments within HCA authority; and implement PEBB Board resolutions passed by the Board.

Slide 4 – Administration and Benefits Management. Additional details were added regarding “What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for Medicare?” to assist with the administration of that process.

PEBB Program rules were amended to clean up inconsistencies in the use of terms like health plan, PEBB benefits, and PEBB insurance coverage.

Slide 5 – Administration and Benefits Management (*cont.*). “What options for continuation coverage are available to employees during their appeal of a dismissal?” was amended to add a court to the list of entities an employee can be awaiting the hearing outcome of a dismissal action.

Slide 6 – Regulatory Alignment. There was confusion around an employee regaining eligibility. They had eligibility, they lost eligibility through continuation coverage leaves, and returning and regaining benefits. Should they be allowed 31 or 60 days to make their elections? To align with IRS regulations, the rule was clarified that they should have 30 days to make the election and day 31 to turn in their paperwork.

Amendments were made to the PEBB Contracting Rules in support of RCW 28A.400.350. This RCW allows school boards to contract for PEBB benefits. This was done previously through the SEBB Organizations and was removed when the SEBB Program started, and now we need to put this back just for the boards.

Slide 7 – Amendments within HCA Authority. Clarified that the eligibility certification process for extended dependents, and dependents with a disability, must be complete before the change in enrollment is allowed.

A global change was made to change “entitled to” to “enrolls in” coverage under Medicare (multiple special open enrollment events).

Slide 8 – Amendments within HCA Authority (*cont.*). Related to requirements in RCW 41.05.009, eligibility notification requirements, an amendment was made to ensure employees have at least ten days after being notified of their eligibility to make benefit elections.

Amendments were made to HCA’s Family and Medical Leave Act (FMLA) rule to remove the ability to take away benefits while still receiving the employer contribution.

Slide 9 – Amendments within HCA Authority (*cont.*). A clarification was made in our appeals rules that if a state agency fails to render a decision within 30 days of the receipt of an appeal, the employee may continue to appeal that decision to HCA within 30 days after the state agency’s administrative review was deemed denied.

The eligibility rules were amended to include hours worked while there was a “governor declared emergency” when determining eligibility for benefits.

Slide 10 – Implement PEB Board Resolutions. Two resolutions to be implemented after approval from the May 29 meeting are related to MA-PD split accounts and default enrollment for newly eligible employees who fail to make an election. The three resolutions approved at the April 2 Board Meeting related to COVID-19 were not incorporated into rules. Those three resolutions are currently being used as the authority to go forward and act on those resolutions.

In addition to implementing resolutions, HCA is closing out SEBB grandfathered eligibility, removing eligibility for dependent parents that were grandfathered as of July 1, 1990. This resolution impacted about 500 individuals. The last dependent parent eligible under that resolution passed away in October of last year. And we are now removing that resolution for that eligibility from the rules.

Public Comment

Fred Yancey: I'm going to apologize, I thought I was on mute earlier, and I didn't make a lot of noise. Anyway. I'm pleased to see that you're going to do some scenarios for the next meeting, if I understood you correctly, to show a summary list of how to be covered by various plans and so forth. The issue I had particularly with the PEBB Complete and the PEBB Balance plans is anecdotally I have heard that portability is a huge issue with United, the issue of pre-existing conditions, and I certainly would like Health Care Authority to analyze that. Every year we have open enrollment, and though we have structured our own personal retirement, in terms of we're going to be in this plan up until this moment, then, our insurance agent probably doesn't want to hear this, we're going to be in this plan up until this moment, and then we intend to shift to this plan at this moment, all based on what we project to be our medical needs as we age. The issue of pre-existing conditions and affordability among plans is going to be a critical question.

I am a retiree speaking on behalf of Washington State School Retirees, the very existence of that subsidy, if you look at that chart showing how that subsidy relates to rates. Lowering of that subsidy will be a real cost burden to retirees. Of course, we'll be working with the Legislature to try to combat that, as will a thousand other groups working to combat changes and projected cuts to their needs as well. But we certainly have real concerns. Again, thank you for all your work. It was a long meeting and lots of data. Thank you.

Next Meeting

July 15, 2020
1:00 p.m. – 4:00 p.m.

Preview of July 15, 2020 PEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the July 15, 2020 Board Meeting.

Meeting Adjourned: 4:24 p.m.

