

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

April 15, 2020  
Health Care Authority  
Meeting Held Telephonically  
Olympia, Washington  
12:00 p.m. – 3:30 p.m.

**Members Present:**

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

**PEB Board Counsel:**

Michael Tunick, Assistant Attorney General

**Call to Order**

**Sue Birch, Chair**, called the meeting to order at 12:02 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 2, 2020 meeting.

At the April 2 meeting, the Board passed an eligibility requirement to set up emergency eligibility for health care workers, first responders, individuals who work in medical facilities. As of yesterday, the Department of Health was the first agency to use that eligibility criteria. It's fascinating to me that in less than 15 days, an eligibility framework

was created, enacted, and utilized for hiring some state employees. The action this Board took was important and a testament to the times we are in.

**Approval of April 24, 2019 Meeting Minutes**

Yvonne Tate moved and Harry Bossi seconded a motion to approve the April 24, 2019 PEB Board Meeting minutes. Minutes approved as written by unanimous vote.

**Approval of May 21, 2019 Meeting Minutes**

Tom MacRobert moved and Harry Bossi seconded a motion to approve the May 21, 2019 PEB Board Meeting minutes. Minutes approved as written by unanimous vote.

**Approval of June 5, 2019 Meeting Minutes**

Harry Bossi moved and Yvonne Tate seconded a motion to approve the June 5, 2019 PEB Board Meeting minutes. Minutes approved as written by unanimous vote.

**Approval of June 19, 2019 Meeting Minutes**

Yvonne Tate moved and Tom MacRobert seconded a motion to approve the June 19, 2019 PEB Board Meeting minutes. Minutes approved as written by unanimous vote.

**Approval of July 10, 2019 Meeting Minutes**

Tom MacRobert moved and Harry Bossi seconded a motion to approve the July 10, 2019 PEB Board Meeting minutes. Minutes approved as written by unanimous vote.

**Approval of January 30, 2020 Meeting Minutes**

Tom MacRobert moved and Yvonne Tate seconded a motion to approve the January 30, 2020 PEB Board Meeting minutes. Minutes approved as written by unanimous vote.

**Agenda Item: Legislative Update: PEBB 2020 Supplemental Budget**

**Tanya Deuel**, ERB Finance Manager, Financial Services Division. At our last meeting we discussed the Governor's budget. Today's presentation is a result of the final conference budget and recaps how the funding rate landed.

Slide 2 – Final Funding Rate. For the first time in many years, there was no action on the funding rates in the supplemental budget. For Fiscal Year 2020, ending June 30, 2020, the funding rate is \$939. For Fiscal Year 2021, the funding rate is \$976. These are paid per employee per month by each agency and higher education institution for each eligible employee, regardless of how they enroll in benefits. HCA has no concerns with these funding rates as they are adequate to maintain the current level of benefits, plus a few additions I'll describe shortly.

Slide 3 – Medicare Explicit Subsidy. The Medicare explicit subsidy remained unchanged at \$183 per month. This is per Medicare eligible retiree and is \$183 or 50% of the premium, whichever is less.

Slide 4 – Final Conference Budget Funding. The three items on this slide are the final amounts received from our original decision package requests. First, HCA received \$233,000 for two audit FTEs in the budget. We requested four FTEs, two for PEBB and two for SEBB, to support audit capabilities. We received two total FTEs.

**Dave Iseminger:** Health Care Authority is charged as the sentinels on eligibility and making sure our employers, which between the two programs is almost 800 separate employers, are administering the eligibility rules, set by you and by the Legislature, as consistently as possible across the system. The PEBB Program has been in existence for several decades, over the years, one of the primary ways we ensured consistent rules application is in the appeals process. We identify areas that consistently come up for training and opportunities to course correct on eligibility determination. That's far down the pipeline, and has gotten to the point where an individual was denied benefits and they're appealing that denial.

HCA has wanted to create an audit eligibility check system on the front end. This decision package was funded and supported by both the Governor's Office and the Legislature. There will be front-end periodic audits and we will cycle through the various employers in both programs and do audit checks of eligibility determination before we get to a point of denials. We will continue to use the appeals process as another opportunity for course correcting on misunderstandings about the eligibility framework for our employers. This package allows us to do front-end audit of eligibility. They will be based in Olympia, with some site visits from time to time.

**Tanya Deuel:** The strike out of text in the next item is unique. HCA was funded in the final conference budget \$119,000 for one FTE to support our Medicare plan offerings. Along with this funding was proviso language for HCA to participate in a work group and create a report to the Legislature on a study regarding our Medicare offerings. This was vetoed by the Governor, so we will not be receiving that one FTE.

The third item is \$75,000 for a Diabetes Management Request for Information (RFI). This item was a request for \$150,000 to split equally between the PEBB and the SEBB Programs. We received the full funding between the two programs. This would be one-time administrative funding for HCA to complete an RFI.

HCA currently offers a Diabetes Prevention Program to PEBB Program members through Omada, a virtual program. However, we do not have a formal Diabetes Management Program. The RFI will allow HCA to see what is available in the market place for such a program.

Slide 5 – Final Conference Budget Funding (cont.). The first circle on this slide is \$1.7 million – ESSB 6189 funding. This is funding for technology changes for HCA to implement this legislation, which prohibits dual enrollment between the PEBB and SEBB Programs. This is one-time funding to modify our systems.

The last circle does not have a dollar amount because it's buried within our claims cost for benefits. This is to align with legislation passed in 2018. E2SSB 5179 states that hearing coverage must include a new instrument every five years. The UMP benefit currently covers \$800 every three years. This will align HCA with this legislation for plan year 2021.

**Dave Iseminger:** The reason this doesn't have a dollar figure, if you go back to Slide 2, the funding rates are \$939 and \$976, and legislative budget processes said there is enough to cover this benefit change in those numbers. It's buried in the funding rate.

