

Public Employees Benefits Board
Meeting Minutes

July 14, 2021
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 2:00 p.m.

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

Members Present via Phone

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

PEB Board Counsel

Michael Tunick

Call to Order

Sue Birch, Chair, called the meeting to order at 9:02 a.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting is via Zoom only.

Meeting Overview

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

Today we highlight Yakima County. Presenters have an image from the Yakima Valley behind them today. Between the PEBB and SEBB Programs, about 9% of the county population is covered in our two commercial books of business. For the Medicaid Program, about 43% of the population of Yakima County is covered. Between PEBB, SEBB, and Medicaid, approximately 52% of the entire county is covered by programs administered by the Health Care Authority. I think that's one of the largest percentages I've reported in our journey across the state this season.

When it comes to unemployment, uninsured, and poverty rates compared to statewide averages, all three of those are higher in Yakima County compared to statewide averages: 6.6% unemployment compared to 5.3% statewide; 13.5% uninsured compared to 6.8% statewide; and the poverty rate is 26% in Yakima County compared to 15% statewide.

Medicaid coverage for Yakima County averages 43% compared to 24% statewide. That is a significantly higher enrollment and use of the Medicaid program. Several pieces impact that number like slightly lower hospital bed availability in that county compared to the state; worse rates of cardiac incidences; slightly higher rates of preventable hospital admissions; and more medical debt collection in Yakima County compared to the statewide average. Medical debt collection in the state is around 6%, but in Yakima County, it is around 11%.

A regional factor that impacts Yakima County is the evolving relationships between Yakima Valley and Virginia Mason. The dynamics of that relationship have changed multiple times, and HCA continues to monitor its impact for our membership.

I will end my opening remarks with the land acknowledgment statement. I acknowledge our meeting is being supported physically in Olympia on the traditional territories of the Coast Salish people. This area was the primary portage way to and from the Puget Sound, and these lands were shared by several tribes, including those we know today as the Squaxin Island Tribe and the Nisqually Tribe. HCA honors and thanks their ancestors and leaders who have been stewards of these lands and waters since time immemorial.

I don't have a specific follow up to the June 30, 2021 Meeting. I just forgot to delete that line from the agenda.

Sue Birch: Thank you, Dave. That is really interesting information about the payer mix and that 52%. I know in some of our very rural frontier counties and regions it's even higher, but that is really significant. I'll also point out that Virginia Mason – CHI Franciscan partnership has implications for that region as well.

2022 Uniform Medical Plan Benefit Resolution

Beth Heston, PEBB Procurement Manager, brought Resolution PEBB 2021-23 back for Board action.

Slide 2 – Reasons for Proposed Change for Uniform Medical Plan.

Slides 3 & 4 – Recommended IRS Allowed Changes to UMP CDHP. There is one small change to the chart on Slide 3 noted in red. After the last meeting, UMP managers pointed out that even though we had it listed as pharmacy changes, it's actually a medical change, as well, because some specific continuous glucose monitors are grandfathered under our medical plan. This change will affect all glucometers.

Sue Birch: Vote - Resolution PEBB 2021-23 – UMP CDHP Preventive Care

Resolved that, beginning January 1, 2022, the UMP Consumer Directed Health Plan will allow coverage to treat certain chronic conditions, those presented at the July 14, 2021 PEB Board Meeting, before having to meet the plan deductible.

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

Dave Iseminger: I do want to highlight the only change was the date reference to reflect the piece of the chart Beth highlighted as a change. We wanted to tie that together. If you literally compare last meeting to this, the date has changed to reflect the chart you just saw.

Voting to Approve: 7

Voting No: 0

Sue Birch: Resolution PEBB 2021-23 passes.

Beth Heston: Slide 6 – IRS Notice 2019-45 Discretionary Preventive Coverages: Under Review for 2023 addresses questions that were raised at the last Board Meeting about what other items were on IRS notice. This list is discretionary preventive coverages. HCA staff will research and report back to the Board during the 2023 procurement season.

