Washington State Health Care Authority

Public Employees Benefits Board
Meeting Minutes

May 21, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:30 p.m. – 4:00 p.m.

Members Present:
Sue Birch, Chair
Greg Devereux
Yvonne Tate
Tom MacRobert
Harry Bossi
Carol Dotlich
Tim Barclay
Myra Johnson

PEB Board Counsel:
Katy Hatfield, Assistant Attorney General

Call to Order
Sue Birch, Chair, called the meeting to order at 1:32 p.m. Sufficient members were present to allow a quorum. Audience and board self-introductions followed. TVW livestreamed the meeting.

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

April 24, 2019 Meeting Follow Up
Dave Iseminger: At the April 24 Board Meeting, the Board voted 4-3 to pass the UMP Value Formulary resolution. As described in the past several meetings, both the PEB and the SEB Boards needed to act on and approve the same resolution before their respective June meetings in order for the resolution to be effective in the 2020 plan year. The SEB Board took action last Thursday and passed that resolution 8-0. Now that both Boards have passed identical resolutions, the agency is moving forward with implementation.

Carol, you asked for a detailed description of the exception process. We were almost ready to bring it today, but realized our pharmacy staff were unable to attend. We will bring it to the June 5 meeting so you can get any questions you may have answered. This work also jump starts our obligation under a bill that passed the Legislature requiring us to have a written description of the exception process by 2021.

Rachel Lowe provided public comment at the April 24 Board Meeting. I want to describe her foundational concerns, as we understand them. Ms. Lowe is a part-time faculty member at Bellevue College. Her work schedule is such that her PEBB Program benefits eligibility fluctuates. There's a two-year averaging rule where some people may be on the edge of eligibility that, depending on their work circumstances, may bounce in and out of eligibility. As she has engaged with the PEBB Program system over the years, when she's gained eligibility she's been presented with the need to make an affirmative election, waive, or be defaulted into the Uniform Medical Plan and Uniform Dental Plan. She successfully waived several times. Last year she missed that affirmative question to waive. She was defaulted into the plans. From that, she went through the eligibility appeals process.

You received client advice recently from the Attorney General's Office about HCA and PEB Board litigation on this appeal. Miss Lowe withdrew her appeal and the case was dismissed. That portion of her question is resolved from a legal standpoint. She also filed a rulemaking petition with the agency with specific requests about how she would like different rules changed within the eligibility framework. The response from the agency, statutorily, is due by the end of this week. We will meet that timeline to respond to the specific rulemaking request.

Ms. Lowe has raised several core concerns. I will bucket them into high-level pieces and identify which parts you have discretionary authority over, which parts are within agency administrative authority, and the parts within legislative authority.

Fundamentally, from those interactions and fluctuating in and out of eligibility, she's raised several different possible ideas. One would be to have this Board, which is within your power, change the decision that when somebody doesn't engage in enrollment process, they are defaulted into coverage. Instead, she proposes they are defaulted out of coverage.

This Board, years ago, made a decision that when somebody doesn't engage in enrollment processes after 31 days they are defaulted into coverage. It has a very long history in the PEBB Program. You could change course and when people don't engage they would be out of insurance coverage. That is within your policy decision making discretionary authority. We can engage in that discussion. There are strong views about that particular policy decision. It has been revisited a couple of times, based on larger pieces of litigation that have happened with the Program. If the Board wants to engage in that conversation, we will. But I would want specific direction from the Board that you want to revisit that, because of the historical nature of that particular policy decision, we would not bring that to you unless you specifically request it.

A second option Ms. Lowe suggested is when people waive benefits, they be allowed to permanently waive benefits instead of having to turn in a waiver form every time they

bounce into eligibility. There can be a proactive waiver for all subsequent eligibility determinations. We've looked at the statutory framework and believe the legislative intent of the statutes, in whole, leads that to be something that would need to be addressed in the legislative arena. It's not something we believe the Board or HCA can do, even if we think it's a correct policy decision.

A third area where Ms. Lowe raised ideas is when an individual receives their eligibility determination, there's often a lag. If somebody is deemed eligible at the beginning of October, they may start employment at the beginning of October. The agency may not realize the individual is benefits-eligible until the middle of October. They give that individual their positive eligibility determination. The individual has 31 days to elect. They turn in their form in the middle of November. It can be keyed for up to 90 days. There's a retro enrollment where all of the premiums are due in full from the original eligibility date.

Another suggested idea is to change the practice at which an individual is actually enrolled in benefits based on when their elections occur so there isn't this situation where an individual doesn't understand they have coverage they may or may not have been able to access, and may have had other insurance options. They may be in a situation of dual coverage. That is an area we also believe has some legislative underpinnings that would be challenging for the Board to take action on, or the agency to take administrative action on.

Greg Devereux: Would the suggestion in that instance be not to do retro enrollment?

Dave Iseminger: That is part of the idea. An individual would be prospectively enrolled in benefits instead of retro enrolled in benefits.

Greg Devereux: Thank you.

Dave Iseminger: The last area, which we are working to address, is providing transparent information about the financial implications of not engaging in the system and being defaulted into plans. At the last meeting during pubic comment, Miss Lowe handed me an enrollment form with language suggestions. We're looking at ways to address that, not necessarily the exact ways that were proposed, but to make it clear if you don't engage in the system, you would be defaulted into a plan and monthly premiums would be deducted from your paycheck and citing the approximate monthly UMP Classic's premium

We're working to include that information on enrollment forms, the enrollment guidebook, and within the worksheets the agency produces and agencies use to make the eligibility determinations, as well as the model notice we provide for an agency to use after it makes that eligibility determination. The agency must provide a notice to the employee with their appeal rights. They either have to use the worksheet we produce or the model notice. If we add it to both of those, it will increase the information provided to individuals when they get those eligibility determinations. We're working at cleaning up and providing more information in all of those communication materials. I'm sure many of you are aware there are a wide range of reasons that there are cycles that

happen in the PEBB Program. We are in the midst of doing that for materials produced for the 2020 plan year.

I also want to highlight assertions about savings in the system during the public comment last meeting because the Board is looking for money to increase the basic LTD benefit. The claim was there are thousands of dollars being wasted, taxpayer dollars, because of this default system.

This gets into how the funding rate is created. I'll remind the Board that foundationally, the funding rate includes assumptions about the population that is going to waive benefits, based on historical waiver practices. Whether an individual permanently waives, if that were an option, versus having to waive every time they were eligible, wouldn't materially change those fundamental assumptions. The funding rate represents an average that's needed to fund the entire system. Agencies and higher education institutions are obligated to pay the Health Care Authority that funding rate even if that individual waives benefits. These proposed changes would not result in additional relief within the employer funding rate that funnels through agencies. While there would be a financial impact from the individual's paycheck and what they're paying for those defaulted benefits, there wouldn’t be savings generated on the employer side.

The employer contribution, under the Collective Bargaining Agreement, is 85% on a tier-weighted average. The bulk of the funding coming through the program already has accounted for historical waiver practices. I want to be very clear that we do not believe any of the ideas proposed would result in material changes to the funding model that's been created for the employer-funding rate.

That was the issue described last meeting. The agency is working on the rule-making petition, to explain the various pieces of the ideas we believe need statutory amendments. We are making efforts to improve the communication piece in the various communications agencies are required to use, or that are given to employees, to make it clear about the financial implications of being defaulted into a medical plan.

Sue Birch: That was a very thorough presentation of follow up items. I want to ask for clarification because I wasn't there, did all five of these come from Miss Lowe?

Dave Iseminger: Miss Lowe had an eligibility appeal dismissed out of Superior Court, a rulemaking petition, and has engaged in correspondence with the agency and the Governor's Office with various ideas. I've synthesized the core of the entire package. These weren't all pieces specifically raised last month, and felt I could give you more of a holistic view, now that the Board and the agency aren't under a litigation context.

Sue Birch: Thank you, that's very helpful. Do Board Members have suggestions? I have some thoughts about asking staff to go back, do some work, and bring these issues back to the full Board so we can get more information and staff have more time to thoroughly present to us.

Tim Barclay: Would it be feasible, or how much disruption would it cause, to allow people a window of time that they could later decline coverage once the paycheck adjustment has caught their attention. For whatever reason, they didn't take action and

then we get down the road to the sequence of delays you talked about that are in the system. They notice when it hits their paycheck. If they immediately respond, is there a way we can give them a window to do that and undo the whole thing?

Dave Iseminger: This gets into the IRS Cafeteria Plan election rules. They are stringent in being able to retroactively adjust your elections mid tax year. Even in instances of mistakes or misunderstandings. I think that is why higher education has a two-year averaging rule to help smooth out the fluctuating eligibility that happens on the edge of the PEBB Program eligibility framework. Many people, including in Miss Lowe's circumstance, realize this right at open enrollment. Her out-of-pocket premium was limited to that fall, 3-4 month period. Then, during the annual open enrollment, she waived coverage effective January. When an individual notices this and it is close to the annual open enrollment, they're able to fix it prospectively. But unwinding it under the Cafeteria Plan rules presents significant legal risk.

Sue Birch: Having come now from a decade of trying to make sure that people have access and coverage, it does concern me that everything that's been proposed moves in the opposite direction. I feel like staff need to come back to the full Board with more thorough information if we're going to move in that direction. I certainly have a duty to remind everybody that access, coverage, and moving in the direction of keeping people covered, appropriately, and I understand the affordability piece, but I think we're going to need a little more information if we're going to dive into something of this detail of what's being requested. This is a significant step backwards to what we've been working on for the past decade.

Greg Devereux: I second what Chair Birch said. I think this opens a Pandora's Box and cuts coverage. The chaos it would create in many instances would be negative. I would be reluctant to go backwards. HCA staff time is incredibly valuable. I think there are other things more valuable than this.