### **Agenda Item: Legislative Update: Bills**

**Cade Walker**, Executive Special Assistant, ERB Division. Slide 2 – Number of 2020 Bills Analyzed by the Employees and Retirees Benefits (ERB) Division. There were 384 bill analyses completed. The ERB Division was tracking 158 pieces of legislation as high priority, with another 226 as a lower priority. A high priority bill has a fiscal impact of \$50,000 or greater, or would impact our rules. Low impact, low supports have neither of those as part of the legislation.

Slide 3 – Legislative Update – ERB High Lead Bills. These bills on Slide 3 are individual bill numbers. A bill may have several different versions introduced throughout the session. There are engrossed bills and substitute bills, as well as other prefixes. This slide tracks the particular number of that legislation, four of which were high priority and signed by the Governor.

Slide 4 – PEBB & SEBB Program Impact Bills. There wasn't a lot passed this session that directly impacted the PEBB or SEBB Programs. ESSB 6189 impacted the SEBB Program, but I'm sharing with this Board as it may have some impacts in the future.

Engrossed Substitute Senate Bill 6189 - Eligibility for School Employees Benefits Board Coverage, was signed by the Governor. A report required by this bill is for the Joint Legislative Audit and Review Committee to conduct a study on the number and types of part-time employees in the SEBB Program and their eligibility for SEBB benefits. It's due to the Legislature in September 2021. HCA and the Office of the Superintendent of Public Instruction will assist with this report.

A second required report is for the Health Care Authority to prepare a report on waivers and analyzing the impacts of changes to the requirement that school employers must remit premiums for employees who have waived medical coverage and the fiscal impact. Tanya and her team will be leading that report effort and it's due to the Legislature September 2021.

The legislation also requires enhanced reporting by school districts on their part-time employees. The legislation also prohibits, beginning January 1, 2022, dual coverage under the SEB Board and benefits provided under the PEB Board from the same type of coverage. This is an impact to the PEBB Program. Dual coverage between the programs will no longer be allowed.

Both the SEB and PEB Boards passed resolutions, either recently or historically, that prohibit dual enrollment *within* the programs. This legislation also prohibits dual enrollment *between* the programs. If a member is eligible for PEBB Benefits, as well as eligible for SEBB Benefits, whether it's dependent on one or the other, they're limited to enrolling in one type of benefit between the two programs where that member is allowed to decide. There will be more information on this legislation as we continue to develop rules regarding the dual coverage.

There was a provision added at the last hour before the session ended addressing COVID and the eligibility of school employees in preserving eligibility and benefits for school employees.

**Dave Iseminger:** I think it's impossible for HCA to administratively accomplish implementation of dual enrollment prohibition between PEBB and SEBB without additional action by at least one, if not both, the PEB and SEB Boards. There will be policy decisions and proposals we will bring to this Board, and your sister Board, either later this season or next season. HCA will continue to evaluate and make recommendations to the Board. For example, in neither program is there currently the ability to waive dental. When the legislation says limited enrollment to a single dental plan, if you have eligibility in both plans, there is physically and legally no way right now under the existing policies for that to occur. Action will be required by at least one Board in order make that happen within the eligibility framework for the two programs.

We will continue to evaluate this internally determining what areas need to come before the Board. I did want to make sure the Board knows there will be an active Board discussion either later this season, or the beginning of next season, or most likely, in both instances to bring forth policy proposals to be able to move forward and implement a cross PEBB/SEBB dual enrollment prohibition by plan year 2022.

**Elyette Weinstein:** Do you foresee there are WACs that will need drafting?

**Dave Iseminger:** Yes. Typically, we'll bring a broad policy statement necessary for the Board to take action on. We then move into formal rule making processes and write those policy decisions into WACs/rules in the official code. We may have to modify existing rules, but that process begins with policy resolutions we bring to you. Once we have the broad policy direction, HCA takes care of the rule making activities.

**Cade Walker:** Slide 5 – SEBB Program Impact Bills - Eligibility. None of the bills that impacted SEBB benefits eligibility passed. 6189 became the primary piece of legislation regarding SEBB benefits eligibility. While that piece of legislation passed, it did not make direct changes to program eligibility. Instead, it created studies for the Legislature to get more information.

Slide 6 – SEBB Program Impact Bills. HB 2458 directly impacts the SEBB Program regarding optional benefits offered by school districts, prohibiting them from offering optional benefits to employees that compete with the basic or the optional benefits that are offered by the SEB Board, as well as under the authority of the Health Care Authority. The legislation delineates which optional benefits school districts may offer, if not offered by the SEB Board, and authorizes the SEB Board to study, and subject to available funding, offer the same delineated benefits as employee-paid voluntary benefits to school employees.

The legislation also requires school districts and applicable carriers to work with the Health Care Authority to modify, remove, or discontinue any benefits offered by a school district deemed to be in conflict or competition with HCA or SEBB benefits offered.

School districts are able to consider travel insurance, incident triggered/illness triggered specific insurances like cancer insurance or hospital stay insurance, things not in competition with the benefits currently offered by the SEBB Program. This does not require the SEBB Program to offer additional optional benefits. It merely gives the authority to study, and subject to funding, offer additional optional benefits listed in the legislation.

**Dave Iseminger:** If there is an evaluation of one of those enumerated benefits for the SEBB Program you would like HCA to pursue, this agency will do the evaluations for both programs and cross the legal authority bridge for this Board if we get there.

**Cade Walker:** I want to go back briefly and clarify a question raised regarding 6189. I've since received an email question on ESSB 6189. The legislation does not say you can only enroll in SEBB or in PEBB benefits. It says you can only enroll in one type of benefit through those programs. You can only enroll in one dental, one medical, and one vision for SEBB. There will probably be additional refinement, but I do want to make clear the legislation does not specifically say dual enrollment prohibition is limiting someone to enrollment in the entire suite of benefits within either the PEBB or SEBB Program.

Slide 7 – Topical Areas of Introduced Legislation. There were a couple pieces of legislation passed and signed by the Governor regarding provider and health carrier credentialing. 2SSB 5601 was partially vetoed by the Governor. He vetoed the requirement of a work group that was unfunded by the Legislature and signed the rest.