Dave Iseminger: For clarity, the 2023 procurement season is the same thing as next Board season.

Chiropractic, Acupuncture, and Massage (CAM) Utilization Summary & Benefit Proposal for Uniform Medical Plan (UMP)

Selena Davis, UMP Senior Account Manager, ERB Division and **Sara Whitley**, UMP Fiscal Information and Data Analyst, Financial Services Division, are asking the Board to take action on the CAM Resolution introduced at the June 30 PEB Board Meeting.

Selena Davis: We have no follow-up questions from the previous meeting, so that takes us straight to our resolution for action.

Dave Iseminger: I have one piece of additional information before moving to a vote. Sara is here to support any financial questions that may come up. It's rare for me to get personal outreach on a resolution after it's been introduced at a Board meeting, but I informed the Board I did receive several inquiries asking if this resolution had already passed.

Sue Birch: I think this is a significant push for more inclusive, complimentary, preventative, nontraditional medical. So, thank you for that information.

Elyette Weinstein: I got an inquiry from a massage therapist because "even though the massage visits are limited to 24 per plan year, for every three visits you need a new treatment code to justify it." For example, sometimes a condition doesn't change,

you've already used that code, so regardless of whether the condition is always there, and you're just keeping it from getting worse, if you've run out of your codes, you don't get the 24 visits. I'm sure staff could clarify this for me because I hadn't thought of this, and I have no idea how it works.

Sue Birch: Thank you, Elyette. I'm not sure that interpretation is accurate, and I'm asking Dave to get further information if he cannot answer that on the spot today.

Dave Iseminger: I can provide a little insight. The important thing when it comes to benefits, but importantly with massage because it has the most prevalence for being able to treat both medical and non-medical conditions and to provide support both in a medical sense and in a non-medical sense, is there does have to be a diagnosis that is being treated. I'm not aware, until you raised this question now, Elyette, that there's a cap on specific diagnosis codes. I do know it's important there is a diagnosis code to show it is treating a medical condition and it's for medical purposes. We can do some follow-up about the administrative aspects, prior authorization, codes, and pieces to ensure the Board's intent, assuming passage of this Resolution, is met. I'd appreciate an opportunity to come back with more detail.

Selena Davis: I would recommend we research and come back to this topic. I don't know of anything related specifically to a diagnosis code, but we can check and get back to you.

Dave Iseminger: Dr. Transue, do you have information that supplements anything Selena or I said?

Emily Transue: I would agree with your understanding, Dave. I think the key part is that the number approved matches the appropriateness of the diagnosis. I would be surprised if it turned out to be three. That's different from my understanding, but it might be if you have this condition, then for that initial course of treatment there would be a certain number of visits. If it's a more complicated underlying problem, it would be longer. If the problem persisted, you might need to redocument. We'll get the details, but I think the goal is to match the need of length of therapy to the medical problem in question for treatment.

Harry Bossi: I'm certainly not an expert in this, but I think it would be helpful to know if Elyette knows what the carrier was because this, of course, applies to UMP, and perhaps the situation she ran into was other than UMP.

Elyette Weinstein: No, it was UMP.

Dave Iseminger: Elyette, I'll reach out to you for more details. It will be helpful for us in our review.

Sue Birch: Let's vote on this resolution. I would like to use the voting process used earlier for the dual-enrollment policy resolution vote, meaning I would not read the full text of the resolution, which is allowed under Robert's Rules. This resolution was distributed to Board Members last meeting, and in advance of this meeting, and published for public view, most recently, on Monday, July 12. Does the Board have any concerns if I don't read the full text? Okay. Hearing none.