Myra Johnson: My question piggybacks off that. How many members would this impact? I'm concerned, too, about actually having the coverage that's needed. I want to know how many people would say, “I need my money and I'm out.” I'm concerned about that.

Dave Iseminger: Even if we went down the path of these ideas, I would anticipate the agency would strongly encourage both the Legislature and Board to keep in place the requirement that you can't just waive coverage and not be insured. Right now, you can only waive if you have certain qualifying coverages. You can't waive to not have insurance coverage. We would still strongly encourage that piece stay in place.

When it comes to data, there are a couple of different ways to think about this. In our modeling, based on historical averages, there's around 7%-8% of the population that waive benefits. In theory, all of those people could be individuals who would want to waive permanently, if that were an option. The other way to think about it is how many people are defaulted into coverage? That has turned out to be a data point that does not exist in our data systems. At least not very easily, and the numbers that do exist are underrepresenting the default rate.

We did an analysis of data in 2018 that showed something close to 325-350 people that defaulted. It showed that only 16 people in higher education were defaulted. That seemed like an odd number so we started digging into it. It turns out what we are measuring as a default is after somebody makes a selection, there's 90 days for that form to be keyed. The default we're registering are people who after 90 days the system defaults them. But what happens, and this actually happened in Miss Lowe's circumstance, after 31 days, her agency keyed the default. That doesn't show as a default in our system even though she was defaulted into coverage. Layer on top of that, because of the Workday system and we don't accept empty fields in our interface, none of that data represents anything that's happening at UW, our largest employer.

We are looking at different ways to capture the data. We're trying to tackle that in the IT build we're doing on the SEBB Program side, which we hope to use in the PEBB Program in the future to capture more accurate default rates. As it stands now, it's proving to be quite elusive to get that data without a manual check of files. Even then, it would not prove to be very precise.

Sue Birch: Dave, your suggestion at this point is?

Dave Iseminger: My suggestion is, unless the Board wants something specific back, we continue to work on improving communications. We are going to change the enrollment form, the guidebook, the eligibility notice worksheets that we provide to agencies, and the model notice. All of the other components we've evaluated, with the exception of the Board's decision to default people into or out of coverage, are all things we think require at least some legislative discussion. We could certainly engage about those ideas with the Board, but it would also require, in most instances, legislative action. I could do a status update at a future meeting as to how our communication efforts are going. If the Board specifically wanted to engage in a conversation about what the default position is, we could do that. I'm sensing from at least two or three Board Members there's not a particular interest in going down that path. I want to make sure I understand correctly.

Harry Bossi: I'll be clear. I think the option of improving communication is the only one that requires any real effort.

Sue Birch: Thank you for that, Harry. We'll give staff the direction to proceed with the communications piece. If, over the summer, you were to receive some legislative interest in this, you could bring it back to the Board. I think at this point, I'm seeing folks don't want to go back and revisit these issues.

Dave Iseminger: The overlay of that eligibility appeal in Superior Court was challenging for the agency to engage with Miss Lowe. Now that the eligibility appeal is no longer pending in Superior Court, we can have more direct communications with Miss Lowe to make sure we understand everything I've said today is comprehensive of the concerns and ideas she's raised. We can talk through with her the more detailed challenges related to those issues and what we are able to do to address concerns she's raised.

2019 Legislative Session Debrief

Cade Walker, Executive Special Assistant, Employees and Retirees Benefits Division. Slide 2 – Number of Bills Analyzed by ERB Division. At the end of session, we completed 336 bill analyses. We were lead on 135 bills and support on 201 bills. Ninety bills had high impact to the agency and 246 had low impact.

Slide 3 - Passed Legislation – Bills signed by the Governor. 2SHB 1065 protects consumers from charges for out-of-network health care services. This balance bill issue is resolved after many attempts. It specifically relates to services received in an emergency setting. Anesthesiologist services. Things that a member wouldn't have any control over whether or not the provider providing those services are in network or out of network.

Dave Iseminger: That's a change across the entire commercial health insurance market and also includes the Uniform Medical Plan.

Cade Walker: EHB 1074 increases the legal age of sale for tobacco products from 18 years of age to 21 years of age. The SEBB Program and PEBB Program tobacco surcharge is assessed to members who attest to using tobacco products. That surcharge is not applicable to those who use vapor products. Given this legislation and the way they have couched the definition of vapor products, and including it in these tobacco increased taxes and increased age of accessibility for tobacco products, we think it warrants bringing to your attention as something that will come before you.

Dave Iseminger: Since you, as a Board, enacted a tobacco definition when the surcharges were required in 2014, we have been watching how various parts and levels of government and agencies are treating vaping products. At some point, there may be a fulcrum passed, and the world has changed enough that we would bring back to you a suggestion to modify your definition of tobacco products. This is another piece of that puzzle. We're not anticipating anything this Board season related to tobacco products and vaping. But we will be looking at this legislation and other things happening in the market in the past couple of months to see if there is something to bring back to you during the 2020 Board season.

Cade Walker: ESHB 1099 requires each health carrier to post on its provider network whether mental health providers are accepting new patients and publish certain information of its network accessibility. A bill we were in support of and our carriers are already in compliance with. We will continue to see enhanced accessibility and transparency related to mental health services in our state's health carriers.

Harry Bossi: On 2SHB 1065, was there a PEBB fiscal note or cost associated with this enactment on PEBB itself?

Dave Iseminger: Yes, we did produce a fiscal note. Our agency identified it as indeterminate, but our best estimates at the time were around a potential $7 million impact to the claims fund. We will be monitoring closely to see if that warrants any adjustments to the funding rate in future years.

Cade Walker: ESHB 2140. We bring this to the Board's attention because of the impacts it has on the SEBB Program population. 2140 primarily was adjusting the levies for K-12 school districts. However, included in that legislation was a carve out, or a delay, of the Educational Service District employees who are not represented. It carves them out from participating in the SEBB Program until January 1, 2024. It also made sure to include language that allowed permissible participation by the ESD non-represented employees in the PEBB Program. Again, that's permissive and there are some ESD employees currently in PEBB Program benefits as an employer group. They are allowed to remain and any other ESD non-represented employees could join the PEBB Program at their discretion. But as of 2024, they will be required to participate with the SEBB Program. That was the only eligibility change this session to the SEBB population's eligibility for benefits.

Tom MacRobert: Why wouldn't they automatically wish to join? Who are the non-represented ESD personnel? Are we talking custodians, or who makes up that population? What was the rationale behind carving them out?

Cade Walker: I don't have that information readily available. I could give you an estimate on the numbers that shows the split between represented and non-represented ESD employees. From our understanding, there's approximately 300 represented ESD employees and approximately 3,000 non-represented ESD employees. Approximately 9% of them will be participating in the SEBB Program, as of January 1, 2020.

As far as a rationale goes, we did hear from public testimony from the ESD representatives there were significant budget concerns. It's worth noting that their funding model in the ESDs is substantially different than the funding model for K-12 districts. ESDs are funded largely through purchasing of services from the school districts and not through the funding model that funds K-12 school districts in general. That issue was raised on several occasions related to the expense the ESDs would incur for benefits for those employees.

Dave Iseminger: Another part of 2140 requires a new legislative report from the agency to talk about the funding mechanisms of ESDs to help address the concerns related to their funding models and the SEBB Program.

Cade Walker: ESSB 5526 - Cascade Care/Public Option, requires the Health Benefit Exchange and the Health Care Authority, in conjunction with Office of the Insurance Commissioner (OIC), to develop standardized plans, contract with health carriers, and develop a plan for premium subsidies for individuals purchasing coverage on the Health Benefit Exchange. It's anticipated that the ERB Division will lend its expertise to acquire available commercial plans and assist in those efforts as the law continues to roll out.

Dave Iseminger: This doesn't directly impact the PEBB Program or the SEBB Program. We want you to be aware of commercial activity in the products and efforts HCA is doing in its portfolio, even if it doesn't directly impact you.

Sue Birch: I want to applaud your participation particularly, Dave, in the process. I think the Board needs to be aware as we have more defined tools and refined all payer

claims database information. We can look at precise costs. There is a benchmark now in Cascade Care. It gives us the opportunity to look to see if we really are driving the value proposition, and can we get costs down? It will ultimately help our book of business.

Cade Walker: 2SSB 5602 directs the Health Care Authority to administer family planning programs for individuals 19 and over, prohibiting discrimination on the basis of gender identity or expression. Health plans are required to cover certain reproductive treatment and services.

SSB 5889 protects communications between health carriers, providers, and adults covered as dependents on a parent or legal guardian's health insurance. If you have adult children covered under your health benefit plan, they have the same privacy and security as their parents, and the communications are sent directly to those members, not solely to the subscriber.

Slide 6 – Passed RX Legislation. E2SHB 1224 requires health carriers, pharmacy benefit managers, service administration organizations, and drug manufacturers to report certain pharmacy data to the Health Care Authority and provide advance notice of price increases on certain drugs. It also requires the Health Care Authority to provide an annual report to the Legislature on the data submitted related to pharmacy.

Dave Iseminger: As E2SHB 1224 made it through the process, it did not ultimately result in a mechanism for members of the public to look at the information, but the Legislature is able to see that information. It keeps the spotlight on the purchasers.

Cade Walker: ESHB 1879 requires health carriers to use evidence-based pharmacy utilization management criteria and have a clear and convenient exemption/step therapy exemption process.

Dave Iseminger: Carol, that is what I was alluding to in answering your question and being able to prepare that for members as we move forward with the UMP Value Formulary implementation. ESHB 1879 applies to plans that are in the market as of January 2021. We will be doing the steps necessary to describe the exemption process to members long before the law requires it.

Tom MacRobert: There were several bills initially that talked about transparency with the cost of pharmaceuticals. Those bills were fairly specific. They would have to report the rationale for why they were raising the prices of certain drugs. Based on what you said, I assume those bills did not happen, is that correct?