E2SHB 2662, related to diabetes medication, was signed by the Governor but the pharmacy tourism and pharmacy importation bills were not. Legislation passed on substance use disorder, as well as expanded durable medical equipment coverage.

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

**Ellen Wolfhagen**, Senior Account Manager, ERB Division. Slide 2 – Today's Agenda is to provide an update on recent developments and a timeline.

HCA is considering expanding the portfolio. The Medicare Advantage plans that currently exist in the retiree portfolio are not going away.

Medicare Advantage plans cover part A, the hospital plan, and Part B, the medical plans for Medicare. The Medicare Advantage Part D plans include Part D prescription drug coverage, which is the outpatient standard drug coverage. We're looking at is an expanded set of benefits as well.

HCA is looking at National Preferred Provider Organization plans, which means any provider who accepts Medicare as payment is included in the network and it's national coverage.

Slide 3 – Recent Developments. In January, there were two apparently successful bidders, Regence and UnitedHealthcare. HCA entered into negotiations with both and ran into difficulties with Regence in achieving a timely resolution. We have suspended negotiations with Regence, which could be restarted if there's a significant change, but that would be impossible for plan year 2021.

Negotiations continue with UnitedHealthcare with significant progress made. Those negotiations are ongoing.

Slide 4 – Updated Timeline. Currently, we're in the March to June period, completing contract negotiations. We'll finalize benefit design and proposed rates. During summer,

we'll bring proposed rates and final benefits design to the Board for a vote. During 2021 open enrollment, subscribers can enroll in these plans.

**Dave Iseminger:** We do have ongoing conversations in Executive Session about the status of these negotiations. I want to reassure the public the appropriate use of Executive Sessions, negotiations, and information shared with the Board as allowed under state law. When we started this journey, we anticipated presenting two plans, one from each of the apparently successful bidders for consideration by the Board. With suspending negotiations with one of our apparently successful bidders, we're still anticipating presenting two plans to the Board, but both from the same carrier.

**Agenda Item: Eligibility & Enrollment Policy Development**

**Rob Parkman**, Policy and Rules Coordinator, ERB Division. Slide 2 – Introduction of Proposed Resolutions. We are introducing two resolutions today. The first is Proposed Resolution PEBB 2020-04 - Default Enrollment for An Eligible Employee Who Fails to Make a Timely Election, and Proposed Resolution PEBB 2020-05 - Medicare Advantage Prescription Drug (MA-PD) Plan Enrollment.

Slide 3 - Proposed Resolution PEBB 2020-04 - Default Enrollment for An Eligible Employee Who Fails to Make a Timely Election. 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.

The proposed resolution would default employees only into coverages included with an employer contribution. Employees would not default into supplemental coverages. Dependents would not be enrolled in coverage.

There have been past resolutions approved by the Board related to this subject, but they did not completely incorporate all parts of current practice in the policy we're bringing to the Board today. Those previously passed resolutions are included in the Appendix for your review. Currently, about 32 employees per month in the PEBB Program are affected by this resolution.

**Dave Iseminger:** I want to assure you this resolution we're teeing up for you really reflects what has historically happened in the program. Working with the SEB Board, we would pick up historical resolutions from the PEBB Program and rework them for the SEBB Program context. We noticed this Board didn't have a comprehensive single resolution that describes defaulting into basic life insurance, basic AD&D, basic LTD. The resolutions that existed are the ones in your Appendix and slowly built up pieces of it. We wanted to bring you a single holistic resolution. We didn't include the tobacco surcharge because it's a slightly different framework. You have already passed a resolution related to the tobacco surcharge default. This resolution is really memorializing and tying up loose ends from a procedural standpoint. This is not substantively changing anything.

The second piece I want to mention is Rob gave you a number of potential people that are impacted. We know 32 is a conservative number because in our system, we have 90 days for an employer to key into Pay1. On day 91, the default logic in Pay1 is applied. Between day 31 when the employee's election is due and day 90 that an agency can key, they often ultimately key the default plans. Those do not show up in our data. The numbers Rob reports are what we see on day 91, because agencies input data between day 31 and day 90 to avoid a retro collection of three months of premiums.

**Rob Parkman:** Slide 4 - Proposed Resolution PEBB 2020-05 - Medicare Advantage Prescription Drug (MA-PD) Plan Enrollment. If a subscriber elects to enroll in a PEBB Program MA-PD plan, any non-Medicare enrollees on the account will be enrolled in the Uniform Medical Plan (UMP) Classic.

Considerations: the proposed resolution would require a Medicare subscriber who elects to enroll in an MA-PD plan to enroll any of their non-Medicare enrollees on the account in UMP Classic. This is a similar process we have for subscribers to select the Medicare supplement plans at this time, and their non-Medicare enrollees in UMP Classic.

Example 1: Our retiree Sally is 67. She is Medicare eligible at this time, but her husband, Fred, who is 60, is not. If Sally selects the MA-PD plan, her husband would enroll in UMP Classic.

Example 2: Our retiree Sally is 60. She is not Medicare eligible. Her husband, Fred, is 67 and Medicare eligible. Since Sally is the subscriber, she selected the MA-PD plan for her husband and she enrolled in UMP Classic.

We will incorporate any feedback on the proposed resolutions and start the stakeholdering process. We will bring the resolutions to the Board for action at the May 28 meeting.

I have one item to correct from our last meeting. One of my examples was incorrect and I want to correct it for the record. Slide 14 in the Appendix – Example #2 to Proposed Resolution PEBB 2020-02 – COVID-19 Enrollment Timelines.

Resolution PEBB 2020-02 – COVID-19 Enrollment Timelines was passed at the April 2, 2020 Special Board Meeting. There are no changes to this resolution. There are also no changes to Example 1.

On Slide 14, the last day to enroll in continuation coverage was on May 30. The state of emergency ended on May 15, and we incorrectly stated their deadline would not change. That is not correct. If we can go to slide 15, we'll see a correction for example two.