TAB 4



Follow up from PEB Board Retreat January 27, 2021

Dave Iseminger, Director
Employees and Retirees Benefits Division
March 17, 2021

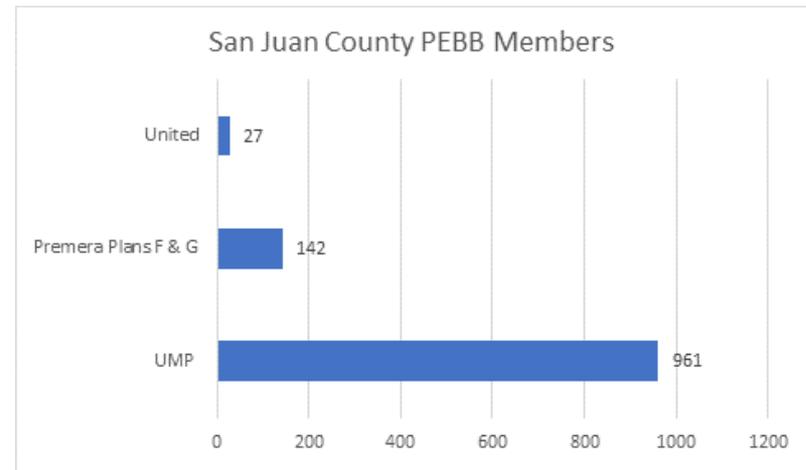
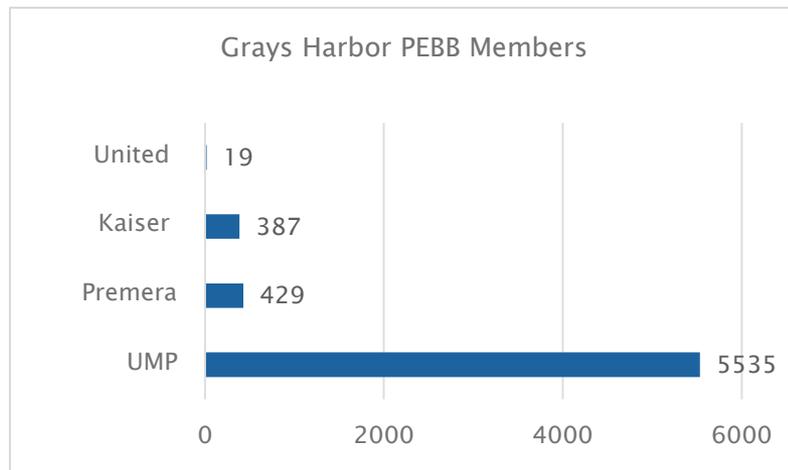
Follow up

- Tom asked for a summary of the current UMP chiropractic, acupuncture, and massage benefits

	PEBB			
	Uniform Medical Plan			
	Classic	Select	CDHP	Plus
	Coinsurance/ Treatment Limits			
Acupuncture	15% 16 visits	20% 16 visits	15% 16 visits	15% 16 visits
Massage Therapy	15% 16 visits	20% 16 visits	15% 16 visits	15% 16 visits
Spinal manipulations	15% 10 visits	20% 10 visits	15% 10 visits	15% 10 visits

Follow up (*cont.*)

- Tom asked about enrollments in Grays Harbor and San Juan Counties



* February 2021 enrollment data

Follow up (*cont.*)

- Scott requested customer survey information on the SEBB plans. The survey information for plan year 2020 will not be available until late summer 2021.
- Harry requested information on the Premera plans. That information is included on the next page(s).

	SEBB			SEBB	
	Premera			Premera	
Annual Costs/Benefits	High PPO/ Peak Care EPO	Standard PPO	Annual Costs/Benefits	High PPO/ Peak Care EPO	Standard PPO
Deductible - Individual	\$750	\$1,250	Rx deductible (individual)	\$125*	\$250*
Deductible - Family	\$1,875	\$3,125	Rx deductible (family)	\$312*	\$750*
Out-of-pocket limit - Individual	\$3,500	\$5,000	Rx out-of-pocket limit (individual)	Combined with medical OOP limit	Combined with medical OOP limit
Out-of-pocket limit - Family	\$7,000	\$10,000	Rx out-of-pocket limit (family)	Combined with medical OOP limit	Combined with medical OOP limit
Coinsurance	25%	20%	Retail: Costs based on 30-day supply		
			Value tier	N/A	N/A
Acupuncture	25% 12 visits	20% 12 visits	Tier 1 (generics)	7*	7*
Ambulance (air or ground, per trip)	25%	20%	Tier 2 (preferred brand; high-cost generic drugs, and specialty drugs for UMP)	\$30	30%
Diagnostic tests (laboratory, and x-rays)	25%	20%	Tier 3 (non-preferred)	30%	50%
Durable Medical Equipment (DME) (supplies and equipment)	25%	20%	Most Specialty Rx	N/A	N/A
Emergency Room	\$150 + 25%	\$150 + 20%	Mail order: costs based on 90-day supply		
Hearing (annual exam)	\$0	\$0	Value Tier	N/A	N/A
Hearing Aid	\$0 one per ear every 5 years	\$0 one per ear every 5 years	Tier 1	\$14*	\$14*
Home health	25%	20%	Tier 2	\$60	30%
Inpatient Services	25%	20%	Tier 3	30%	50%
Massage Therapy	25% 12 visits	20% 12 visits	Tier 4	\$50	40%
Office visit (chemotherapy) Does not include chemotherapy treatment	25%	20%	*Waived for preferred generic prescription drugs.		
Office visit (mental health)	\$20	\$20			
Office visit (primary care)	\$20	\$20			
Office visit (radiation) Does not include radiation treatment	25%	20%			
Office visit (specialist)	\$40	\$40			
Office visit (urgent care)	25%	20%			
Outpatient Services	25%	20%			
Preventive care ²	\$0	\$0			
Spinal manipulations	25% 12 visits	20% 12 visits			
Telemedicine/Virtual Care	General medical/dermatology: \$5 Behavioral health: \$20				
Therapy Physical therapy (PT), Occupational therapy (OT), Speech therapy (ST), Neurodevelopmental therapy (NT)	\$40 (45 PT/ST/OT combined/year; 45 NDT/year)	\$40 (45 PT/ST/OT combined/year; 45 NDT/year)			
Vision (not included in medical)	Not included in Medical				