Cade Walker: That's my understanding as well.

Slide 7 – Newly Required reports for ERB. Today we were informed the Governor vetoed the requirement for HCA to submit the report for the Medicare eligibility retirees addressing the rising costs of prescription drugs and member premiums.

Dave Iseminger: I read the veto message today and it indicated HCA has effectively provided this report already to the Legislature. The veto message was about the

Governor's request for funding to be able to add supplemental lower cost Medicare options in the Medicare risk pool. It informed the agency to continue with efforts at looking at procurement activities for moving forward with presenting additional options, rather than using the time to do another report. It didn't veto the idea of moving forward with procurements.

Cade Walker: On February 5, 2020, a report is due to the Legislature regarding the total amount the SEBB Organization's billed for benefits and which districts and SEBB Organizations that did not submit payments by January 31, 2020.

Dave Iseminger: The way the funding mechanism works with K-12, it's similar to the PEBB Program area where the Legislature gives the employer funding rate to the home agencies. The Health Care Authority bills the agency for the number of eligible subscribers and the money comes to the Health Care Authority. It's similar, but more complicated in K-12. The money goes from the Legislature, to OSPI, to the district, and then HCA. A lot of that happens at the end of the month. The Legislature is interested in making sure the cash flow is up and running with the program. HCA is to report to the Legislature who is paying in a timely manner and who is not.

Cade Walker: By November 15, 2020, HCA is to report to the Legislature regarding the feasibility of consolidating the SEBB Program into the PEBB Program, with an anticipated start date of January 1, 2020.

Greg Devereux: Cade, does that imply there was an earlier feasibility study?

Cade Walker: In 2014, Senate Bill 5940 required HCA to submit a report that looked at various options for consolidation of K-12 benefits. I was the lead author on that report so I do know that report included various options for the Legislature to consider consolidating K-12 benefit purchasing into a single program, combined with the PEBB population. It considered a single PEBB Program with two different pools under the same jurisdiction of the PEBB Program. It also looked at a separate SEBB Program in different iterations. The Legislature's asking for a specific report related solely to the feasibility of SEBB as it currently sits being added into PEBB by 2022.

Dave Iseminger: Greg, there hasn't been a SEBB Program in order to do a specific study of the exact program with the PEBB Program. The concept of the various pooling options within a single program has been tossed around in a variety of different reports related to the consolidation of K-12 benefits. This is a specific report about combining SEBB and PEBB. We will be looking at that with the assumption of a consolidation by January 2022.

If this were to happen, it would require legislative action. The Legislature is asking if the the decision was made in 2021 to move forward, could it be in place in 2022. There will be many stakeholders between both programs, both populations, that will have an interest. HCA is working through the planning phases. We will bring this to as many stakeholders as we can to talk about the different pieces as we build that information for the Legislature.

Yvonne Tate: It's a good idea in terms of cost containment to combine the two. It's almost like they're doing duplicate work anyway. I know there's some variation, but from a cost containment and staff workload standpoint, it would be better.

Dave Iseminger: Yvonne, thank you for those comments. Having to keep track of which Board I'm talking to on which day would be a little easier. The prep work for Board Meetings would be a little easier. There are many pros and cons to go through. There certainly are some efficiencies, but other things would be lost having two programs with unique features consolidated into a single pool. I definitely appreciate from the administrative complexity, those comments. Having a single purchasing lever would be beneficial if it was one program. It would be easier from the contracting mechanism to be able to leverage that purchasing power.

Sue Birch: With all the transformation efforts in place and playing out in our state, other variables will play into this feasibility as well. So 2408, public option, movement on cost containment, many issues will play out. This is a long way away and I applaud staff for getting on it, but lots of work to do.

Cade Walker: The last report referenced is due by December 31, 2020 in regards to House Bill 2140. HCA will report on current costs and the health plans offered by educational service districts (ESDs), a comparison of those costs, the benefits of the ESDs that would participate in the SEBB Program, and report on the revenue sources for ESDs. We look forward to working with the ESDs.

Tom MacRobert: There were two bills somewhere in process and I'm assuming they didn't pass. One was to change the risk pool so the K-12 non-Medicare retirees would switch to the SEBB Program. The other was to add a non-voting member from the Office of the Insurance Commissioner to the Board. I'm assuming neither of those passed.

Cade Walker: Correct.

PEBB Finance 2019-21 Budget Update

Tanya Deuel, PEBB Finance Manager. I'm back to give you the final numbers of the 2019-21 Biennial Budget. On April 24, I gave you an overview. Today, I will share the final numbers.

Slide 2 – Funding Rates. The funding rates are the amounts paid by state agencies and higher education, per employee per month, to HCA for medical/dental/life/LTD coverage. These amounts were set for fiscal year 2020 at $939, and for fiscal year 2021 at $976. These amounts are adequate to maintain the current level of benefits, plus a few additional ones. We don't have significant concerns with any of these rates or the underlying assumptions.

Tom MacRobert: I am curious if the funding rate for 2018 and 2019 was $939 also.

Tanya Deuel: No. For the current fiscal year, it's $916 and I cannot remember what it was the year before.

Slide 3 – Medicare Explicit Subsidy. We had an exciting year when the subsidy increased from $150 to $168 for plan year 2019. In plan year 2020, there was an increase to $183. As a reminder, the language states, "or 50% of the premium, whichever is lesser." You will see those reflected when we come back and present you the premiums for 2020.

Slide 4 – Decision Package Funding. Third Party Administrator (TPA) administrative fees for the Uniform Medical Plan, the Uniform Dental Plan, and the Medical Flexible Spending Arrangement are $6 million. These accounts are where we need the spending authority to go and increase the amounts we pay these TPAs, mainly driven by the increased enrollment in these plans.

The Centers of Excellence decision package was $1.3 million. Again, the spending authority for the administration that goes with our total joint replacement and spinal fusion bundles, plus the potential administration associated with a third bundle in calendar year 2021.

Dave Iseminger: HCA does not have a specific service described for the third bundle. HCA is working on identifying that potential topic for this fall to go forward with procurement later this fall or early next year in time to launch for 2021. The funding to support the launch of that bundle was provided.

Tanya Deuel: The ERB Division staffing decision package is to staff Customer Service for retiree support, additional outreach and training, and increased responsiveness.

Carol Dotlich: I'm interested in, at some point, knowing how many patients are using these bundles and what their success rate is. If we could get data about that, I'd be very interested.

Dave Iseminger: Carol, we can bring back two years' worth of the total joint replacement bundle in place and so we have a more robust information about that. The spinal bundle launched January 2019 so as we get further in, we will bring information back to the Board. We can do an update on the Centers of Excellence Program.

Carol Dotlich: That would be very good. I've been talking to people about these bundles and a lot of folks are not aware. Anything we can do to make people aware of that opportunity would be good.

Dave Iseminger: We'll describe the communication efforts and outreach. We will include what the communication efforts are and how we proactively reach out to people that might be interested in the program.

Tom MacRobert: The $6 million TPA fees are an increase? What is the total amount of TPA fees paid per year?

Tanya Deuel: For the Uniform Medical Plan, approximately $60 million per year. I don't have the UDP and FSA data with me. They change every month based on enrollment. I'll get you the most recent closed-year numbers.

Dave Iseminger: Tom, when you look at our enrollment, every year we get somewhere between 2,000 and 2,500 members through natural growth in the program, or a new political subdivision wants to join. Occasionally there are larger groups that want to join and be part of the PEBB pool. Those numbers will be even higher. For the past few years, there's been natural growth. Every January there's a bump of about 1,000 to 1,200 new members. On a monthly basis, it's about 200 new members. There is this natural subscriber and member growth that happens. We have been trying to account for that in the spending authorities within the accounts.

Tanya Deuel: You might see this again next biennia that we may have to submit another decision package just to keep up with that increase in enrollment.

Greg Devereux: Is the $6 million driven mainly by the anticipated increase in the flexible spending accounts, under 50,000?

Tanya Deuel: No. That was included in a fund transfer from OFM that we'll get on the next slide.

Slide 5 – Other Budget Language. These were items funded through the budget but not necessarily through the decision package process. Nutritional counseling was the first one. Beginning in calendar year 2020, in the Uniform Medical Plan will increase the lifetime visits from three to twelve.

Dave Iseminger: I would refine. We'll bring to the Board a resolution to make that benefit change. That benefit change is within your authority but everything is teed up. Everyone agrees you have the financial ability to make that change if you wish.

Tanya Deuel: The long-term disability language allows the Board the authority to increase the basic LTD benefit through changes within the current benefit structure, meaning it stays cost neutral within the program.

Dave Iseminger: At the April 24 Board Meeting we started to set a framework for a discussion about how the timeline looks for potential changes, both within this benefit swap authority, as well as a potential future decision package. We will have another discussion about this authority before the June 5 Board Meeting.

Sue Birch: Dave, can you explain to the Board what we'll be doing to tie in our work and thought process about the new long-term care trust benefit, and how that impacts our LTD coverage? Far out into the future. Four years out, so I know we have plenty of time. Can you help the Board understand a little bit about that, as well?

Dave Iseminger: If you are following the news, Washington is the first state in the country to come up with a long-term care trust, which is setting up a new benefit structure. I believe it's at least five years out, because it doesn't show up in the four-year outlook for the budget modeling of the state. With that change it’s having a benefit funded by employee contributions. We're still working on understanding the details. HCA has already identified implications of this long-term care benefit on overall medical spend, and how we're accounting for that in our future trend assumptions, for example, as well as the interplay between this long-term care trust benefit and the disability

products. It does have a fairly long on-ramp, as Chair Birch mentioned. HCA isn't the agency directly charged with creating the Trust. We have a supporting role in administering the benefit, but we will be looking at the implication it has on the disability insurance market, as well as medical spend in future projections.