Slide 15 – COVID-19 Enrollment Timelines - Example 2 (Updated). The words “would not change and the deadline would remain as May 31, 2020” are stricken. The correct verbiage is added, to read: “will be extended to June 14, 2020 because the subscriber's continuation coverage enrollment period ended following the end of the emergency period, and before the end of the 30-day extension period.”



**Dave Iseminger:** The correction doesn't change the substance of anything discussed two weeks ago, but many employers rely on our examples. It needed to be corrected for the record.

**Sue Birch:** Being a member of the Uniform Command Group, I want to make sure people understand this is a hypothetical example of the emergency termination date. No decision has been made about the COVID emergency status. We'll keep you posted as we know, but I do want to clarify these are just illustrative examples. No inferences made there. And stay healthy and inside, stay home, as much as possible. Those are our big messages.

**Rob Parkman:** Slide 16 – COVID-19 Enrollment Timelines – Example 2. This wire timing diagram supports the update to Example 2.

**Agenda Item: UMP Additional Plan Proposal**

**Lauren Johnston**, SEBB Procurement Manager, **Shawna Lang**, UMP Senior Account Manager, and **Tanya Deuel**, ERB Finance Manager.

**Lauren Johnston:** Slide 2 – Objectives. Today we're going to present an additional plan option to offer under the Uniform Medical Plan portfolio with an approximate actuarial value at 82%. Going forward, we will refer to this plan as the UMP 82 AV plan. Keep in mind the AV level is approximate.

**Dave Iseminger:** Today it's called the UMP 82 AV plan, but we are going through a marketing exercise to officially name the plan. We will bring you a fully named plan at the May 28 meeting.

**Lauren Johnston:** Slide 3 – PEBB Portfolio Employee Only Deductible Levels. This slide looks at the deductible level for a PEBB Program subscriber enrolled on an employee-only plan. The range of deductible levels is listed across the top, which range from \$125 to \$300. The next plan jumps up to \$1,400 for the CDHP plans. The text in red represents the UMP 82 AV plan, which would add an additional deductible level, with a mid-range at the \$750 deductible level. The subscriber's deductible can be reduced by \$125, or have \$125 added to the subscriber's health savings account for those enrolled in the CDHP plan when they earn the SmartHealth incentive.

Slide 4 – Proposed UMP ~82 AV Plan. When we started down the path of considering whether or not to introduce a new PEBB Program plan, we look at it from different perspectives. One perspective was asking what things the subscriber or a member would consider when looking at this proposed plan option. We felt they might consider the UMP 82 AV plan provides them another plan option with that mid-level deductible range. Although it may have a 20% coinsurance, which is 5% higher than other UMP plans, it offers a lower monthly premium. In addition to a higher deductible with the lower premium means subscribers should be prepared to meet this deductible prior to the plan paying for services.

We also felt they would consider the UMP 82 AV plan has the same provider network as UMP Classic. As of March 6, of 2020, the UMP 82 AV plan had the third highest SEBB Program enrollment during the first year of the program with 29,180 enrollees, of which only 2% defaulted into the plan.

Slide 5 – Proposed UMP ~82 AV Plan (cont.). Things to consider when offering the UMP 82 AV plan is this additional plan could help add to the breadth of plan options for all income demographics within the PEBB Program population, but especially for employees who have less pay.

Slide 6 – PEBB Program Member Income, shows data on PEBB Program subscriber incomes, which includes state and higher education employees. This data is based on income data from 2018. Approximately 29% of PEBB Program employees make \$50,000 or less a year. It then bumps up to a total of 76% of employees who make up to \$80,000 per year.

**Dave Iseminger:** The income distribution of the population was ultimately one of the driving forces that had the SEB Board authorize this additional plan. This 82 AV plan we're talking about with the PEB Board is an additional Uniform Medical Plan that the SEB Board already authorized for school employees. One of the major drivers in the SEB Board's consideration was the significant portion of the school employee population that is part-time who want additional price points and deductible options. As we looked at the distribution of pay per state employees and higher education, we saw a similar potential need for PEBB Board subscribers.

**Sue Birch:** I think given our current economic catastrophes that are out of hand, and the challenges of COVID, it's timely you brought this forward because if our state is in dire budgetary constraints, they'll be looking at all sorts of avenues to keep people covered, to create savings, but still make sure people are covered. So very timely, as usual. You all are mind readers.

**Dave Iseminger:** A question brought up to me many different times is the concern that people will just race to this plan. We learned in the SEBB Program many people were looking at higher AV plans. They weren't racing to the bottom on premium. While premium is an important component, the SEBB Program open enrollment showed our consumers are more savvy than solely looking at monthly premium.

**Lauren Johnston:** On Slide 7, you'll see other Program and Board considerations if this plan were to be offered under SEBB. One consideration is without an active open enrollment, it may take time for enrollment to grow in this new plan. Another consideration is that adding a UMP 82 AV plan could offer a new default plan option.

**Shawna Lang:** Slide 8 – UMP Benefit Design Comparison. The first plan comparison is Classic (~88 AV), CDHP (~88 AV), UMP Plus (~89 AV), and the new UMP ~82 AV Plan.

Deductibles for single and family are: Classic (\$250 and \$750), CDHP (\$1,400/\$2,800), UMP Plus (\$125 and \$375), and UMP ~82 AV Plan (\$750 and \$2,250).

Out-of-pocket maximum for families: Classic (\$2,000/\$4,000), CDHP (\$4,200/\$8,400), UMP Plus (\$2,000/\$4,000), and UMP ~82 AV Plan (\$3,500/\$7,000).

Coinsurance for Classic, CDHP, UMP Plus are 15%. The UMP ~82 AV Plan is 20%.

Slide 9 – UMP Benefit Design Comparison. This slide is a cost comparison of different types of services. In Classic, CDHP, and UMP Plus, ambulances are 20% across the board because they are not considered a network service. Any kind of ambulance is covered at 20% and that continues in the UMP ~82 AV Plan. As you look at the table, most services are still covered at 15% in Classic, CDHP, and UMP Plus with a coinsurance of 20% for the new UMP ~82 AV Plan.