TAB 5



2021 Legislative Session

Cade Walker, Executive Special Assistant
Employees & Retirees Benefits (ERB) Division
March 17, 2021

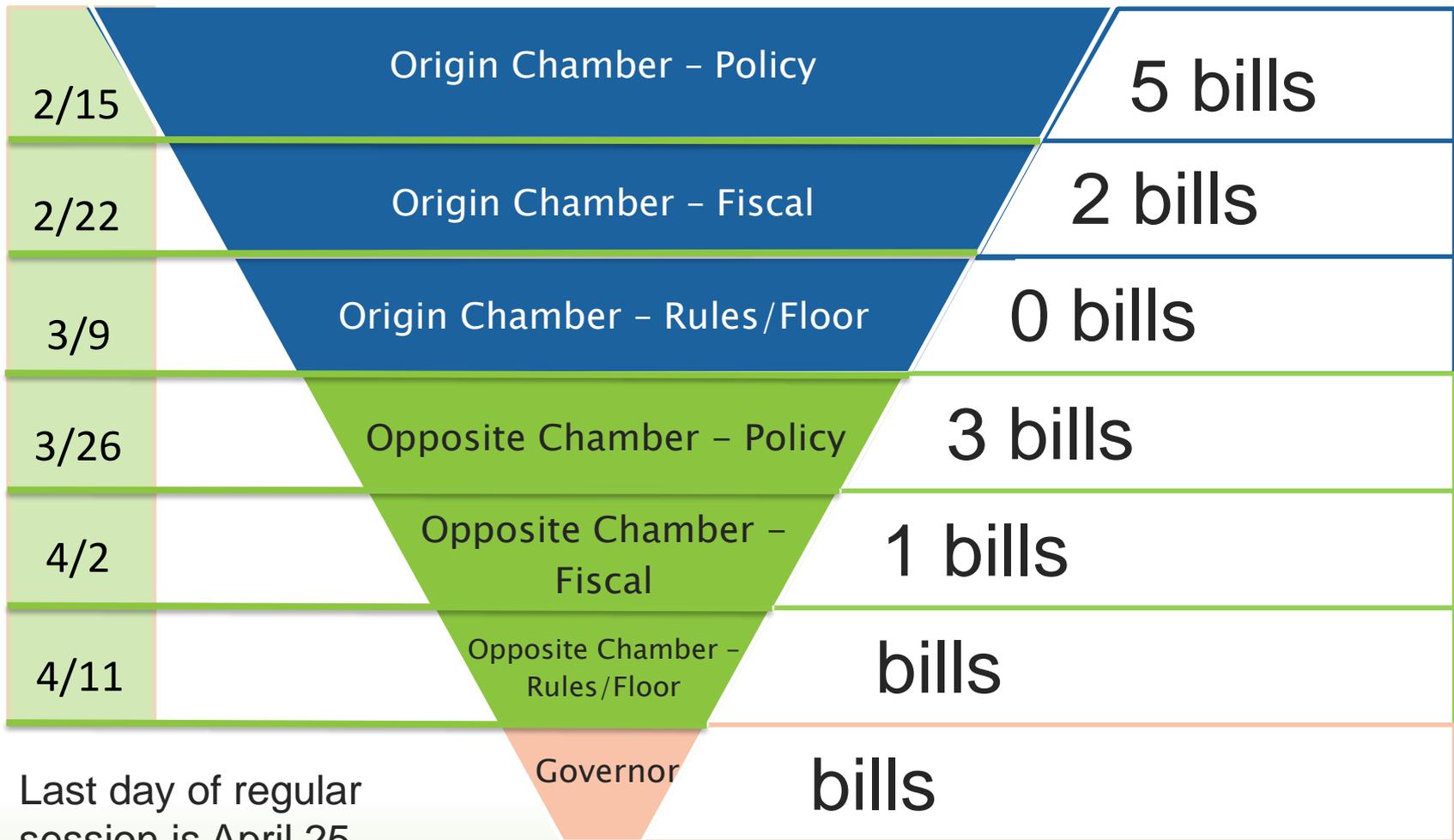
Number of 2021 Bills Analyzed by ERB Division

	ERB Lead	ERB Support	
High Priority	13	31	44
Low Priority	13	58	71
	26	89	115

High Priority Bill Hearings (some bills have multiple hearings)	51
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As of March 5, 2021

2021 Legislative Session – ERB High Lead Bills



Upcoming Session – Agency Request Legislation

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

HB 1052 – Group Insurance Contracts

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

Topical Areas of Introduced Legislation

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

Topical Areas of Introduced Legislation (*cont.*)

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

Questions?