Greg Devereux: LTD, it says, "allows the Board the authority to increase the basic LTD benefit through changes within the benefit structure." Is that the benefit structure just of LTD?

Dave Iseminger: It's the entire PEB Board portfolio benefit structure. It's similar to the authority the SEB Board has now. We described at the last Board Meeting some of the options the SEB Board asked us to evaluate. That included decreasing the basic life insurance benefit in order to increase the basic LTD benefit, changing the benefit structure in a variety of different ways in the dental benefits in order increase the basic LTD benefit. As Tanya said, it's a cost-neutral swap within the entire portfolio, not just within the LTD benefit.

Tanya Deuel: The last reference is funding for the collective bargaining impacts. This $6 million funding will be transferred to HCA to fund the $250 Flexible Spending Arrangement contribution each calendar year for those represented employees who make less than $50,004. Greg, the $6 million includes the associated administration costs.

Dave Iseminger: In the budget language, the tobacco surcharge description is slightly different. We will bring you a resolution in June for action in July. Previously, the budget provision said the tobacco surcharge had to be exactly $25. The budget language just signed says it has to be at least $25. You have discretion as a Board to set the surcharge amount. It can't be lower than $25.

Eliminating Hepatitis C Virus in Washington State

Emily Transue, ERB Associate Medical Director, Clinical Quality and Care Transformation. Slide 3 – Background. Hepatitis C (HCV) is the leading cause of infectious disease death in the United States, exceeding deaths from all of the other 59 reportable infectious diseases combined. It's hard to express the scale of the importance of this disease.

Our estimate is about 60,000 Washingtonians are currently infected. It's difficult to get an accurate estimate because most people who have this disease are not aware they have it, typically, until complications develop. To put those numbers in perspective, for the state and for UMP and PEBB, roughly 25,000 are within a state system, 20,000 in Medicaid, 2,000 in UMP, and 1,000 in Kaiser. There's another 3,000 within state systems like the Department of Corrections.

HCV is a curable disease. In 2012-2013, a new class of medications were developed that can eradicate this disease for most people. So more than 95% of people treated with the new highly effective medications can achieve a sustained virologic response, which is ID-speak for "cure." We're always a little careful in our speech.

The Uniform Medical Plan has treated about 477 members for this disease over the last four years. We estimate we would treat about 63 a year.

Slide 4 – Governor Inslee's Executive Order directed HCA to enter into an agreement on behalf of all Washington State covered lives to contract for these direct-acting anti-viral medications, again, impacting about 25,000 lives. We were instructed to pursue a not-to-exceed arrangement for the Medicaid covered lives, and a larger discount for the non-Medicaid lives. A not-to-exceed arrangement has been referred to as a Netflix model, or a modified Netflix model. You pay a certain amount and then use it as much as you want. It's not entirely accurate, but generally the Medicaid arrangement will be a strict amount, and then a relatively low incremental cost for people who are getting coverage. On the PEBB Program side, there will be a deeper discount than we currently have based on this agreement. The contracted vendor must also partner with us on a public health campaign.

Slide 5. The second part of the Executive Order involves the Department of Health. Part of the Executive Order is about purchasing drugs and the other part is about a public health outreach effort, with the goal of identifying and treating all Hepatitis C-positive Washingtonians. It's an ambitious and exciting, but achievable goal. This is happening under the auspices of Hepatitis C-Free Washington, which is shepherding community and provider engagement efforts. They have three major committees making recommendations around clinical strategies. What does the health delivery system need to do around data and strategic information, capturing those screened, capturing everyone with a positive diagnosis ensuring they get treatment to achieve cure, community services, and links to testing and treatment. How do we ensure those working closely with at-risk populations are doing that outreach and linking people into treatment, including those least likely to seek care.

Slide 6 – Current Status. On April 25, we announced an apparently successful bidder for this contracting effort, AbbVie. Currently, we're in negotiations to achieve that contract. The Hepatitis C Free C committees have developed preliminary recommendations that will soon be out for public comment and then finally approved. Those committees have a very broad range of stakeholders involved, providers, community organizations, patient advocates, local health jurisdictions, the public health teams, etc. Beyond that, in the future we will have the potential to expand this beyond the initial scope of UMP and other publicly funded programs to include fully insured lives. This also could expand to other states and other purchasers.

I talked about the efforts the apparently successful bidder will be involved in, in terms of the public outreach. They have a testing van that goes to places like motorcycle rallies where there's a high concentration of people who might be at risk, does on-site testing, counseling, links people into treatment. They have support programs for providers who might not be comfortable treating this condition, to make sure that they are trained in how to do so appropriately and get adequate support if they have questions. They also have connections with social media outlets. This will be a multi-faceted campaign.

For the member, there won't be a lot of change. Members in the middle of a course of treatment will continue that, even when the contract goes into place. The preferred agent will change once the contract goes into place. If all else is equal, we would be

starting with the AbbVie medication. There is currently coverage essentially for all patients who have Hepatitis C. The current requirement is that treatment must be done by a specialist, which will probably be relaxed to make sure other providers comfortable treating this disease are able to do so. The current copay is 10%, up to a 25% copay. UMP has an out-of-pocket member cost of $150 for a 30-day supply for most specialty drugs. This is a specialty drug, so those limits won't change. There is a potential for a significant cost savings. These are extraordinarily expensive drugs and the total cost of the program will go down. But, since the member costs are already limited, there won't be much of a change for them directly.

Carol Dotlich: You said patients are already undergoing treatment. They're going to stay on their same medication? They're not going to have to switch to the AbbVie brand?

Emily Transue: Absolutely not.

Carol Dotlich: Good.

Dave Iseminger: Emily, is AbbVie a company, a brand, a drug name? Can you clarify?

Emily Transue: AbbVie is a drug company that produces Hepatitis C drugs.

Sue Birch: What is the name of AbbVie's drug?

Emily Transue: Just as he said that it flew out of my head. I knew you were going to ask, and I'm so sorry.

Yvonne Tate: Are they still primarily targeting the baby boomer generation?

Emily Transue: There are a group of at-risk folks for this disease, and baby boomers are one of them. Demographically, and as an age band, the baby boomers are most likely, partly because they didn't test the blood supply for Hepatitis C until a test was developed. That group was most likely to receive a blood transfusion during that period. Additionally, this is a bodily fluids transmitted disease and higher rates of drug use in the 1960s may be a transmission factor. The primary areas of focus include baby boomers, the IV drug use community broadly, and a number of other pockets. It's not exclusive to that, but in terms of outreach to people who may not know they are at risk, that continues to be a significant population.

Sue Birch: I just want to commend Dr. Transue and the team that pushed this forward about a year ago, because Australia has successfully embarked on eliminating Hepatitis C, and Louisiana was just a few days ahead of Washington in announcing their plan. This is extraordinary work globally. The fact that our state is leaning in to try to eliminate this disease, and dent it like was done with HIV/AIDS in the past, with getting that disease under control, it's remarkable.

Several of us were in Washington last week and our federal partners were considering how they might credit us with some shared savings on this work, if we can figure out

how to do that extraordinary complex calculus. I know you inherited this from Dr. Lessler, but you've been part of this since the get-go. This is truly a standout effort, again, for Washington. Thank you all for what you're doing. You can see the beauty of our purchasing power and alignment in working together. This will help reign in costs because I believe we will get a much better deal for our state for this very extraordinarily expensive drug. So thank you.

Emily Transue: The long-term cost savings and the short-term cost savings from this should be substantial. The long-term cost savings in terms of people not needing liver transplants and treatment for chronic liver disease and cirrhosis, the impact on cost and even more importantly on people's longevity and quality of life is extraordinary. This is really a once-in-a-lifetime opportunity, and it's amazing to get to be part of it.

Sue Birch: I believe Washington in 2020 is going to be celebrating its success around HIV/AIDS and getting those viral loads under control.

Emily Transue: We've had tremendous success with programs looking at identification, tracking, and ensuring people who are treated achieve lowering of their viral rates among other things, to a point where they can't transmit it to someone else. That's a harder task in HIV, where you have to keep somebody motivated to do that for the rest of their life. The thrilling thing about Hepatitis C, it's a couple of months and then you can move on.

Sue Birch: You're going to take that good public health effort work and move into our next disease elimination. That's great. Get this one done. Awesome. Thank you so much.

Emily Transue: We've learned a lot. Thank you.

Eligibility and Enrollment Policy Development

Rob Parkman, Policy and Rules Coordinator, Employees and Retirees Benefits Division. I am introducing three policy resolutions today. PEBB 2019-01 modifies the resolution that passed last year dealing with CHAMPVA deferral eligibility. PEBB 2019-02 addresses retiree term life insurance for future SEBB Organization retirees. Resolution PEBB 2019-03 came in late and it's an additional type of error correction we're seeing from agencies.

Slide 4 - Proposed Policy Resolution PEBB 2019-01 – Retiree Insurance Coverage Deferral – CHAMPVA Survivors. Beginning July 17, 2018, enrollment in a PEBB Program health plan may be deferred when the subscriber is enrolled as a retiree, or survivor of a retiree, who is enrolled in the Civilian Health and Medical Program of the Department of Veteran Affairs, CHAMPVA.

Policy considerations. The Board passed a policy resolution last year that allows deferral and a PEBB health plan enrollment when the subscriber is enrolled as a retiree, or a dependent of a retiree, beginning July 17, 2018. Upon a closer look last year, we realized survivors needed adding and dependents removed because dependents are no longer eligible as a dependent when the retiree dies. They are eligible as a survivor.

Dave Iseminger: We realized there was an edge of the eligibility framework misidentified and we meant to include all survivors, not just dependent survivors. Fortunately, nobody has qualified under that part of the provision so we feel comfortable putting the retroactive date. Many of you will remember there was a long discussion about retroactive/perspective/instantaneous implementation dates, but here they have not been used. We thought it would be nicer to clean it up.