Hearing aid benefits and inpatient services remain the same as the rest of the plans. The only caveat would be CDHP, which has a coinsurance instead of a copayment for inpatient services.

**Dave Iseminger:** I want to highlight the hearing hardware benefit described is \$800 every three months. We are working on the transition Tanya alluded to earlier in the budget, moving to a full set of hardware every five years. This table reflects the current coverage.

**Shawna Lang:** Slide 10 – UMP Benefit Design Comparison (cont.). For office visits, the coinsurance for Classic, CDHP, and UMP Plus is 15%. The new plan is 20%. The different types of spinal manipulations, acupuncture, and massage therapy are the same at 16 visits for Classic, CDHP, UMP Plus, and UMP ~82 AV. Physical therapy, occupational therapy, speech therapy, and neurodevelopmental therapy for Classic, CDHP, and UMP Plus are 15%, and UMP ~82 AV is at 15%.

Slide 11 - UMP Benefit Design Comparison (cont.) compares the pharmacy benefits. There is little difference between UMP Classic and the new UMP ~82 AV Plan. The main difference is the RX deductible.

**Tanya Deuel:** Slide 12 – UMP ~82 AV Rate Considerations. We haven't started procurement for plan year 2021, including rate development. However, we have started evaluating things we would need to take into consideration for any potential rates and premium differentials for offering this plan in PEBB. The first thing we are considering is the membership would primarily switch from UMP Classic at the level of switching that was similar to the last couple of times when new plan offerings happened in the UMP portfolio. Short term, we're not expecting a significant amount of enrollment to switch into this plan without an active open enrollment. We've been looking at those different levels of switching, which brings me to my next point.

The level of switching is significant to the state index rate. The state index rate is the employer's contribution towards employees' medical benefits. This is set in the state Collective Bargaining Agreement and is currently set at an 85% projected weighted average of health care costs for the upcoming plan year.

Since the state contribution for medical is based on a weighted average, as we introduce a new plan, that new plan would become part of the average. Looking at the last two plans offered into the UMP portfolio, we saw a 5%-6% switching assumption from the other plans into the new plan offering. With that level of switching in the first year, we would expect to see the state index rate lower by approximately \$2, based on current modeling.

If the Board adopts this plan, full rate development would begin and we would offer you premium levels for the various UMP plans, as well as the impact on the state index rates in those premiums for our members. This only impacts our non-Medicare plans as it would not be offered in the Medicare portfolio.

**Dave Iseminger:** To set the historical stage, in the beginning there was UMP. It began in the early 90s and was the only self-insured plan in the portfolio for roughly 20 years. In 2011, this Board authorized, at the direction of the Legislature and partly because of statutory requirements by the Legislature, the High Deductible Health Plan, called UMP CDHP, for plan year 2012. The first UMP product became “UMP Classic” to differentiate between the two UMP plans. UMP Plus was introduced beginning in plan year 2016.

That was the most recent introduction into the Uniform Medical Plan portfolio. We’ve had 20 years when UMP Classic was the only plan. In 2012 we added CDHP and in 2016, UMP Plus. Those recent experiences over the last decade guide our financial assumptions on switching.

**Tanya Deuel:** Between CDHP and UMP Plus in the PEBB portfolio, we saw 5% and 6% switching and we believe that would be an appropriate level of switching to assume.

**Shawna Lang:** Slide 13 – Proposed Resolution PEBB 2020-06 – Self-insured Plan Offering. 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:

Slide 14 - Proposed Resolution PEBB 2020-06 – Self-insured Plan Offering (cont.).  
Next slide, please.

- 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)

**Sue Birch:** Do we have projections on the state savings at this point and/or will we get that information?

**Tanya Deuel:** We can definitely pull that information. We are starting the rate development process the first week of May. That would be something we can look at and bring back to the Board.

**Dave Iseminger:** It’s possible that based on where we are in the rate setting process we may need to do the initial revealing of discussions in Executive Session because it impacts the remaining of the rate setting process for the fully insured plans before we’re able to share it publicly.

**Sue Birch:** Given all the instability of COVID, COVID testing, COVID surveillance and monitoring, and maybe the unknown of a new normal, how are we factoring that into the

rate development processes? How might that impact folks making a choice about coverage? Can you speak to that?

**Tanya Deuel:** I can speak to how we are managing that. Dave, Megan, I have been in conversations with the carriers regarding COVID impacts and how that will impact their bid rates. An RFR went out and we are releasing the bid rate portion of that this week for carriers who have not yet received our instructions. In part of those instructions, we will be addressing COVID as an incremental part of their bid rate and asking for multiple sets of bid rates so we can isolate any COVID impacts as a total part of the bid rate.

**Tim Barclay:** It's my opinion that with the introduction of a lower AV plan, the process of calculating the state index rate and the resulting plan premiums should be revisited. There's a certain logic behind the current process that introduces a leveraging effect on the premium differentials. That logic makes perfect sense when the plans are all roughly the same AV because that leveraging tends to disproportionately affect member premiums relative to plan performance. I don't think that leveraging concept really makes sense with the introduction of a lower AV plan. I think there are ways we could adjust. This would obviously be an easier conversation to have if we were all in the same room and we could use a whiteboard. But I just think at a high level, leave it at that for now, the index rate calculation and the premium calculations need to be modified.

**Sue Birch:** Thank you for that input, Tim. We look forward when we're all back in the same room and have that whiteboard time.

**Dave Iseminger:** I'm interested if there are any particular concerns from the Board that we need to, as an agency, prepare for the follow-up presentation in May. In order to hit the full rate development process correctly, we would need the Board to act on this resolution at the next board meeting. If at this point there are concerns or questions, please raise them. If you identify them, over the next couple of days as you're reflecting on this meeting, you can shoot me an email so we can make sure we can adequately bring follow up for the public meeting about the introduction of this plan and address any concerns.

**Harry Bossi:** Would you anticipate Kaiser coming in and saying they would like you to consider a \$750 or similar for us? Because my concern then would be too many plans. I don't know how that process would evolve or not evolve.