Sue Birch: Vote – Resolution PEBB 2021-24 – UMP Chiropractic, Acupuncture, and Massage Benefits

Resolved that, effective January 1, 2022, the Uniform Medical Plan (UMP) benefit design, for all Medicare and Non-Medicare plans, of the Chiropractic, Acupuncture, and Massage (CAM) benefits included in prior Board policy decisions and resolutions is rescinded and replaced with the following CAM benefit design:

- Treatment limitations will be as follows:
 - Chiropractic visits are limited to 24 per plan year;
 - Acupuncture visits are limited to 24 per plan year;
 - Massage visits are limited to 24 per plan year;
- Cost-sharing for all UMP plans will be as follows:
 - In-network services will have a copay and neither the services nor the copay will apply toward the deductibles (except for UMP Consumer Directed Health Plan (CDHP) as described below), but the copay will apply toward the annual out-of-pocket maximums;
- Out-of-network services will not have copays and will have:
 - a 40%-member coinsurance of the allowed amount for all UMP plans except UMP Plus, which will be a 50%-member coinsurance, applies after the deductible is met and the coinsurance applies to the annual out-of-pocket maximum;
 - no charges above the allowed amount apply toward UMP plan deductibles or the annual out-of-pocket maximum; and
 - coverage only for Chiropractic and Acupuncture services,
- UMP CDHP members need to meet their deductible before the plan will pay any portion of the allowed amount for any claim, for both in-network and out-of-network services; and
- Medicare claims will be processed in accordance with coordination of benefits rules.

This benefit design applies only if approved by both the PEB Board and the SEB Board.

Yvonne Tate moved, and Leanne Kunze seconded a motion to adopt.

Leanne Kunze: I wanted to share that when speaking with several of the employees covered by our program, and we were looking at utilization, many use these alternative forms for pain management that would otherwise put them in a situation where they would either avoid care or not, due to the lack of being able to afford it because of a deductible, or possibly could be going in where they are being prescribed medications that can be habit forming. We're very excited, from the standpoint of the employees who benefit from this plan, to be able to have greater access to alternatives for pain management, in addition to other ailments, but very pleased with this opportunity to put this forward.

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

Voting to Approve: 7

Voting No: 0

Sue Birch: Resolution PEBB 2021-24 passes.

Dave Iseminger: Sue, I want to add one more piece about the next steps on this resolution. Now that this Board has passed the resolution, the other component for it to go into effect is the SEB Board to take similar action on a comparable resolution. We introduce the comparable resolution at tomorrow's SEB Board meeting, we'll ask them to take action on it at next week's SEB Board meeting. We should know within a week. Unfortunately, your last Board meeting is the day before they consider it, so I, at least, will send an email to the Board with an update on the results of that vote.

Dual Enrollment COBRA Eligibility Resolution

Emily Duchaine, Regulatory Analyst, Policy, Rules, and Compliance Section, ERB Division. Slide 2 – PEB Board Policy Resolution PEBB 2021-25.

Slide 3 – RCW 41.05.065(4) is the applicable statute as you consider this policy.

Slide 4 – Resolution PEBB 2021-25 – PEBB Continuation Coverage Eligibility for Employees' Dependents.

Sue Birch: Vote – Resolution PEBB 2021-25 – PEBB Continuation Coverage Eligibility for Employees' Dependents

Resolved that, if an employee's dependent was auto-disenrolled from PEBB dental because the employee was auto-disenrolled from PEBB benefits to remain in SEBB benefits, the dependent may elect to enroll in PEBB dental. These benefits will be provided for a maximum of 36 months on a self-pay basis.

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

Voting to Approve: 7

Voting No: 0

Sue Birch: Resolution PEBB 2021-25 passes.

Emily Duchaine: Slide 5 – Next Steps.

2022 Rates Overview

Tanya Deuel, ERB Finance Manager, Financial Services Division, introduced the proposed 2022 rates. Historically, this presentation also included our Medicare premiums, however, the Board acted on those premiums at the last Board meeting. Today's presentation is limited to active employees and non-Medicare retirees.

Slide 3 – Calculating the State Index Rate. This slide is an illustrative example of how HCA calculates the state's contribution towards health care. It's defined in the Collective Bargaining Agreement as 85% of the weighted average projected health care costs. HCA negotiates with all of our carriers, as well as ourselves for our self-insured product. We develop our own rates for the UMP and determine what the plan bid rate is going to be for all of our UMP plans.