Rob Parkman: As modified, only the retiree or survivor of the retiree may defer coverage. PEBB Program health plan coverage will defer prospectively, one modification to the resolution that passed last year.

Slide 5 – Proposed Policy Resolution PEBB 2019-02 – SEBB Employees and PEBB Retiree Term Life Insurance Eligibility. Beginning January 1, 2020, an eligible school employee who participates in SEBB Program life insurance and meets the eligibility requirement for PEBB Program retiree insurance coverage is eligible for PEBB Program retiree term life insurance.

Policy considerations. This policy addresses PEBB Program retiree term life insurance eligibility for an eligible school employee enrolled in SEBB Program life insurance who also meets requirements for PEBB Program retiree insurance coverage. Currently, only an eligible employee who participates in PEBB Program Life insurance is eligible for PEBB Program retiree term life insurance. This would include a school employee enrolled in full PEBB Program benefits under a contractual agreement with the HCA at this time.

If passed, this resolution will allow SEBB Program subscribers that have life insurance through the SEBB Program to have access to the PEBB Program retiree term life insurance. The ERB Division Portfolio Management and Monitoring team and MetLife considered the possible increases to enrollment in the PEBB Program retiree term life insurance due to the implementation of the PEBB Program during previous negotiations. This was included in the procurement of the PEBB Program life insurance product at that time.

Dave Iseminger: This would be an example of one of those administrative complexities of having two programs. Essentially, people can only get PEBB Program retiree life insurance if they've been part of the PEBB Program. Now, since we have a separate program, same vendor, and same benefit design, we recommend this Board allow people to access your PEBB Program retiree life insurance benefit when they have access to your sister SEB Board's benefits. We don't anticipate a change in rates as a result. The Board must establish eligibility because you have jurisdiction over the eligibility of the retiree life insurance benefit in your portfolio. We're recommending you honor and recognize the SEBB Program's life insurance benefit as qualifying just like a PEBB Program life insurance benefit.

Greg Devereux: If the two programs remain separate and this goes through, SEBB Program folks would have access to the PEBB Program benefit.

Dave Iseminger: Greg, to clarify, as of 2020, there are completely separate life insurance benefits that happen to be identical with the same vendor with different

eligibility requirements for accessing the benefits between the two programs. Under the current model, with no changes, as a result of the retiree risk report that was submitted and we discussed here with the Board, and no changes to consolidation as envisioned in the next legislative report, when people transition to the PEBB Program as retirees, they have access to PEBB Program retiree coverage. If this didn't pass, when K-12 employees transition into the PEBB Program as retirees, they would only have access to medical and dental. Now you would say, “and you also have access to retiree life insurance.”

Greg Devereux: Is there a SEBB retiree program?

Dave Iseminger: No. There are no retirees in the SEBB Program. All K-12 retirees are in your program. That's why you have two voting members - Tom and Carol and one non-voting member named Myra.

Greg Devereux: Okay. Thank you.

Rob Parkman: Slide 6 – Proposed Policy Resolution PEBB 2019-03 – Error Correction Incorrect Information. If an employing agency provides incorrect information regarding PEBB Program benefits to the employee and they relied on that information, the error will be corrected prospectively with enrollment and benefits effective the first day of the month following the date the error is identified. The Health Care Authority approves all error correction actions and determines if it warrants additional recourse.

Policy considerations. Employing agencies must correct eligibility and enrollment errors they caused prospectively unless the Health Care Authority determines it warrants additional recourse. Recourse may include reimbursement of dollars paid on claims or dollars paid for other coverage by the employee while the error was in effect. It may also include retroactive enrollment.

Greg Devereux: The word “prospectively” jumps out at me. What is the current system when someone detrimentally relies on the agencies or information. What happens now? Is it prospective or is it retroactive?

Rob Parkman: It goes into the appeal process if the employee appeals based on incorrect information actioned.

Greg Devereux: How often do people in the appeal process get retroactive coverage? I assume you don't have an answer now. To me, that's an important question to answer.

Dave Iseminger: That is a great question and we’ll follow up. Last Thursday we had a similar resolution with the SEB Board, and a similar question came up about “prospective.” We clarified when an error is identified, the urgent and immediate issue is to fix things going forward and then sort out what is appropriate. We may amend the last sentence and bring back a slightly revised version at the next meeting.

The SEB Board asked us to change the last sentence to include, “if additional recourse including retroactive enrollment,” to be very clear that the Board is saying there may be

instances where retroactive enrollment is warranted. It's set up so the Health Care Authority approves all error corrections. We have over 500 employers and closer to 800 employers with the SEBB Program. We want general consistency across both programs. In some instances, it will be coverage. We want to be vigilant about making sure there's consistency to ensure some employers aren't being more generous than other employers. We'll get you that information and revise the last sentence in a way that gives an illustrative example that retroactive enrollment would be allowed.

Carol Dotlich: I, too, was concerned about the "prospectively" word. I was concerned about the idea that somebody could just decide one way or another about the error correction action and additional recourse, if it's warranted or not. I think it's really loose language and leaves the consumers not in a good place. I would like to see improved language here.

Dave Iseminger: We will definitely add that in, Carol. The goal is to identify and fix the error going forward, then everybody huddle together and talk about appropriate action.

Myra Johnson: Will there be a timeline that the consumer would receive that information because it says we'll fix it as fast as possible and we recognize the error. But will they be given a timeline of how much time they wait to listen to hear when it will be fixed for them in the past?

Rob Parkman: They'll be enrolled prospectively. But, immediately, we have a group that works, once we get the facts in, many of the facts are very different in these situations. We gather all the facts and then usually with the employer/employee we make some decisions on the recourse.

Dave Iseminger: I think, Myra, what we'll do is bring back follow-up information about timelines for error correction when we bring back this resolution. That will provide the Board a better understanding as to the pace at which we address the retro situations. I think that's the heart of what you're asking. When a decision is made, it always comes with appeal rights. Even the decision about what HCA's authorizing an employer to do comes with appeal rights.

Sue Birch: Dave and Rob, you might want to think about a flow diagram that shows how those processes play out because this has been rectified in appeal. It's not like there haven't been corrections made. Dave's going to lay that out for us.

Greg Devereux: I understand, Dave, there have been many appeals. I've been a part of many of them when people brought things forward. I think it's a huge change to have the word "prospective" because I understand consistency is important. But all of a sudden it feels like we're substituting an appeal process for "okay, everything's going to be prospective except there may be some exceptions." I get from the employer's standpoint you want to fix it and move ahead. From the employee's standpoint, they want to know when did I have coverage and what am I going to have to pay? Those are two very different perspectives. I understand the desire, but that word really stands out and has broad implications.

Dave Iseminger: We are looking for Board feedback as we refine things to bring back to the Board. I'm curious if there is additional feedback; but we'll take a look at that point, the questions that Greg, Myra, and Carol have raised about bringing back more information and the process flow that Chair Birch asked for. Are there other things?

Carol Dotlich: My other concern is you become corrected effective the first day of the month following the date the error is identified. If my error was identified on May 5, there is going to be no fix until June 1, right? Is that what I'm understanding from this language?

Dave Iseminger: There would definitely be a fix as of June 1. That doesn't mean there wouldn't be a fix that addresses the month of May. Getting back to Greg's question about how clear, or if it's putting up too rigid of a guard rail to say the word "prospectively, but, effectively, what happens is all medical effective dates are pushed to the first of the next month. It's acknowledging, under the current system, when you are identifying an error mid-month, the medical effective date for benefits is always the first of the next month. It's just aligning with the other core effective date that's a central pillar of eligibility within the PEBB Program. Benefits are always effective at the beginning of the month.

Carol Dotlich: I understand that. But if there was an error and I'm supposed to be covered and I'm not, and it's more than two weeks before the first, what's happening to my coverage between May 5 and June 1?

Dave Iseminger: That's where the error correction recourse comes into play. This entire journey the PEB Board rules has embarked on for the last four or five years is to try to put guardrails, timeframes, and processes around that very question. In some instances, it was always addressed prospectively and it was sorting through and building the process by which an individual could say, "these are the reasons why I need this recourse" that isn't just prospective. It also involves retro. This would not be limiting any ability to address coverage in May. It would guarantee the coverage is there as of June in that scenario, then going through the error recourse process and clarifying whether the retroactive enrollment for May or more months, depending on how long the error had been in place, is appropriate.

Sue Birch: As you bring information forward and show us the flow diagrams, you'll be showing people the retroactive action you've been taking through the appeal process, and how you're codifying this going forward so the client/member/patient isn't penalized. I think your presentation in the future needs to include those components, because I hear questions from Board Members. I think staff get a sense of what we're looking for and we look forward to getting that information.

Dave Iseminger: Error correction is one of our favorite topics, as it is for all of you for four years. We'll bring back more information about this policy and additional information.

Rob Parkman: We'll incorporate Board feedback today on the proposed resolutions and bring them back for action at the June 5 Board Meeting.

Dave Iseminger: We will see if the Board's ready to take action on June 5, pending the information we provide. Even if you aren't ready on one resolution, if you're ready on the other two resolutions, you can take action on those resolutions.

SEBB Program Update

John Bowden, Manager, School Employees Benefits Section. There is a tremendous amount of work happening. We have four months until the SEBB Program open enrollment and seven until benefits go live. Today I want to focus on preparing for open enrollment.

Slide 2 – SEBB Program Funded. In the operating budget, the Legislature approved the Collective Bargaining Agreement the Labor Coalition set forward. The Legislature funded the SEBB Program with benefits materially similar to the PEBB Program and in accordance with policies adopted by the SEB Board. One piece in particular is the wellness program, SmartHealth. The Legislature also included surcharges similar to, or the same as, the PEB Board, $25 per account per month if the employee or dependent uses a tobacco product. There is a $50 surcharge if a spouse or state-registered domestic partner has access to employer-based coverage but waives, and then is enrolled in the SEBB Program.