**Dave Iseminger:** Important strategic question, Harry. Thanks for reminding me to bring this up. When we look at the SEBB portfolio now, there are roughly 17 medical plans compared to the PEBB portfolio, which I believe has roughly eight or nine plans. One of the big differences beyond just the sheer number of plan comparisons is, in the PEBB Program, I believe we have 15 counties where the only plan options for those residents are the Uniform Medical Plan. In the SEBB Program, there are only three counties, which have choices only within the Uniform Medical Plan Portfolio.

For plan year 2021, we're bringing to you the self-insured piece of basically copying and leveraging the experience we just went through in launching for the SEBB Portfolio. It is likely we will visit this topic again with you next year about the fully insured part of the portfolio. We did not want was to prematurely bring over and have conversations about

additional fully insured options. The SEB Board indicated when they launched the number of plans they did, they wanted to evaluate and consider whether they ultimately may reduce some of the plans in their portfolio. We want a full year of experience when it came to the full breadth of the SEBB Program and for your sister Board to evaluate the breadth of options in their portfolio, and maybe recalibrate, as they feel necessary, before we simultaneously brought conversations to you about any additional plan options from fully insured carriers for the PEBB portfolio.

I am certain our fully insured partners are interested in visiting different parts of their offerings within the PEBB Program just as they are learning about the experience they're having in a consolidated SEBB Program. There is likely a part two to this conversation for plan year 2022. Given our experience in our own ownership of the Uniform Medical Plan, we felt comfortable bringing this piece to your attention and consideration for 2021.

**John Comerford:** This is my first meeting where we've talked about AV. My assumption is that AV is the percentage of the state's commitment to the overall cost. Is that correct? So it's 82%? Or is it 88%?

**Tanya Deuel:** Yes. In this situation, 82% actuarial value is the state will pay approximately 82% of the cost for covered benefits.

**Dave Iseminger:** That's on average across the plan.

**John Comerford:** On average. But basically, if I were looking at this from an employee standpoint, it's getting a better bang for their buck with the 88%, is that correct?

**Tanya Deuel:** Yes, but they're paying more in premium.

**John Comerford:** Yes, I understand that.

**Sue Birch:** I think it's not fair to say they're getting more bang for their buck. It depends what kind of utilizer there are. If they're a low utilizer that doesn't use their care benefit offerings, then I think others would say, well, no, they're being made to pay for something they're not using. It gives our employees more choice. I think there's a number of ways you could interpret that.

It was something we've learned with the SEBB population that we needed to create this differentiated AV plan. I think that is why the staff brought it forward to the PEBB side of the house and I appreciate that.

#### **Agenda Item: UMP Vision Proposal**

**Shawna Lang,** UMP Senior Account Manager. Slide 2 – Background. In 2018, there was a procurement for a Uniform Medical Plan third party administrator, which was awarded to Regence. Due to multiple implementation plans with PEBB and SEBB going live January 1, 2020, we decided to stay with the current vision network for one more year. Regence Vision Solutions was used into 2020, and they currently continue using that network for UMP. However, as part of the procurement, the plan was to move over to Vision Service Plan (VSP). That move will take place January 1, 2021.

**Dave Iseminger:** When Regence won and we negotiated their contract, their financial modeling included a switch of networks. Because of the complexities of launching the SEBB Program, HCA asked them to maintain the status quo for the vision component for one more year. That had an administrative cost because their contract negotiation accounted for this switch. We have been in conversations with Regence on how to administer this vision benefit within the Uniform Medical Plan as an embedded benefit with their intended VSP provider network. They have been quickly retiring their homegrown network. We're one of the last vestiges using it via UJMP. If we were to try to maintain the current network use, it would become more expensive. We had intended to have the switch go live with the new contract for the PEBB Program in 2020. We just couldn't get there. Regence was accommodating us to extend the status quo for one more year, but we have this network change that needs to go into effect. As a result of that network change, there are a few relatively minor benefit changes that need to happen alongside of it that Shawna is about to go over.

**Elyette Weinstein:** What does VSP stand for?

**Dave Iseminger:** VSP stands for Vision Service Plan. That's the name of the company. Most members are used to hearing VSP instead of the full name.

**Shawna Lang:** Slide 3 – PEBB UMP Current Vision Benefit. The current benefit, 12/24/24, refers to exam/lens/frames or contacts. Currently, for adults, there's a maximum of \$150 per two-year period and it resets on an even year. There's a contact spending fee that's paid at \$65 every two years. The out-of-network benefit is 60%. The only exception to that is UMP Plus is at 50%.

The UMP benefit currently for children is 12/12/12. They get one set of frames and lenses covered every year and scratch resistant coating for polycarbonate lenses, each covered at one per year. Out-of-network benefit is 60%. The only outlier is 50% for UMP Plus.

Slide 4 – Proposed PEBB UMP Adult Vision Benefit. This benefit is very similar at 12/24/24. In-network member cost share would be zero for the exam, which it is currently. Contacts and fitting fees covered at \$30, and frames and elective contacts at \$150 every two years. Out-of-network schedules are listed at the bottom of the slide.

**Shawna Lang:** Slide 5 – PEBB Proposed UMP Pediatric Vision Benefit. This benefit is Affordable Care Act (ACA) compliant, is 12/12/12, and has covered caustic shares. The exam is covered in full at 100% of allowed amount. Frames and lenses are covered yearly.

Slide 6 – Overview Summary. Advantages to UMP members are lower out-of-pocket costs when using VSP providers, lower claims costs due to provider discounts, a nationwide network of over 96,000 access points that include chains like Costco, Walmart, and Visionworks, and a collaborative management of members with chronic conditions like diabetes through Eye Health Management.

Possible concerns may be some members need to find a VSP choice network provider to receive the highest level of benefits and may need to change providers because of this network change.

**Dave Iseminger:** As we launched the SEBB Program and their standalone vision plans, the number one question consistently asked of SEBB Program members was, “Where is my VSP?” VSP is one of the broadest based vision networks possible. It is unlikely a member would not be able to find a provider. Our experience in the SEBB Program was that many people know who VSP is, it's a broad-based network, and people were hunting for VSP wherever possible. For those who historically accessed and utilized VSP vision benefits, this will likely be a very acceptable, if not welcome, provider network.

