

Public Employees Benefits Board Meeting
Meeting Minutes

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

Members Present:

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

Members Absent:

Yvonne Tate

PEB Board Counsel:

Katy Hatfield, Assistant Attorney General

Call to Order

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

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

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

Meeting Overview and Follow Up

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

Follow Up: HCA previously described some COVID-19 responses from our carriers regarding coverage within the plans related to emergency orders from the Office of the

Insurance Commissioner. Since the last Board Meeting, Kaiser Northwest and Kaiser Washington informed us that the waiving of cost shares for treatment related to COVID-19 they had originally anticipated would be waived for a subset of this year will now be waived COVID-19 treatment through December 31, 2020. As a reminder, the Uniform Medical Plan currently has a similar policy that goes through June 30, 2020. HCA is currently evaluating the need to modify that date due to current circumstances.

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

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

PEB Board By-Laws Update

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

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

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

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

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

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

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

Slides 5 & 6 - Article I – 4 Non-Voting Members. Due to the new SEB Board and SEBB Program, there is now one non-voting member appointed by the Governor instead of

two. The non-voting K-12 active employee representative no longer exists due to K-12 active employees moving from the PEBB Program to the SEBB Program. The Legislature amended the PEB Board statute to remove that non-voting member. Although the Legislature re-amended the statute to let Educational Service District employees stay with PEBB for a couple of years, they did not revisit the Board composition. This proposed update cleans up those references that no longer exist in statute. The rest of the items in Article I are technical changes.

Slide 7 – Board Officers and Duties. No Changes.

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

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

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

Slide 10 – No Changes.

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

Slide 12 – Meeting Procedures. Article V – 7 – Manner of Voting. The additional verbiage relates to proxy votes not being permitted among Board Members but there's an acknowledgement that a proxy vote does not occur if the Chair’s duties have been

delegated from Director Birch to a Designated Chair of the meeting. This is true whether it's in the By-Laws or not. Under 41.05.021, the Director has inherent authority to delegate their duties and powers that are vested in law, which includes the Chairship of the PEB Board. We wanted to make sure it was clear that if there is a Chair Pro-Tem designated by Director Birch to chair a particular meeting, that delegation happens under their inherent statutory authority as the director, includes the vote, and it's not a violation of the proxy vote description that exists within Article V.

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

State Budget Forecast & Budget Reduction Options

Megan Atkinson, Chief Financial Officer, Financial Services Division

Dave Iseminger, Director, ERB Division

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

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

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

The Economic and Revenue Forecast Council met this morning and the new revenue update for the next few years is a decrease of about \$9 billion for just the General Fund State portion of the state's budget. That's a reduction in revenue estimates of about

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

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

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

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

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

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

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

money is then paid into the Health Care Authority. HCA put forward budget reduction options, like all agencies in mid-May, which are published on the OFM website.

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

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

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

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

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

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

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

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

Slide 7 – HCA's Budget Options Submission (*cont.*). HCA's goal is to preserve health care services for Washington residents. We will be expected to help address the

revenue shortfall. HCA and OFM will continue to work together to refine the proposed budget reductions for the Governor's and Legislature's consideration.

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

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

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

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

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

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

Another option is to delay implementation of the next Centers of Excellence bundle. Currently we have a total joint replacement for hips and knees bundle and a spine care bundle that has helped reduce variability in cost and had good outcomes in preventing

costly readmissions within the system. HCA did a request for information (RFI) related to a potential third bundle around bariatric surgery. That bundle could be delayed. It would be an expenditure that isn't made.

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

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

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

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

There is the option to introduce the retiree Medicare Advantage-Prescription Drug plans (MA-PD), which is the proposal we've been presenting to you in various iterations for the last at least two years. This was not designed to save money. It was designed to help with the general solvency and sustainability of the retiree portfolio in general. In describing budget options and potential savings, we costed out enrollment assumptions if these plans were introduced that would ultimately describe savings. Savings are realized because in an MA-PD Plan, the carrier is able to access more funds from CMS and accessing of those additional subsidy funds by the carriers then results in lower retiree premiums. The way the subsidy works is that it's a flat amount, right now \$183 or 50% of the premium, whichever is less. As we introduce the MA-PD rates and the other Medicare rates, you will see the MA-PD rates being presented to you would

exercise that 50% clause. The state would not have a subsidy that is the full \$183 for MA-PD enrollees. That difference between \$183 and the 50% represents the potential savings and reductions of the total amount of spend without actually changing the subsidy itself.

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

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

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

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

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

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

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

Elyette Weinstein: Thank you.

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

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

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

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

At the time, close to Memorial Day, there were still possibilities in Olympia of a special session, but now that we are nearing the end of June, that seems unlikely. But in the crucible of the last few days of May since the Board Meeting, we had to assess the

timeline and determined with Regence and our finance team that if, in fact, any decision was made by anybody with the authority to make that decision to implement UMP Select, it could be implemented if the decision was made no later than June 30. Knowing the June 30 deadline and knowing there was additional fiscal information that might be relevant to that conversation, we wanted to bring this to you and to also describe it as a possible budget savings option within the submission that went to OFM at the beginning of this month.

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

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

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

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

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

I want to be very clear on this point that just because the Board does take action on a proposal, it does not foreclose or prevent additional action by the Legislature. It would

be a way for the Board to send its message of where it prioritized, or made decisions, to provide budget relief.

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

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

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

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

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

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

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

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

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

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

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

lawyer, I was curious what the Supreme Court's budget is and \$5 million is half of the annual budget of the State Supreme Court. Those are some illustrative examples. Is that responsive to your question?

Leanne Kunze: It is. Thank you.

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

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

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

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

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

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

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

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

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

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

Elyette Weinstein: Why is that?

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

Elyette Weinstein: And the state cannot contract with CMS.

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

Elyette Weinstein: Okay. Okay, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sue Birch: Resolution for Vote

Resolution PEBB 2020-06 – Self Insured Plan Offering

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

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

Leanne Kunze moved and John Comerford seconded the motion to reconsider

John Comerford: What is the downside of this motion?

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

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

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

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

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

John Comerford: It is. Thank you very much.

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

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

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

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

Tom MacRobert: Yes. Thank you.

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

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

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

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

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

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

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

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

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

Voting to Approve: 4

Voting No: 2

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

Voting No: Tim Barclay, Harry Bossi

Sue Birch: Resolution PEBB 2020-06 passes.

PEBB Program 2021 Annual Procurement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Expanding PEBB Medicare Options Update

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

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

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

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

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

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

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

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

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

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

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

Tom MacRobert: All right, thank you, Dave.

2021 PEBB Medicare Rates

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Elyette Weinstein: Thank you.

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

Dave Iseminger: No, we do not.

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

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

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

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

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

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

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

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

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

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

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

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

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

2020 Annual Rule Making

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Public Comment

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

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

Next Meeting

July 15, 2020
1:00 p.m. – 4:00 p.m.

Preview of July 15, 2020 PEB Board Meeting

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

Meeting Adjourned: 4:24 p.m.