Slide 3 – School Employees Moving from PEBB Program to SEBB Program. We've already discussed earlier today House Bill 2140 regarding Educational Service District (ESD) employees. All current K-12 employees in the PEBB Program from school districts that are fully or partially in the PEBB Program will transfer to the SEBB Program on January 1, 2020. Represented employees within the ESDs will also be moving to the SEBB Program. The non-represented employees will stay within the PEBB Program until January 1, 2024. ESDs can either join or continue their participation in the PEBB Program until December 31, 2023, barring any other legislative changes. All retired school employees are staying in the PEBB Program for now. The Legislature did not act to move the retirees into SEBB.

Sue Birch: What is the retired school employees' count?

Dave Iseminger: There's about 50,000 covered lives within the retiree portfolio from K-12. I should say there's about 100,000 in the portfolio and it's about a 50/50 split between K-12 and state agencies/higher education. I was speaking about the subset and not the whole.

John Bowden: Slide 4 – SEBB Procurement and Contracting. Legislation that created the School Employees Benefits Board directed the Board to leverage as much as possible from the PEBB Program. The SEB Board requested HCA submit a Request for Proposal (RFP) for fully insured medical, standalone vision, and long-term disability.

The SEB Board elected to leverage the PEBB Program for self-insured medical (UMP), dental (UMP Dental), and life and accidental death and dismemberment (AD&D).

Dave Iseminger: I will just give you a quick tour of where there are differences. Life insurance and AD&D is identical. For dental benefits, fully insured and self-insured are identical. Self-insured medical is almost identical. The SEBB Program in their versions

of Classic and CDHP have 16 annual chiropractic visits instead of ten. They changed to number of therapies to 80 combining physical therapy, speech therapy, neurodevelopmental therapy, and occupational therapy (PT/ST/NDT/OT), whereas in PEBB it's 60. They've also established another version of UMP Classic.

The long-term disability benefit structure is extremely similar, but because of the occupational differences of school employees versus public employees, the same amount of money makes a slightly richer benefit. The SEBB Program version of the basic benefit, with same dollars spent, is $400 a month instead of $240. It's structurally the same. The difference in the benefit is the occupational load differences between the populations.

Vision is embedded in PEBB benefits. We're going to talk about that in the next presentation versus a standalone in SEBB benefits.

In fully insured medical, the SEBB Program has two addition carriers beyond what the PEBB Program has that are still in the running for contracts. The SEB Board has not made its final decision about which carriers, which plans, where they are, or how much.

John Bowden: Slide 5 – SEBB Program Employer Medical Contributions (EMC). In the PEBB Program, the employee contribution is 15% of the tiered weighted average.

Slide 6 – 2020 Employer Medical Contribution (EMC) and UMP Employee Premiums Based on Final Not-to-Exceed Rates. Within the SEBB Program, it's done differently. In the Collective Bargaining Agreement, the SEBB UMP Achieve 2, which is similar to UMP Classic, has an 88% actuarial value, which is the benchmark plan. The employee pays 15% of that plan at each of the tier levels. The employer pays 85%.

In the SEBB Program, the dollar amount generated from that 15% of the total premium, under "Employee Only," is what the employee pays, 15% of $679. 85% is the employer's medical contribution, 85% of $679 is $578. The employee's contribution is $101 for UMP Achieve 2.

Under the SEBB Collective Bargaining Agreement, that $578 employer contribution is the same for all plans. On the plans below Achieve 2, again you see the $578. The employee contribution as percent of the total premium is listed in the far right column on Slide 6. The percentage varies depending on the plan.

Since we haven't finalized the contracts and rates with the other carriers, we are unable to show the percentages for those plans. They could go above the 15% and some will. We'll see a variety of percentages on the employee's contribution.

Dave Iseminger: We wanted you to see what the rates are looking like on the SEBB Program side. If you line them up with today's existing rates, in a month or two you'll be able to line them up with the PEBB Program's 2020 rates and see they are generally comparable. The hypothesis was large employer groups start to look alike. There are slight differences and they bear out in the rates. We're all in the same ballpark when it comes to rates.

Slide 6 also highlights one of the other benefit differences between the PEBB and SEBB Programs. The PEBB Program has four versions of UMP. UMP Classic is the equivalent of UMP Achieve 2, with the exception of the chiropractic and PT/ST/NDT/OT limits I referenced. The UMP High Deductible is the equivalent of your UMP CDHP. UMP Plus is the exact same piece that is the UMP Plus within the PEBB Program. The SEB Board has added UMP Achieve 1, which is similar to UMP Classic, but the deductible and out-of-pocket maximum drops to an 82% actuarial value. The SEB Board was interested in adding another slightly lower AV plan to the portfolio because of the wide range of salaries and incomes that exist across classified and certificated staff within the K-12 system. They wanted to provide additional affordable options and still have a robust benefit at a lower AV compared to UMP Classic.

Sue Birch: Can you say more about the deductibles on the UMP Achieve 1?

Dave Iseminger: I will bring that information back because it's nuanced enough I can't remember it, but they are higher out-of-pocket maximums and deductibles. As we go forward in learning things from the SEB Program, we will present a variety of different opportunities over the next couple of years to this Board of things that you may want to leverage. There may be another UMP version you want to copy and bring into the PEBB Program. We will definitely give you information about UMP Achieve 1.

Harry Bossi: I'm interested in the tier cost. Why isn't the employee, spouse, and family 2.75? Why is it three? Is that different than the PEBB Program?

Dave Iseminger: Yes, it is different in the PEBB Program. There are things to keep track of between the two programs. That is yet another one. The Tier ratio is different when it comes to that Tier 4 rate. Now in the K-12 system, there is currently wide variability when it comes to the Tier ratios. John, in a previous incarnation of his work at JLARC, did a study related to the tier ratios that exist. It showed a robust unaffordability of being able to add dependents. The Legislature, in the consolidation of the SEBB Program, said the ratio shall not be more than 3:1. The SEB Board could have set any number it wanted, just like you could. Megan Atkinson, our CFO, would say, "there is no perfect tier ratio." You're talking about the amount of money needed in the system, and exactly how it's being spread across different enrollment situations. It's not a perfect, mathematical equation.

The SEB Board could have condensed to 2.75 at the family ratio. In fact, they asked about information related to that. The concern the SEB Board had was there's so much change and shock going into the K-12 system at the same time, they were not comfortable to further compress beyond 3:1. It was a deliberate conversation at the SEB Board and there is a long history of the tier ratio compressions within the K-12 system. Changing to 3:1 was a significant enough advancement and to go to that extra quarter people weren't ready to do that.

Harry Bossi: Past experience in open enrollment meetings had employees saying, "my neighbor has seven kids and I only have one. Why shouldn't they pay more?" The feedback we got from actuaries was it doesn't matter. In a large group, one or seven is going to average out to one. Whether you believe it or not, that's what the numbers say. I thought that would hold true, that if it's 0.75, I've got however many

children/dependents, and I was single but then I added a spouse, why would I go up to three instead of 2.75? It's certainly their decision and I'm sure it was a carefully thought-out one. It's different than what we're used to.

Dave Iseminger: Harry, it definitely doesn't change the truism that the actuaries really show the number of kids washes out in the grand washing machine. But the SEB Board was worried about just that extra little piece. You will have some interesting scenarios that individuals often have to think about in the K-12 system. If there are dual eligible spouses that are married and one of them waives to be on the other and they have a child, then they're going to pay three times, which would be different if they stayed on separate accounts and only one of them enrolled the child. Then they might pay 2.75. Then you start thinking about the out-of-pocket maximum, combined family deductibles, and determine its worth? That was a very deliberate conversation. Yet another difference between the two programs.

Greg Devereux: In our system, the weighted average is 85%/15%. The 15% for Achieve 2 is the benchmark. But what would be the weighted average of everything in their system?

Dave Iseminger: We can't produce that weighted average until after the enrollment occurs. That is another fundamental difference you see between the two programs here, is the PEBB Collective Bargaining Agreement is a 85%/15% split of a tier-weighted average. We have the enrollment mix when we started the collective bargaining process for the PEBB Program. PEBB Program benefits have been in existence for years. There was already a general understanding of the enrollment mix. That doesn't exist yet in the SEBB Program and won't exist until after November 2019.

The SEBB Collective Bargaining Agreement was a benchmark plan to apply on all employees instead of a tier-weighted average. That means the number is fixed. The $578 is a fixed amount across all tiers in this table. If you elect a richer plan from the benchmark, your employer contribution won't go as far. You'll have a greater share as an employee if the premium split. If you pick a lower AV plan, or a less rich plan compared to the benchmark, your employer contribution goes further. Calculations will eventually be done to see what the actual mixed average would be. We aren't there, yet, Greg.

Greg Devereux: So, potentially, the Legislature may be putting in more than 85% for the overall amount even though it's $578.

Dave Iseminger: I don't think that's the case, Greg. It's a benchmark of, "here are the number of eligible employees and, for each employee, the fixed dollar amount is 85% of an 88% AV plan." It's whether that goes further.

Greg Devereux: Of one plan. But if you look at the employee contributions, 15% is only a benchmark for one plan. Presumably, the weighted average would be less than 15%, which by definition, means the employer share has to be higher.

Dave Iseminger: Greg, I think you're saying if everybody enrolls in UMP Achieve 1, then the state will have paid more than 85%. If the enrollment mix ends up that, then

certainly that could be the end result of the most recent Collective Bargaining Agreement.

John Bowden: If an employee picks a plan with a premium of $800 and you subtract the $578, the employee will pay closer to 25%, $200 out of the $800.