**Shawna Lang:** Slide 7 – Proposed Resolution PEBB 2020-07 – UMP Vision Benefits. 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.

**Harry Bossi:** With VSP, I have familiarity with it and I would agree with Dave. I think members, in general, will see this as an upgrade. So I'm in line with this plan. But I want to go back if I could, and ask a question. On the adult vision slide, I don't see any mention there, and perhaps I missed it, of add-ons, like scratch resistance and polycarbonate. Those would be a buy-up. Is that correct?

**Shawna Lang:** I can take that away and bring back information at the next Board Meeting.

**Harry Bossi:** I want to make sure we address this upfront because with my past experience when we show a slide like this that says single vision lenses, zero cost, total exam, and glasses co-pay, the reality is people want to get the scratch resistance or a better carbonite material. When they do, they are surprised and didn't know they had to pay for that. I am asking to make sure we have clarity. Thank you.

**Dave Iseminger:** Thanks Harry, Shawna will bring that up as a follow up. If there are modifications to the slide, we will add them in the next meeting, and the reference in the resolution as we present at the May 28 meeting.

At a high level, if you compare Slides 3, 4, and 5, you'll see the differences. The three main benefit design differences are:

- On Slide 4, the contact lens exam fitting fee copay is currently \$65, and it reduces to \$30. Members would see that as an advantage. It's a lower copay.
- On Slide 4, the out-of-network schedule is currently a coinsurance model of 60%, unless you're in UMP Plus, which is 50%. It moves to a copay model. The big switch is from coinsurance to copay.
- On Slide 5, there is no out-of-network option for the pediatric vision benefits. PEBB Program members are international. Some accommodations can be made on a case-by-case basis with Regence and VSP for children covered who happen to be living internationally and under PEBB plans. If you are within the United States, you need to go in-network.

**Shawna Lang:** Correct.



**Dave Iseminger:** The plan design before you is very similar, if not almost identical, with one of the SEBB vision standalone plans. The plan design here is leveraged from the SEBB Portfolio.

**Elyette Weinstein:** Dave, can you explain what you mean when you say that if you're going from an insurance to copay model, it's an advantage. I'm not clear what that means.

**Dave Iseminger:** Thanks, Elyette. To clarify, if I said it that way, what I meant was going from \$65 to \$30 for the copay of the contact lens fitting fees, it would be seen as an advantage. The coinsurance, I didn't mean to imply that one is better or worse than the other. There are different philosophies from members about the predictability of a copay or the potential for a coinsurance to be a better deal compared to a copay. I was simply trying to reflect that one of the two main features is the out-of-network schedule is flipping from coinsurance to copayment. The part where I think there's a clear advantage to members is the fitting fee for contacts, if they're a contact wearer. Currently they're paying \$65. Under the new plan, if approved, they would pay \$30. It would be hard for a member to say that's not a new advantage to them. If I misspoke, I apologize. I'm glad you asked a clarifying question.

**Elyette Weinstein:** Thank you.

**John Comerford:** Out of curiosity, how many employees do we have internationally?

**Dave Iseminger:** It's somewhere between 100 to 125. They're primarily with higher education institutions. If I remember correctly, we have roughly 45 countries. Basically, one family per country except there's a bunch in Canada.

**John Comerford:** Great, thank you.

**Agenda Item: HCA Legislative Report on Consolidating PEBB & SEBB Programs**

**Marcia Peterson**, Benefit Strategy and Design Section Manager, ERB Division. In 2019, the Legislature asked the Health Care Authority to prepare a report about consolidating the PEBB and SEBB Programs. No action is required of the Board, but we want to keep you informed so you can provide input as appropriate.

Slide 2 – Legislative Charge. HCA's charge is to study the potential cost savings and improved efficiency in providing insurance benefits to the employers and employees participating in the Public Employees and School Employees Benefits Boards Systems that could be gained by consolidating the systems.

Slide 3 – Legislative Charge (cont.). The consolidation options studied must maintain separate risk pools for Medicare eligible and non-Medicare eligible employees and retirees. They must assume the consolidation date of January 1, 2022 and incorporate the experiences gained by the Health Care Authority during that initial implementation and operation of the School Employees Benefits Board Program.

Slide 4 – Legislative Charge (cont.). The study will be submitted to the committees of the House of Representatives and the Senate overseeing health care and the omnibus operating budget by November 15, 2020.

Slide 5 – 2019-2020 Timeline. HCA was not asked to provide a recommendation. We will simply look at the differences and identify if there are cost efficiencies or savings by putting the two programs together. The timeline shows that we started last fall to identify and evaluate the differences between the two Programs. Rather than trying to have them diverge, we have consciously tried, where we could, where it was appropriate, and where the Boards were amenable to it, to make them more similar than different.

We're now in March through June, looking at enrollment experience. It's too early within the SEBB Program, which started January 1, 2020, to have any actual utilization experience. We do the demographics of who enrolled in what plans, which we didn't know before. We didn't know how many dependents would be enrolled. We didn't know what that ratio would be or which plans they would select. Now we do so it's easier for us to construct a model and look at what the effects of consolidation would be if they were one program. We're in the process of doing that. We will be developing a report, going through extensive internal reviews, and reviewing with stakeholders.

Slide 6 – Milestones. Listed are some big constraints we always think about as we do this kind of planning: legislative session, Collective Bargaining, Budget. Some things the Legislature has authority over, the Board has authority over some, and the agency has authority over some.

Collective Bargaining occurs in the summer and will impact plan years 2022 and 2023. That's always a couple of years out. The report is due November 2020. In 2021, a year from now, the Legislature will go back into session and there will be a new budget put forward, which begins July 1, 2021.

Those are the big constraints and milestones we need to consider if things need to be consolidated or made the same, and were out of the authority of one group or the other. We would be constrained by any of these milestones.