Cade Walker, Executive Special Assistant
Employees and Retirees Benefits Division

cade.walker@hca.wa.gov



TAB 6



K-12 Non-Medicare Retiree Risk Pooling Update

Molly Christie
Fiscal Information & Data Analyst
ERB Rates & Finance
March 17, 2021

Legislative Report

- Submitted January 17, 2019
- Directed HCA to analyze the most appropriate risk pool for retired and disabled school employees

A risk pool is a group of individuals whose medical risks and costs are combined to calculate premiums. Pooling risk offsets the costs of members who use more benefits by those who use fewer. The amount of risk calculated for the entire pool impacts premiums.

Current Risk Pool Structure

PEBB Program Non-Medicare Risk Pool

State & Other*
Employees

State & Other* Non-Medicare Retirees

Non-Medicare School Retirees

PEBB Program Medicare Risk Pool

State & Other*
Medicare Retirees

Medicare School Retirees

SEBB Program Risk Pool

School Employees

*Other includes political subdivisions, non-represented ESDs, COBRA, LWOP, etc., employees or retirees and their dependents

2019 Report Recommendation

Create a **Non-Medicare Risk Pool** for the SEBB Program

PEBB Program Non-Medicare Risk Pool

State & Other
Employees

State & Other
Non-Medicare
Retirees

PEBB Program Medicare Risk Pool

State & Other
Medicare
Retirees

Medicare School
Retirees

SEBB Program Non-Medicare Risk Pool

School
Employees

Non-Medicare
School Retirees

Impacts

- **Minimizes member disruption**
 - New Non-Medicare school retirees can select from same plans available under the SEBB Program for continuity of benefits
 - Existing Non-Medicare school retirees would remain in PEBB
 - All Medicare-eligible retirees would transition to PEBB Medicare Risk Pool
- **Minor rate impacts***
 - Gradual increase of 0.0-1.0% on SEBB Non-Medicare bid rates due to greater average cost associated with retirees
 - PEBB rates would gradually decrease by same magnitude

*Based on 2018 SEBB Program enrollment assumptions and 2017 risk scores for State Non-Medicare Retirees

Considerations & Next Steps

- Creating a Non-Medicare Risk Pool for the SEBB Program requires changes to existing statute (RCW 41.05.022)
- Changes unlikely in 2021 legislative session for implementation by January 1, 2022
- We will update the Board on the new anticipated implementation date when statute changes are confirmed

Questions?

More Information:

<https://www.hca.wa.gov/assets/program/ehb-2242-retired-disabled-school-employees-risk-pool-12-15-18.pdf>

Molly Christie, Fiscal Information & Data
Analyst, Financial Services

molly.christie@hca.wa.gov

TAB 7



Medical Flexible Spending Arrangement & Dependent Care Assistance Program (FSA & DCAP) 2021 Leniency

Leanna Olive, Senior Account Manager
Employees & Retirees Benefits
March 17, 2021

Overview

- Refresh the Board regarding:
 - Medical Flexible Spending Arrangements (FSA)
 - Dependent Care Assistance Program (DCAP)
- COVID-19 Impacts and federal legislation
- Impacts on PEBB participants & employers