For simplification in this example, the numbers are made up. There are three plan bid rates listed on the slide. The calculation is: Take the bid rate and multiply by the adult units to get the monthly cost. Add the three monthly cost totals together and divide by the projected enrolled adult units to get a weighted average. Per the Collective Bargaining Agreement, the state will contribute 85% of that weighted average cost. So, take the weighted average cost of \$485, multiply that by 85%, and that's the State Index Rate of \$412. In this example, that would be the state's contribution towards health care for each of the plans.

Slide 4 – Determining Employee Premiums. Take the existing plan bid rates from the previous slide, the plan A, B, and C at the same price points, subtract the state index rate from each of those three plans, regardless of the price of those plans. The state contributes the same amount per plan. The math is the same for all three of those plans.

Slide 5 – Determining Employee Premiums by Tier. Going on step further, we can determine how much each employee will pay based on which tier they choose. To calculate it's the employee contribution for their selected plan, multiplied by the number of subscribers covered. There is a \$10 admin / surcharge. For children, the price is the same regardless of the number of children you are covering.

Slide 6 – Employee / Employer Premium Contributions shows how that state index rate flows into what is being proposed for the employee and employer premiums for 2022. The middle column is HCA's proposed 2022 Employer Contribution or state index rate, which is \$604 for 2022. The proposed 2022 Composite Rate column is the sum of the employee contribution and the state index rate. The Composite Rate (or bid rate) minus the Employer Contribution (or state index rate) = the employee premium.

Scott Nicholson: In the previous slide, you had the tiers by adult units "plus \$10." Where does that come from?

Tanya Deuel: That is an historical surcharge amount. It's \$10. It's been in PEBB for many years before the spousal surcharge established in the state budget. It was a cost of administering spouses on those tiers. This is something we are looking at eliminating in future years, possibly changing the ratios on the tiers, and getting rid of that \$10 spouse charge, as well.

Dave Iseminger: It was a precursor to the modern day \$50 surcharge and, as Tanya said, it's on our to do list. And that work, changing the tier factors and the potential elimination of the plus \$10 requires Board action and is something we'll be analyzing and bringing a recommendation to the Board. Not this board season, but probably in one or two board seasons from now. It has a couple of different moving parts.

Scott Nicholson: Thank you.

John Comerford: If an employee has the Kaiser Northwest CDHP and they are only paying \$26 a month for it, do they get an additional subsidy? A health savings plan or something? No?

Tanya Deuel: There's no additional subsidy, but there is the contribution to the HSA Plan that the state contributes that is included in that total composite rate on the slide. They get, as a single subscriber \$700, and as with any of the other remaining three tiers they get \$1,400 put in that HSA.

John Comerford: So basically, they're paying \$26 a month for single, and they're getting a \$700 annual subsidy.

Tanya Deuel: Contribution toward their health savings.

John Comerford: Thanks.

Tanya Deuel: Slide 7 – Employee Premium Contributions. This slide is looking at the same single subscriber tier from the previous slide. However, it's showing a comparison of the current 2021 premiums for that single subscriber compared to the proposed 2022. The dollar change is in red for clarity and are negative, meaning those premiums are decreasing. When we get to the next slide it will show how that rolls through each tier. The average composite increase on employee premiums is about 2.4% this year.

Slide 8 – 2022 Proposed Employee Contributions by Tier. This slide follows the same math as the previous slide with the tier ratios. Single subscriber on the first column is the 1.0, followed by the subscriber and spouse at 2.0 plus \$10, then the subscriber and children at 1.75 subscriber, and finally subscriber, spouse or state-registered domestic partner, and children at the 2.75, plus \$10.

Slide 10 – Non-Medicare Retiree Rates by Tier. Our non-Medicare retirees are those who retire prior to Medicare eligibility and stay in the active risk pool. These retirees pay the total bid rate and do not receive any direct subsidies towards the cost of their premiums. However, these retirees do benefit from an implicit subsidy. They benefit from community-rated plan premiums in a risk pool that's primarily active employees, and the premium rates are developed to reflect the average cost of the entire risk pool. The key point I want you to take away is our non-Medicare retirees do not receive a direct subsidy. However, they do benefit from lower premiums by being enrolled in the same risk pool as our active population. Typically, in this set of rates, we see between a 2% to 5% average year over year increase. This year we're seeing just under 4% increase.