Dave Iseminger: It's possible, Greg, when the enrollment mix comes in, the money that was promised on the 88% AV benchmark plan will go further than people had anticipated, based on what individuals elect under the current bargaining agreement. Both sides will evaluate that in future collective bargaining. There was no way to start the SEBB Program using a tier-weighted average when the data does not exist for the plans that didn't exist. The procurements hadn't even been completed in the SEBB Program for fully insured. The only thing available at the time of collective bargaining was the framework of these four plans. That was where the SEB Board was in its journey. They established the authority for four self-insured plans just in time for collective bargaining. That was the best information that could be used to craft an agreement in time for the legislative session.

Sue Birch: We simply didn't have the historical data. When we have it, we'll be examining it. We will be revisiting that over time, I'm sure.

John Bowden: Slide 7 – SEBB Program Website and Member Communications. Communications were created for current PEBB Program members transferring to the SEBB Program. We're talking with the SEBB Organizations that have employees enrolled in the PEBB Program and we're sending information to those employees to let them know what the SEBB Program is all about and what their benefits will look like. We are sending toolkits to the employers to help in that transition. One mailing was sent to members letting them know what's happening. They will receive additional mail in September, including the enrollment guide.

Slide 8 – First SEBB Program Open Enrollment. The SEBB Program open enrollment is October 1 through November 15. Employees are getting extra time because of the amount of change they will experience. The current plans of many of the employees will not be available in the SEBB Program. They need to determine where their current provider is located. There is overlap in the provider networks so we're thinking the majority of them will be able to find their provider.

HCA will provide trainings to the districts' personnel/payroll staff in August and September to get them familiar with the changes in order to assist their employees. There will be a toll-free line for technical program support, ongoing phone and secure email support from HCA Outreach and Training staff to help with the process. The required tool for enrollment is through SEBB My Account. There will be limited paper enrollment possible for those employees without access to computers or need an enrollment form in a different language.

Slide 9. School employees will receive newsletter mailings and the enrollment guide. There will be a virtual benefit fair and about a dozen live benefit fairs around the state. There will be a plan selection support tool available called ALEX. HCA will also provide "how to" videos for employees to become familiar with SEBB My Account.

Dave Iseminger: We're piloting the ALEX tool in the SEBB Program. HCA will use the SEBB Program experience and evaluate how it went to determine if we go back to the Legislature and ask for a permanent funding stream for both programs to help people select and understand the benefits before them. With all the changes occurring in the K-12 system, if an employee has access to 17 plans, we want to make sure there is a tool to help in making a decision. We'll evaluate after open enrollment to see if it makes sense to bring it to the PEBB Program, or not use in either program.

John Bowden: Slides 10 – 12 – SEBB My Account. These slides show you what SEBB My Account will look like. It allows you to log in as a benefits administrator or an employee. You can make benefit selections, do attestations, and upload verification documents for dependents. If you have a smart phone, you can take a picture of a birth or marriage certificate, upload it, and have it approved without having to bring in the document. You can make the changes for special enrollments, print a statement of insurance, and access supplemental coverage.

Dave Iseminger: Many of you are familiar with PEBB My Account. It does not have the same functionalities as the SEBB My Account. We were reticent to have an initial enrollment of 130,000-140,000 people with paper, so we used the framework of PEBB My Account and once you're in the system, you're allowed to make certain types of changes. We took that IT system, copied it, and made a vast number of improvements to allow initial open enrollment plan elections electronically.

Our plan is to retrofit PEBB My Account to allow people to enroll in benefits without having to use a paper form and use an online portal for making benefit elections whether they're employees or retirees. Our IT team has spent a lot of time building these pieces.

John Bowden: Slide 13 – SEBB Program Virtual Benefits Fair. This is currently a concept design. I want to highlight the colorful picture in the center. You see booths just like at a benefits fair. The employee can go click on a booth that says, "Medical Coverage," "Dental Coverage," "Vision," etc. From that booth, it takes the employee to videos the carriers will produce about their products. They'll be able to print the information about those different types of services, plans, etc., go into SEBB My Account, and make your benefit selection.

Slide 14 – ALEX – Automated Benefits Counselor. ALEX is a user-friendly tool, highly interactive, and confidential. It follows HIPAA rules so you can enter your personal information knowing it's protected. Once your information is entered, ALEX will make suggestions about plans available in your area and what might be a good fit for you. It does not make a recommendation. You can go online anytime, anywhere, and use ALEX. There are links from SEBB My Account, information, you can go back and make your benefit selection. If you need additional information about what's going on in the SEBB Program, there's an URL, Frequently Asked Questions, and information about what the Board is doing.

Dave Iseminger: There is a lot of work going on developing the SEBB Program. We've done multiple procurements, benefit design, revisited things we haven't looked at

in 30 years, including Pay1 and PEBB My Account. We've made advancements in time for the SEBB open enrollment. During plan year 2020, we'll work with the PEB Board on things within your authority to possibly leverage these advancements for the PEBB Program in 2021, taking those IT investments and other experience tools we've developed for members, evaluating them for use in both programs. It's an exciting time. You get to see the results of some of the pilot pieces being used in the SEBB Program.

Sue Birch: Because our state has made nearly $400 million of investments into the Health Benefits Exchange, we keep looking to our eligibility enrollment partners there see if there is any bridging, technology, or re-use? Our federal partners are seeing our public option work and suggesting we might want to keep looking at how we harmonize things and stop having different tiers. Even some of our commercial friends who have large businesses are looking at how we use that utility. This is extraordinary what staff have put up. This whole space keeps evolving, about eligibility and enrollment, and we still have miles to go, but it's been extraordinary with how far we've come.

Carol Dotlich: I'm concerned about customer service. I know there have been great improvements and I'm very appreciative of that. But I'm wondering, with all of this new business going on, if the consumers we have that are elderly are going to be able to get the kinds of assistance they need during open enrollment. Everybody's going to be in the system all at once or is it staggered?

Dave Iseminger: There's overlap between them, Carol. The SEBB Program open enrollment is October 1 through November 15. The PEBB Program open enrollment is November 1 through November 30. We deliberately did not align the ends of both open enrollments because we know about one third of all PEBB Program changes happen in the last 48 hours of the month. We didn't want the system jammed. The Customer Service line was built for retirees and was not meant to handle questions from state agency employees or school employees.

We will be very clear about that in the materials we publish. The 1-800 retiree line number won't be published in school employees' materials. That doesn't mean people won't be able to find that there's a PEBB Customer Service line, but we will be clear in the call triage that this is not where you go for these questions. You are to go to your school district. We're trying to be as deliberate as we can to make sure it's clear that the Call Center number is designed for use by retirees, not school employees or state agency employees.

When we implemented a triage tree a year or two ago, it helped. I believe it says, "press one if you're an employee of a state agency." When they press one, it explains where to go for to get their questions answered. We diverted two or three thousand calls just by adding that feature. There will be similar information about school employees and directing them to the proper channels for their questions. That's in the works now because we're starting to get the calls already from school employees on the PEBB retiree call line.

Tom MacRobert: As a member of the PEBB Program, if I live in King County I have multiple plans I can choose. If I live in Stevens County, I have a lot less available to me. It's almost like which county you live in determines what's available to you. Looking at

school districts, they cross county lines. How is that going to work? Is every school district in the state going to have access to the same choice of plans, or depending on where you're located? Are you going to have fewer plans available to you, or will it be equal?

Dave Iseminger: Insurance offerings in our state are on the county-wide level. For school districts within a county, the offering is based on county lines not school district lines. School employees will have access to benefits based on where their home residence is. It's based primarily on your residency and which plans are offered by carrier for that entire county. There is a strong possibility of more carriers and additional choices in the SEBB Program portfolio than the PEBB Program portfolio. I believe there are 14 counties that are UMP only in the PEBB Program portfolio. Going forward with the SEBB Program, there will not be 14 counties with UMP-only offerings. There will be additional choices due to the robust carrier offerings that will exist in the K-12 portfolio. The way we did our procurements, HCA would be able to leverage those contracts for the PEBB Program if they sign and launch with the SEBB Program. HCA will look at that in 2020 for plan year 2021.

Myra Johnson: As a school employee, thank you for all your due diligence and hard work on this. I'm excited to see and hope it goes well and there are no crashes because there are millennials who know how to do this stuff pretty quickly. I wish you the best of luck and thank you for all your hard work.

Vision Benefit Strategy

Lauren Johnston, SEBB Procurement Manager. Slide 3 – PEBB Program Vision Benefits. PEBB Program vision benefits are currently covered within the medical benefits, Kaiser Northwest, Kaiser Washington, and the Uniform Medical Plan. It includes one routine eye exam per year covered at 100%, and an allowance of $150 every two calendar years for glasses or contact lenses.

Harry Bossi: A little clarification on the one routine eye exam covered at 100%. My understanding is in the Kaiser Northwest. There is a copay of $15 or $30, depending on which of those that you're in, as opposed to UMP, which has no cost to the insured.

Lauren Johnston: That's not my understanding, but I will look into that. I'm getting a nod from Kaiser Northwest indicating, yes, that's true.

Dave Iseminger: We'll provide additional follow up.

Lauren Johnston: Previously you asked we would look into a separate vision benefit for the PEBB Program. The Cadillac Tax goes into effect in 2022. When making these considerations for the SEBB Program, we ensured we could leverage them for the PEBB Program. There is potential for current funds to go further for this benefit. The member may save money depending on how they purchase their glasses. Going through this procurement also helped provide insight into the difference between the fully insured versus the self-insured separate vision plan.

Dave Iseminger: Greg and I are chuckling because the Cadillac Tax is like the boy who cried wolf. This is the third or fourth implementation date of the Cadillac Tax. I

bring it up in this context because it is one way the agency has identified that could help mitigate the employer financial penalties related to the Cadillac Tax - when a standalone vision benefit doesn't count against you. An embedded vision plan does. If this Board were to carve out the vision benefit, it could reduce that existing tax liability.