Salary Reduction Plan

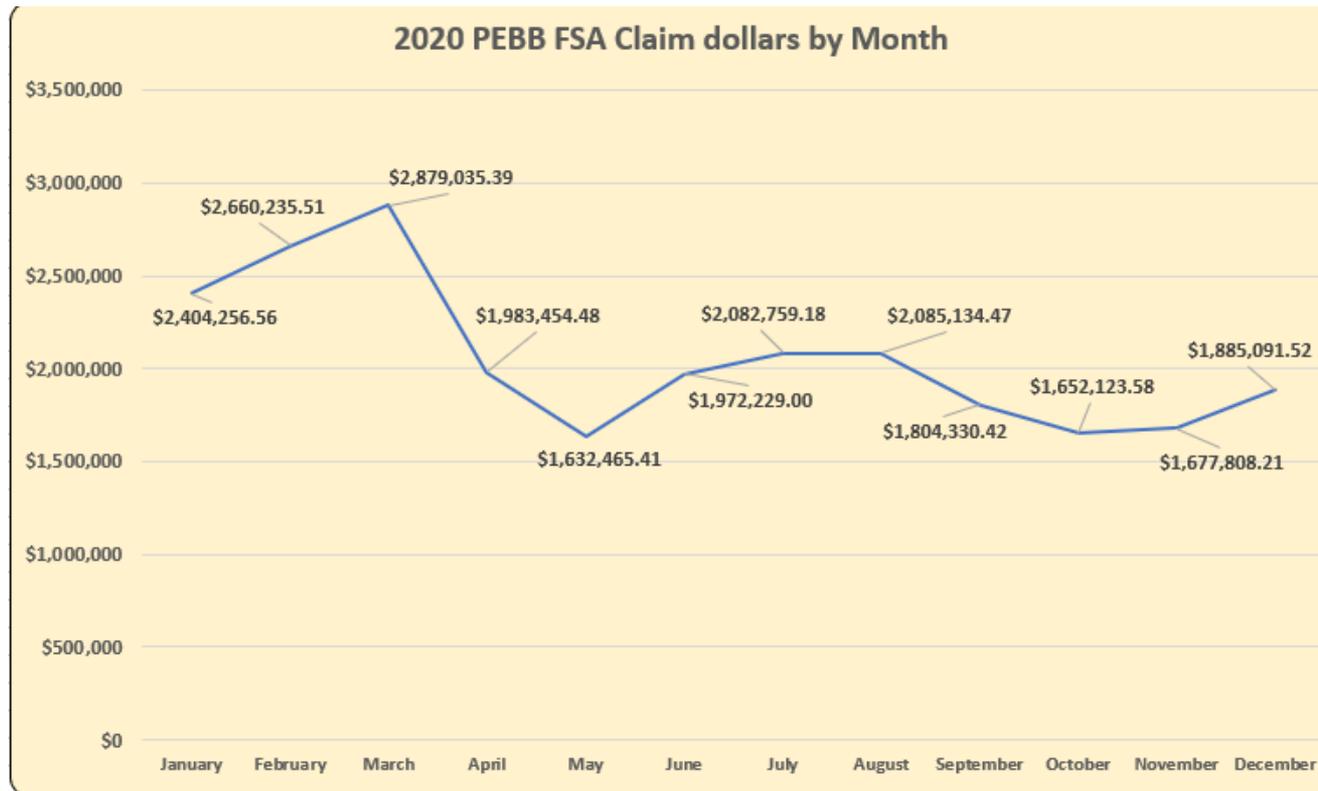
Authorizes “*before tax*” benefits funded through voluntary payroll deductions:

- **Medical Flexible Spending Arrangement (FSA)**
 - Employees pay pre-tax for eligible out-of-pocket medical expenses
 - \$2,750/year for 2021, with annual IRS COLAs
 - Pre-funded with a grace period
- **Dependent Care Assistance Program (DCAP)**
 - Employees pay pre-tax for eligible dependent care expenses
 - \$5,000/year maximum: no COLAs, not pre-funded, no grace period

COVID-19 in the 2020 Plan Year

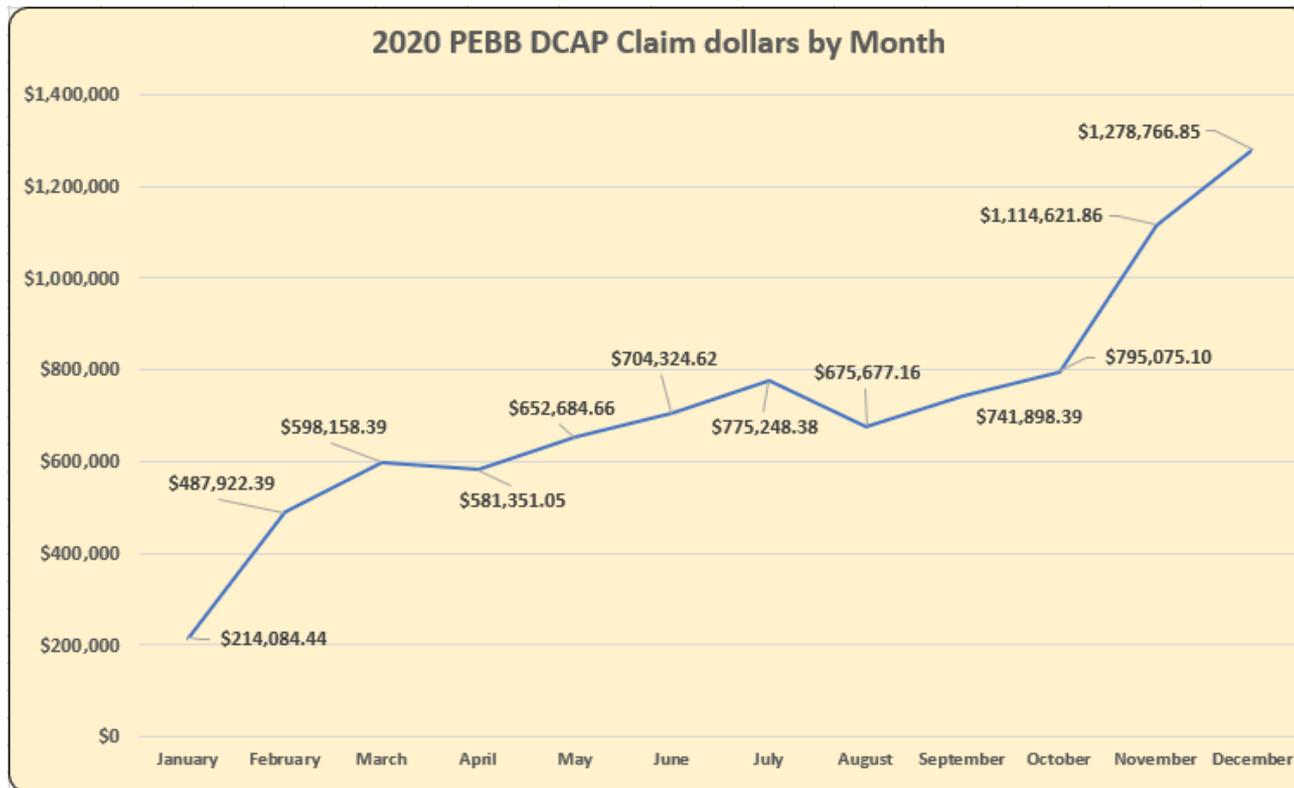
- Initial closures: March through the end of May
- Limitations on access to medical and dependent care
 - Elective surgeries and other health services suspended
 - People choosing to stay away from medical/dental settings
 - Daycare marketplace is hit hard
- FSA and DCAP:
 - Payroll deductions continue with less ability to use them
 - Deadlines for using or losing
 - Pandemic trajectory going forward in 2020: unknown