Slide 12 – Dental Premiums. HCA dental premiums are 100% employer-paid for active employees and retirees pay the rates on this slide. DeltaCare and Willamette Dental Group are both fully insured dental products in a rate guarantee through the end of 2022. The Uniform Dental Plan is a self-insured product where we develop those rates based on claims experience. A third-party administrator (TPA) helps HCA administer our self-insured dental plan, which is also in a rate guarantee.

John Comerford: Is there a mechanism for state employees to sit down with a counselor to decide which medical plan is best for them?

Beth Heston: The Employees and Retirees Benefits (ERB) Division has customer service staff who speak to retirees. The HCA lobby is not currently open to the public due to COVID. We do have the ability for retirees and other employees to make appointments with customer service staff to meet in person and discuss their options. However, we don't generally counsel people. We give them their options. The state also offers retiree counseling through their SHIBA program that's offered through the Office of the Insurance Commissioner, and that is available to retirees, as well, to talk about PEBB, or to talk about things on the Exchange, so they can make informed decisions.

John Comerford: Thank you very much.

Elyette Weinstein: At RPEC, we do have a concern, because we often get complaints, and HCA doesn't see them, about people not getting sufficient counseling. I'm not attacking HCA. Usually what happens is someone retires, and we're told go to your human resources – but we're not always told this. Human resources, in most agencies, focuses on the needs of the employer, not the state employees working there. You go in and they say, "Well, here, we'll process your retirement. Bye." They don't know anything, and they go, "Look, wait. We're understaffed. We're underpaid. We don't have time."

Before you retire, Department of Retirement Systems does have some kind of an event where you can find out about your retirement benefits, and they do so in detail. They leave a tiny little part that goes at 50 miles an hour for people who have never heard this before, what their medical plan options are, and everybody's totally confused. I know that RPEC is looking at doing something about that. And frankly, I went in, and I got counseled by HCA, but most people don't know to do that. When you're going to retire, it's a busy time. I would say the system's broken and it's not HCA's fault at all. But I think the human resources departments in these agencies need to do a better job, but they're not sufficiently funded, so there you go.

Sue Birch: Thank you for those concerns and comments. Dave, I'm going to direct you to consider what sort of follow-up, or solutions we could create, so we'll be back. This will be a follow-up issue. It's not the first time this has been raised about transitions in life, but we will certainly see if we can get any fresh thinking about it. Tanya, back to you for Life and other premium presentations.

Tanya Deuel: Slide 13 – Life and AD&D, and LTD Premiums.

Slide 14 – Supplemental Life (Non-Tobacco) Rates

Slide 15 – Supplemental Life (Tobacco) Rates

Dave Iseminger: I want to highlight for the Board, your authority includes adopting premiums for employees, yet, in this particular instance, we're not going to be teeing up a resolution for you to vote on these new Life and AD&D employee-paid supplemental benefit rates. I want to describe for everyone how you reconcile the two things I just said.

Tanya referenced a five-year portion of a guarantee and a three-year portion of a guarantee. When HCA negotiated and originally brought the benefit design to the Board the summer of 2016, we were bringing you a benefit package that had been negotiated with financials that had accounted for an initial term with MetLife for an eight-year contract. At that time, we were transitioning from our prior vendor to a new vendor, and there had to be a transition of reserve funds from one vendor to the next. While we were negotiating, and even while we were bringing things to the Board, the final accounting of how much money were in the reserves that would transfer was unknown.