Yvonne Tate: I've been retired five years and I was working on the immediate implementation of that when I was working. I don't believe the Cadillac Tax is ever going to happen. It continues to be delayed.

Lauren Johnston: Slide 5 – SEBB Program Vision Benefit Overview. HCA did a SEBB Program fully insured vision procurement separate from the medical plans. We received ten proposals to our Request for Proposal and contracted with three vendors, Davis Vision, EyeMed, and MetLife. There is statewide enrollment for all three plans and it does not matter where you live.

Slide 6 – Proposed Vision Plan Designs In-Network Coverage. This slide shows the proposed in-network coverage information and what the member pays. A routine eye exam renews every January 1 and covers 100% for all three plans. Frames renew January 1 in even years, same as the UMP coverage. For all three plans, the member pays $0 up to $150, and then 80% of the balance over $150. Lenses covered at 100% for all three carriers. Progressive lenses have a set copay based on the lens tier and carrier.

Dave Iseminger: You said lenses are covered by all three, but MetLife shows $10. Can you reconcile those statements?

Lauren Johnston: Sorry, Davis Vision and EyeMed have a $0 cost share to the member and MetLife has a $10 cost share.

Greg Devereux: How did you do this procurement? Did you say this is the dollar amount we would give you and we'd like you to bid?

Lauren Johnston: It's been an evolving process and a learning experience because we've never done a separate vision contract before. Initially, we set it up as here's how we currently cover things within the PEBB Program benefit. If we were to follow this, what would it look like? What would your bid be? How would you cover things? What would your cost shares be, etc.? From that, we learned about the separate vision benefit and how it's different in the medical benefit where it's embedded in the medical program.

Dave Iseminger: Greg, for procurement purposes, we set up a standard plan that said if you took UMP's vision benefit and pulled it out exactly, price that. We used that as the scoring mechanism. A procurement is winning the right to negotiate a contract. Once we got to the negotiation point, we said, "if this is the amount of money we can spend, what will it buy? Based on your experience with school employees, what do you think fits that price tag?" That information helped determine the benefit design.

Greg Devereux: Is the intent to have multiple options or pick one that is better than the others?

Dave Iseminger: In the SEBB Program, they envision all three as competitive parts of the portfolio.

Lauren Johnston: Slide 7. There are different lens enhancements that can be added to glasses, anti-reflective coatings, scratch resistance, polycarbonate, polarized, transitions, etc. This slide lists the member cost share.

Slide 8. It's similar for contact lenses, but there are slightly different nuances between the three vendors. For conventional or disposable contact lenses, the member pays $0 up to $150 for Davis Vision, and then 85% on the balance over the $150. Or they could choose four boxes from the collection of lenses specific to Davis Vision.

The member pays the same thing for EyeMed as Davis Vision for conventional lenses. For disposable lenses, the member pays $0 up to the $150, and 100% of the balance over $150.

The member pays $0 up to $150, and 100% of the balance over the $150 for MetLife.

Medically necessary contact lenses has a $0 copay to the member for all three carriers.

Dave Iseminger: Can you provide an example of medically necessary contact lenses?

Lauren Johnston: If you have a certain type of eye surgery, you may need medically necessary contact lenses to make sure the shape of your cornea doesn't change. They aren't elective for the purpose of being able to see. You need them so there is no damage to your eye.

Slide 9 – SEBB Program Pediatric Benefit. This benefit renews every January 1. It includes the routine eye exam and glasses covered at 100% for a standard set of frames. Polycarbonate lenses or contact lenses in lieu of glasses is a $300 allowance for a year's supply. All three carriers ensure there would be a number of options available under the $300 allowance.

Myra Johnson: What's the age of the pediatric coverage?

Lauren Johnston: It ends once they turn 19.

Slide 10 – PEBB Program vs SEBB Program Frequency. I identified an error on this slide under KPWA. For PEBB UMP, the eye exam renews every January 1 and every 12 months KPNW and KPWA, not every 24 months for KPWA. For the SEBB Program, it renews every January 1 for all three carriers.

For the glasses and contact lenses, the UMP allowance renews every January 1 on even years. For KPNW and KPWA, the allowance renews every 24 months. If I get my glasses in February 2020, I would have to wait until February 2022 to get a new set of glasses. For the SEBB Program, the allowance renews every January 1 on even years. Each member is different.

Dave Iseminger: For KPNW and KPWA, the allowance is a personal rolling two-year benchmark.

Harry Bossi: Looking at allowance renewals every January 1 on even years for the SEBB Program, does that mean if somebody enrolls in 2021 they have not benefits until January 1, 2022? Is there an exception?

Lauren Johnston: It works the same way it does in UMP. If a member were to enroll in 2021 and use their benefit in 2021, it would renew January 1 of 2022.

Dave Iseminger: They get an advantage in that situation and can use the benefit in the odd year. They don't have to wait two years.

Lauren Johnston: Slide 11 – Differences in Separate Benefit. This slide has a correction, too. KPNW has a cost share.

For routine eye exams, UMP and KPWA cover at 100%. The SEBB Program also covers at 100%. For frames, the PEBB Program allowance applies to frames, lenses, and any add-ons. It covers $150 total and the member pays 100% of the balance. The SEBB Program pays $0 up to the $150, and then 80% of the balance for frames. Lenses are $0 cost to the member. Progressive lenses are between $0 to $175, depending on tier and carrier. Lens add-ons are the same. Slides 6 and 7 show the different cost shares for each of the add-ons.

Dave Iseminger: The money that's being spent on the two programs is the same. These slides show a different benefit richness on the same dollar amounts. The SEB Board didn't reallocate or shift benefit money to this benefit to buy up. It's the same dollars going further.

Lauren Johnston: Slide 12 – Member Experience. I went to Target Optical's online platform to show the difference between what a PEBB Program member and a SEBB Program member would pay. As a PEBB Program member, I selected a pair of frames for $110, lenses for $75, and a traditional add-on for $100. I would pay $135. The frame, lenses, and add-on comes to $285 at Target. With my $150 allowance, I would pay $135 out of pocket.

As a SEBB Program member, I selected the same frames for $110, the same lenses for $75, and the same add-on for $75. I used the EyeMed's benefit cost share because it is middle of the line. My frame and lenses would be $0 cost to me and I would pay $75 for the additional add-on. The SEBB Program member pays $60 less than a PEBB Program member using this benefit example.

Slide 13 – Separate Vision Plan Advantages. Having a separate vision plan is advantageous because the provider contracts are more efficient when not embedded in medical plans. The number of frames under $150 a member can choose from and pay $0 out of pocket varies by carrier, but nationwide, between the three carriers they indicate you can choose from about 13,000 frames depending on which office you select.

Slide 14 – Total Unique Vision Providers in Each County. Many providers are overlapping between all three carriers. Thurston County has 91 vision providers. Columbia and Garfield Counties have no vision providers.

Dave Iseminger: Staff have double checked and there are no optometrists or ophthalmologists in those two counties, period. It's not that it's a gap in any of the provider networks. There's a gap of providers.

Harry Bossi: Are we assuming there are providers in Oregon?

Lauren Johnston: Yes. All three carriers are nationwide. There are providers in every state.

Slide 15 – Timeline for Vision Decision Making. This PEBB Program timeline is between 2019 and 2021. In the fourth quarter of 2019, we will submit decision packets and the Governor's proposed supplemental budget comes out at the end of the quarter. The legislative session is between the first and second quarters. The PEB Board season goes through the first three quarters of 2020.

Dave Iseminger: The timeline roughly represents this time next year for a potential change with the 2021 plan year. This needs to go through the legislative decision making process because under the current Collective Bargaining Agreement, if the vision benefit becomes standalone, the full premium becomes the employer's responsibility. With vision currently embedded in the medical benefit, the state is picking up, on a tier-weighted average, 85% of the embedded vision benefit. The extra 15% has a cost piece we'll evaluate and submit for funding in the decision package process. The current CBA for this program preordains a mechanism for how it's paid if this happens. We will go through that process of the Legislature and the Governor's Office deciding whether they want to put funding towards it.

Sue Birch: This reminds me of what happened with value-based formulary. The PEB Board led and the SEB Board adopted. We're seeing the advantages of the SEB Board leading on policy decisions and we'll have to make decisions about PEBB Program adoption. You start to see the advantage of these entities working in greater alignment.

Dave Iseminger: I brought this back to the Board because there have been intermittent discussions about vision. We finally have this information and gone through the procurement process with the SEB Board to be able to bring something with the level of detail we just provided you about what we've learned, what it could look like, and what the strategy timeline looks like to be able to make this type of change.

Sue Birch: Before this comes back to the Board, we'll be certain there aren't medical or pricing implications if we extract to standalone.

Dave Iseminger: The contracts we negotiate in the PEBB Program now with the medical carriers all have indications as to what the cost is associated in the fully insured plans and Regence for administrative costs that would be released or reduced if vision was removed. We've kept an eye on that for several years as we considered Cadillac Tax implications.

Lauren Johnston: Something to keep in mind is we made sure the SEB Board knew this benefit is only for the ability to see - contacts, frames, routine eye exams. Anything to do with the medical side of your eyes goes through your normal medical carrier. Those claims are submitted to the medical carrier. We worked on our contracts so if your vision provider were to identify a need for a medical follow-up, they would refer you back to your primary care physician making sure you're continuing to get the medical care you need.

Myra Johnson: Because you're still under negotiations with MetLife, does that mean on Slides 6 through 8, the MetLife numbers could change? Or are those solid?

Lauren Johnston: Those numbers are done. We're negotiating the contractual terms and conditions of the contract itself.

Next Meeting

June 5, 2019
Starting at 1:30 p.m.

Meeting adjourned at 4:15 p.m.