COVID-19 in the 2020 Plan Year (*cont.*)



Closures due to COVID depressed claiming through May, then evened out for the rest of the plan year.

COVID-19 in the 2020 Plan Year (*cont.*)



The mid-March-April decline is due to closures. Once daycares opened, we saw a steady increase the rest of the year.

Federal Actions Addressing FSAs

- IRS Memo 2020-29 introduces 2020 leniency
 - Limited Open Enrollment (LOE), July 2020
 - Initiating accounts, increasing or decreasing annual elections
- Consolidated Appropriations Act (December 2020):
 - Recognizes the COVID impact on tax-advantaged accounts
 - Congress created more prospective leniency opportunities

Actions for PEBB Program Participants

- Extended 12-month grace period for DCAP
Unspent 2020 funds can be used for 2021 expenses
- FSA allowances for terminated employees
Termed employees in 2020 & 2021 can spend down their balances for services incurred in the plan year they termed without electing COBRA
- Increased eligibility age for dependent care
Age for eligible dependents increased from 12 to 13 for 2021
- Election changes without Qualifying Event
 - FSA/DCAP accounts can prospectively increase/decrease annual election
 - No new accounts
 - 3 opportunities: March, June, and September
 - Each district set's their own deadline within those months

2021 Communications

- **December 2020:** HCA received notice of leniency provisions
- **February 9, 2021:** Agency Benefits Administrators/payroll staff were notified of the leniencies via GovDelivery
- **February 16, 2021:** Updated forms and enrollment guides posted to Navia's websites for PEBB Program members
- **February 17, 2021:** HCA website updated to announce leniencies
- **February 17 and 18, 2021:** February newsletters notify members of changes

Final Insights

- New Leniency is anticipated to benefit PEBB Program participants so 2020 deductions are not forfeited
- HCA is working closely with Navia Benefit Solutions and Benefits Administrators

Questions?

More Information:

<http://pebb.naviabenefits.com/>

Leanna Olive, Senior Account Manager
Employees & Retirees Benefits Division

leanna.olive@hca.wa.gov

TAB 8

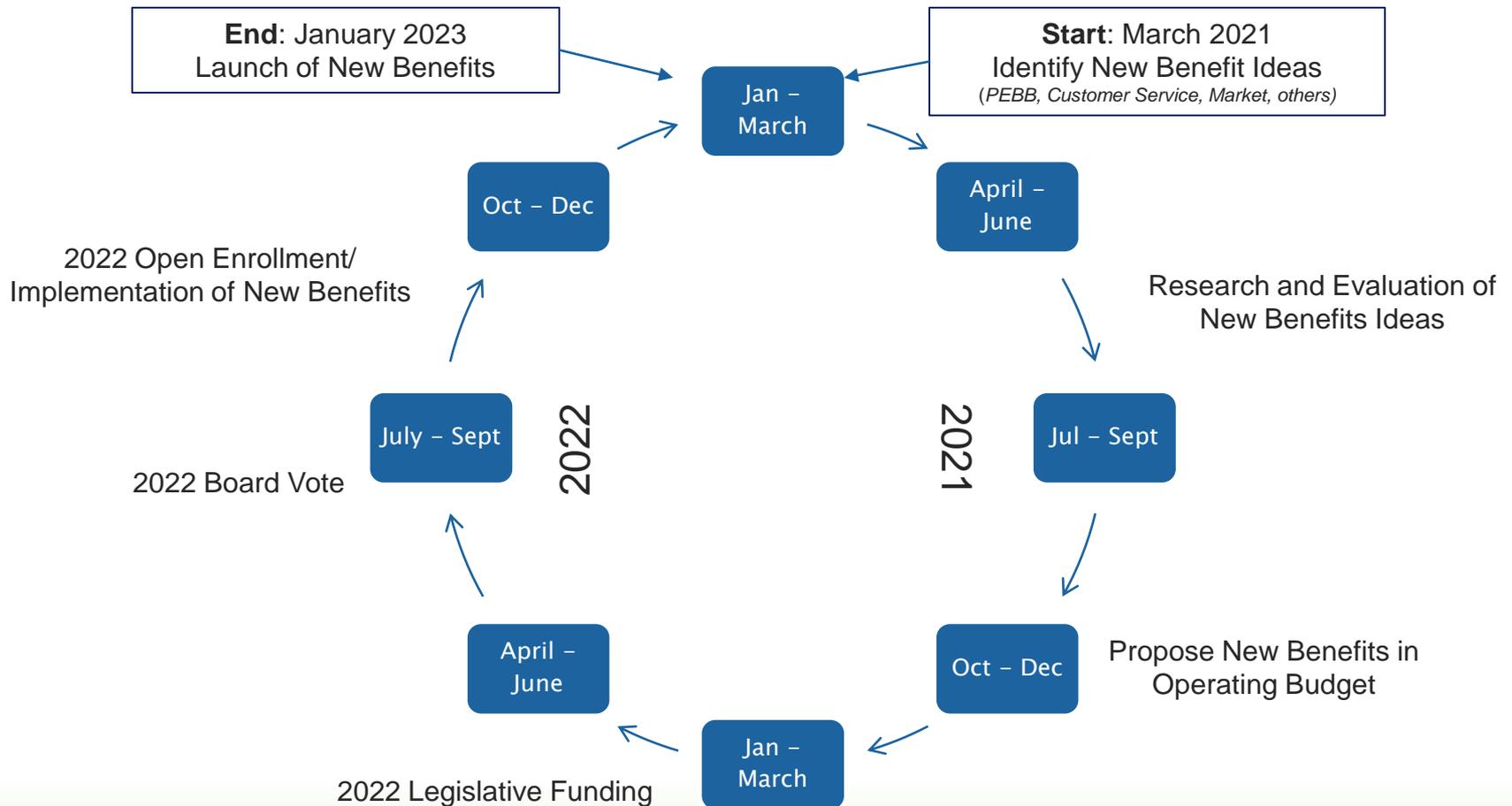


Annual Benefits Planning Cycle

John Partin, Manager
Benefits Strategy and Design Section
Employees and Retirees Benefits Division
March 17, 2021

PEBB Benefits Cycle

for Benefit Year 2023



Discussion

Are there any new benefit ideas you would like explored in the upcoming benefit cycle?

Questions?

John Partin, Manager
Benefit Strategy and Design Section
Employees and Retirees Benefits Division
john.partin@hca.wa.gov

TAB 9



Eligibility & Enrollment Policy Development

Stella Ng, Senior Policy Analyst
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
March 17, 2021

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

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:...

Introduction of Proposed Resolutions

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

Introduction of Proposed Resolutions (*cont.*)

PEBB 2021-02

Employees May Waive Enrollment in Medical

PEBB 2021-03

PEBB Benefit Enrollment Requirements When SEBB Benefits Are Waived

PEBB 2021-04

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

PEBB 2021-05

Resolving Dual Enrollment Involving Dual Subscriber Eligibility

Introduction of Proposed Resolutions (*cont.*)

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

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

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

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

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

Retiree or survivor requesting to enroll in a PEBB health plan after deferment Example #1

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

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

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

Retiree or survivor requesting to enroll in a PEBB health plan after deferment Example #2

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

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

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

Retiree or survivor requesting to enroll in a PEBB health plan after deferment Example #3

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

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

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

Retiree or survivor requesting to enroll in a PEBB health plan after deferment Example #4

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

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

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

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

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

PEBB Policy Resolution #4 SmartHealth (as approved on July 12, 2017) **Proposed to Rescind Effective January 1, 2022**

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

Proposed Dual Enrollment Policy Resolutions

RCW 41.05.742 Single enrollment requirement.

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

SB 5322: Refining the Dual Enrollment Prohibition

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

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

RCW 41.05.065(8)

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

RCW 41.05.050(1)

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

Resolving the Issue of Dual Enrollment in PEBB and SEBB Benefits

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

Challenges and Limitations in Implementing the Requirements of Resolving Dual Enrollments

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

Language Used Throughout This Presentation

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

Examples of Current Dual Enrollment in the PEBB and SEBB Programs

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

Examples of future dual enrollment in the PEBB and SEBB Programs

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

How Will Employees Know What to Do?