The contract envisioned various splits of the eight years between two rates, depending on how much money ultimately transferred. There were three possibilities. It could have been a one year and then seven years rate guarantee combination, it could have been three years and then five, or it could have been five years and then three, with the first number I said in each combination having a lower premium rate for a longer period of time. Fortunately, we had the highest amount of reserves that triggered that third rate guarantee combination, and so we've enjoyed lower rates during this eight-year period for the first five years, and now we're into the final part, where, as originally envisioned, there would be a second level of rates used for the next 3 years. There was always going to be this calculation and this weighing in the rates depending on those reserves.

When the Board adopted the benefit design back in 2016, and I want to be clear, the adoption, at that time, was the embodiment of that rate guarantee. There's not really discretion to reject these rates at this point, because it was the embodiment of the deal and the Board's adoption of the benefit design and rates in the summer of 2016.

Through 2024, we'll begin looking at renewals with the vendor, MetLife. At that time, it will be much like Tanya's discussion on LTD and dental rates where we'll strive to have multiple-year rate guarantees. It will be more piecemeal, and there will be, if there are adjustments, the need for the Board to take action at that time. We don't have anything for you to take action on today because it inherently was part of the original vote by the Board in 2016. At the same time, these are rate changes that are going to be experienced in employees' paychecks, and we wanted to make sure it was brought to the Board's attention. I wanted to give you some context as to why this transition, or this change, happened at this exact point in time, and also why, although typically you vote on employee premiums, in this instance, there is no discretion.

John Comerford: Does MetLife share their actuarial experience with you? For instance, that employees with higher guaranteed issue amounts have higher claims experience?

Tanya Deuel: They do share their experience with us, John, and we do get to review that. We actually did review experience when this term at this point of the contract came up with this increase to confirm this was valid, and it is.

John Comerford: And what's the maximum amount of guaranteed issue life insurance they can get from the state?

Dave Iseminger: It varies by who you are. By that, I mean, for the subscriber, the employee, you can get guaranteed issue of a half-million dollars, and there's a different lower guaranteed issue if you are insuring your spouse. That spouse amount is capped

at 50% of what the subscriber does, or, I believe, it's \$150,000. I'll have to follow up on that exact cap, but it's whichever of those is lower.

John Comerford: Thanks. I just take questions about adverse selection, and the kind of claims experience you have when they max out the policy at \$500,000, and they're over 70. You could see how that compares with the market in general. But that's another day, another time.

Dave Iseminger: When we rebooted the benefit in 2016, I believe we went somewhere from a magnitude of \$2 billion in program coverage that had been elected up to \$8 billion. It was a monstrous increase in coverage because there was so much pent-up demand, and people who had been denied over the years, because you start employment and you don't prioritize life insurance, and then life happens and you might not be able to get life insurance. We had a lot of pent-up demand, and it really changed a lot of people's lives.

HCA is very sensitive that there are a lot of changes happening in state employees' paychecks this January between the long-term care trust costs and the shift to opt-out LTD. Then we have this rate increase of about 5% within life insurance. We're very happy with the medical portfolio. It was really stable. It had several plans going down in cost. We looked to see if there was a way to extend the supplemental Life and AD&D rates that are ending this year for one more year. But as we did the independent actuarial review of the data, it really was necessary, and we are under our contractual obligation to move forward with these rates now with a three year guarantee. I did want the Board to know we tried our best to look for anything we could do for a little longer because we know there are many moving parts to state employee paychecks on January 1.

Tanya Deuel: Slide 16 – Proposed Resolutions. The Board will be voting on these resolutions at the next Board meeting. The Board will adopt one resolution per carrier, not per plan. By adopting the premium resolution for each of the carriers, you are also approving the underlying plan design changes presented by Beth Heston earlier this year.

Slide 17 - Proposed Resolution PEBB 2021-26 KPNW Non-Medicare Premium

Slide 18 - Proposed Resolution PEBB 2021-27 KPWA Non-Medicare Premium

Slide 19 - Proposed Resolution PEBB 2021-28 UMP Non-Medicare Premium

Slide 20 – Next Steps.