Slide 7 – Elements to Consider. Things to consider: plan offerings, impacts of Collective Bargaining, how premiums are calculated, tier structures, invoicing cycles, Board composition, to name a few.

In the SEBB Program, the tier structure is 3:1. The PEBB Program is 2.75:1. What is the impact if those were made the same?

We are very interested in your thoughts, either today or later. If you have thoughts later about consolidation, concerns, or ideas, we would love to hear them. We'd love to include your thoughts within the report itself. We've asked the same of the SEB Board and other stakeholders, as well.

**John Comerford:** The state cap, I think it's \$983. Is that per employee or per participant? In other words, does it include dependents or does each dependent get \$983?

**Dave Iseminger:** To clarify, I think you're talking about the funding rate. Tanya, remind me which number it is.

**Tanya Deuel:** For now, the funding rate for this current fiscal year is \$939. Is that what you're referring to?

**John Comerford:** Yes. So I'm looking at next fiscal year. It goes up --

**Tanya Deuel:** The \$976 is the next fiscal year. That amount is paid per eligible employee regardless of whether they waive medical, enroll in medical as a single subscriber, or enroll in medical with a full family and 15 dependents. Whether they enroll in just dental, life, and LTD. That same amount is paid by each agency for each eligible employee

**John Comerford:** Is it the same for the school employees as it is for other public employees?

**Tanya Deuel:** No, the funding rate on the SEBB Program is slightly different from the PEBB Program. The concept right now works the same where they pay it per eligible employee regardless of how many dependents they enroll.

**John Comerford:** Great, thank you.

### **Public Comment**

**Dr. Douglas Jeske:** I have been an eye care provider in Tumwater for the past 25 years. I'm thankful for the opportunity to join this meeting. It was very enlightening in many different aspects. After listening to the changes in the UMP vision care, I want to add a little perspective to help the Board understand what impact these changes might be having on members' quality of vision care.

As you are all aware, employees are required to utilize more and more digital devices to complete their tasks. Most patients I now see use not one, but two or three monitors. Vision care can determine appropriate vision prescriptions, of course it's critical for the employees' best vision and overall health. We all agree vision care is a key benefit for employees.

To add a little perspective for a doctor office, the doctor's office is typically created by accepting a mixture of different insurances that allow us to provide a standard quality of care and remain financially viable. Some reimbursements are higher and some are lower. Historically, Medicaid and Medicare are on the lower end of the scale. And historically, a lot of private insurances are a little bit on the middle or higher end of the reimbursement scale. Having this mixture is key to allow the doctor's office to function properly. You might have heard that if a hospital only examined patients with Medicare, most would not stay in business, as the reimbursement is too low to maintain the standard of care needed. Insurance mixture is vitally important.

I just wanted to make sure the Board understood that when we talk about a carve out vision plan, such as Vision Service Plans, Spectera, EyeMed, there's multiple different names, all of those to provide routine eye care benefits are not the typical insurance company. They do not have to reimburse based on standard insurance guidelines. Their reimbursements are typically very low end on the reimbursement scale.

Historically, vision care plan reimbursements like VSP is about 63% of what Washington State Medicaid reimbursement has been. In other words, VSP reimburses 37% less than what Washington State Medicaid reimbursement is. They also dictate which frames and labs are required to be used, which limits the freedom of choice for the provider and the patient. It requires a different method of submitting billing, which costs the offices more time to submit. And in 25 years of being in business, the reimbursement from these plans has virtually not changed. They have not and do not provide any COLA adjustment.

As a reminder, the PEBB Program change from Uniform -- or when they changed from Uniform being self-administered to being administered through Regence, the reimbursement for routine eye care was cut by 30%. That was about 9 or 10 years ago. The reimbursement went from high reimbursement to average reimbursement. This was accepted and the eye providers adapted. Since Washington State Government is the largest employer in Thurston County, the change that you're proposing will have a dramatic effect on all eye care providers in our county. In fact, the change will basically correspond to about a 50% plus decrease in reimbursement.

I just want to ask you all to consider the effect that's going to have on the eye care providers in Thurston County, particularly. In that, dealing with the COVID virus that we have right now, everything that's happening, and how it's going to impact our businesses. This is going to be a very significant hit. It will affect the quality of care that will be provided to all the members.

Thanks for listening. I appreciate you all for what you're doing. If you have any questions, please contact me

**Sue Birch:** Dr. Jeske, thank you so much for your public comment. I can assure you, we're keenly aware to the payer mix issues that you alluded to. I'm sure you're very aware too, that there's a move afoot in the United States about getting to the total cost of care or what true costs really are, and trying to even those out between the payers. We really appreciate your comments. It's so noted and staff have your name and contact information.

**Julie Salvi,** Washington Education Association. I wanted to make a couple of quick comments on the consolidation of plans, the last presentation. I shared some of this with the SEB Board but wanted to do the same with the PEB Board. So from the K-12 perspective, establishing the SEBB was a significant upheaval for many K-12 employees. There was an enormous amount of work and a lot of members did see improvements. But we're still working out the kinks with such a quick implementation timeline that was given for SEBB. We're still working through appeals from the first open enrollment as an example. So another upheaval anytime soon would not be welcomed by the K-12 community.

We also feel there are enough significant differences between the plans that there's not going to be an easy consolidation and we recognize that the Boards and the Health Care Authority are already doing a fair amount of leveraging between the purchasing between the two plans and what is offered between the plans.

Where I think the burden is the greatest is on the administrative side for the agency, which I do recognize. We would ask that of the options considered, could there be ways to create some efficiencies between the two boards, such as having more concurrent meetings when similar topics are being handled, which does happen a fair amount. So I want to share those comments with the Board. Thank you for your time.

**Sue Birch:** Julie, thank you. We've so noted your comments and we have your contact information.

### **Next Meeting**

May 28, 2020  
12:00 p.m. – 3:30 p.m.

### **Preview of May 28, 2020 PEB Board Meeting**

**Dave Iseminger**, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the May 28, 2020 Board Meeting.

Meeting Adjourned: 3:02 p.m.