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

What Can Employees Do to Resolve Current Dual Enrollment?

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

What Can Employees Do to Avoid Dual Enrollment?

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

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

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

This will be determined according to certain guidelines and principles.

Guidelines/Principles For Resolving Dual Enrollment

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

Proposed Resolution PEBB 2021-02 Employees May Waive Enrollment in Medical

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

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

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

Waiver of Coverage (as approved in May 1995) Proposed to Rescind Effective January 1, 2022

I move that we accept the recommendations to:

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

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

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

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

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

Proposed Resolution PEBB 2021-04

Example #1

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

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

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

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

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

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

Proposed Resolution PEBB 2021-05

Example #1

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

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

Proposed Resolution PEBB 2021-05

Example #1 (*cont.*)

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

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

Proposed Resolution PEBB 2021-05

Example #2

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

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

Proposed Resolution PEBB 2021-05

Example #2 (*cont.*)

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

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

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

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

Proposed Resolution PEBB 2021-06

Example #1

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

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

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

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

Proposed Resolution PEBB 2021-06

Example #2

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

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

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

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

Proposed Resolution PEBB 2021-07 Resolving Dual Enrollment Involving A Member With Multiple Medical Enrollments As A Dependent

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

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

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

Proposed Resolution PEBB 2021-07

Example #1

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

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

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

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

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

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

Proposed Resolution PEBB 2021-07

Example #2

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

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

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

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

Proposed Resolution PEBB 2021-08 PEBB Benefit Automatic Enrollments When SEBB Benefits Are Auto-Disenrolled

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

Proposed Resolution PEBB 2021-08

Example #1

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

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

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

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

Proposed Resolution PEBB 2021-09 Enrollment Requirements When An Employee Loses Dependent Coverage In SEBB Benefits

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

Guidelines/Principles Recap

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

Next Steps

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

Questions?

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TAB 10



Long-Term Disability Insurance

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

Overview

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

Proposed Employee-Paid LTD Benefit

60% Default Plan

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

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

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

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

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

50% Buy Down Plan

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

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

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

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

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

Comparing Current to Proposed

Current 60% Employee–Paid Plan

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

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

Minimum monthly benefit of \$50

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

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

Proposed 60% Employee–Paid Plan

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

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

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

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

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

Employer-Paid LTD Benefit

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

Up to a maximum benefit of \$240/month

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

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

Implementation Timeline

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

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

- New hires

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

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

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

Opt-Out Communication Strategy

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

Proposed Preliminary Employee-Paid LTD Rates

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

PMPM = Per Member Per Month

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

Similar Situated Employer with Opt-Out Design

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

Employee-Paid LTD Premium & Benefits

60% LTD Plan

(90-day benefit waiting period)

Calculating an employee's insured monthly pre-disability earnings

Example 1:

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

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

50% LTD Plan

(90-day benefit waiting period)

Calculating an employee's insured monthly pre-disability earnings

Example 2:

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

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

**amount before reduction by Deductible Income*

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

60% LTD Plan (90-day benefit waiting period)	50% LTD Plan (90-day benefit waiting period)																
Calculating an employee's insured monthly pre-disability earnings	Calculating an employee's insured monthly pre-disability earnings																
Example 3:	Example 4:																
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<u>Rate (0.0028)</u>	<u>x 0.0028</u>																
Monthly Premium Due	\$11.90																
<i>Maximum monthly benefit when submitting a claim: \$2,550*</i>	<i>Maximum monthly benefit when submitting a claim: \$2,125*</i>																

*amount before reduction by Deductible Income

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

60% LTD Plan

(90-day benefit waiting period)

Calculating an employee's insured monthly pre-disability earnings

Example 5:

Monthly Earnings	\$6,750
(\$81,000 ÷ 12 months)	
Rate (0.0047)	x 0.0047
Monthly Premium Due	\$31.72

Maximum monthly benefit when submitting a claim: \$4,050*

50% LTD Plan

(90-day benefit waiting period)

Calculating an employee's insured monthly pre-disability earnings

Example 6:

Monthly Earnings	\$6,750
(\$81,000 ÷ 12 months)	
Rate (0.0028)	x 0.0028
Monthly Premium Due	\$18.90

Maximum monthly benefit when submitting a claim: \$3,375*

*amount before reduction by Deductible Income

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

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

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

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

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

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

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

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

Proposed Resolution PEBB 2021-11

Example #1

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

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

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

Proposed Resolution PEBB 2021-11

Example #1 (*cont.*)

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

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

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

Proposed Resolution PEBB 2021-11

Example #2

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

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

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

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

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

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

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

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

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

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

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

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

Next Steps

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

Questions?

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

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Appendix

Resolution PEBB 2020-04

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

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

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

August 1995 Election Period

Move that:

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

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

May 1995

Effective date of coverage for employees eligible for the employer contribution

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

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