Benefit Update Medical Flexible Spending arrangement (FSA) & Dependent Care Assistance Program (DCAP)

Marty Thies, Portfolio Management & Monitoring Section, ERB Division. Today's presentation is an update on tax-advantaged accounts offered to PEBB Program subscribers. The updates are effective for plan year 2022 and are authorized HCA's Cafeteria Plan. No action is required by the Board.

Slide 2 – Overview

Slide 3 – Benefit Recap

Slide 4 – FSA/DCAP Savings benefit both household and employer budgets through tax savings. Because the payroll deductions are pre-tax, employees don't pay income tax on the amount of their annual election, nor do they pay FICA taxes on their pre-tax elections, and employers don't either. The table on this slide looks at two years' experience with these accounts. Participation in DCAP from 2020 to 2021 dropped by over 25%, which is related to the COVID-19 impact.

Slides 5 and 6 – COVID-19 Impact & Response. Over the last 15 months, the pandemic had an enormous impact on how, and if, we access health care and dependent care. Many were having difficulty claiming the funds they put aside in flexible spending accounts. They just didn't have the expenses, through no fault of their own. The IRS responded in May of last year issuing a memo allowing subscribers to initiate new accounts and prospectively increase or decrease their payroll deduction within plan limits. HCA provided a one-month limited open enrollment last July for members to take advantage of these leniencies.

With the passage of December's stimulus bill, more leniencies were introduced, which allowed HCA to offer more opportunities to members. For unspent 2020 DCAP funds, HCA instituted a 12-month grace period. HCA is sponsoring three times in 2021 during which account holders can change their annual elections, again, prospectively. The first was in March, the second was last month, and another opportunity in September.

For 2021 only, the American Rescue Plan Act more than doubled the DCAP election to \$10,500. Congress will need to act before the end of the year to make this increased election permanent, otherwise, the DCAP maximum election will revert to \$5,000 in 2022.

Slide 7 – Design Changes Coming in 2022

Slide 8 – Selected Eligible Expenses shows which FSA covers what

Slide 9 – Lowering the Minimum Election

Slides 10 and 11 – Moving to Carryover. Moving from grace period to carryover does not prevent forfeitures. Members will need to do what they can to use their funds.

Slide 12 – Carryover Example #1

Slide 13 – Carryover Example #2

Slide 14 – Carryover Example #3

Slide 15 – Carryover: Example Summary

Slide 16 – Timing of the Carryover

Slide 17 – Letting Subscribers Know

Dave Iseminger: I want to highlight two things for the Board regarding the grace period rule versus the carryover rule. First, why did we ever have the grace period rule? Temporally, there originally were no exceptions to the "use-it-or-lose-it" rule. As time evolved, the IRS evolved and created the grace period rule, and employers either adopted it or they continued the hardline on forfeitures. Several years later, the IRS created the second option, the carryover rule. Some employers began converting from one to the other, and so we've had the grace period for many years because that's what we had adopted at the time, as the modern iteration of flexibility. Here we are taking another step and seeing the virtues of this alternative benefit design which includes a variety of advantages to our members.

Second, I want to highlight what's unique for the PEBB Program, under the Collective Bargaining Agreement, that there is an employer contribution to an FSA account for represented employees who make under a certain salary, as determined on a specific day of the year, and when it happens, that employer contribution is \$250. In those instances, if the employee does not realize that this benefit was for them, they will have additional time to incur expenses because \$250 is over the minimum of \$120 but under the maximum of \$550. In fact, if they didn't realize anything about this benefit and were eligible two years in a row, they would have all \$500 carryover into the third year. It opens up the flexibility for educating members about the new CBA-based benefit that was introduced a year or two ago, giving that additional opportunity for those employees who are making below that salary threshold and represented, to access those funds and the benefits in a way that was the intended goal of the Collective Bargaining Agreement.

Sue Birch: Marty and Dave, I know you both have really been proactive in this space. We appreciate your presentation today, Marty. Dave, thank you for your work with our IRS friends.

COBRA Subsidy Update

Kat Cook, Benefit Strategy Analyst, Benefit Strategy and Design Section, ERB Division. Slide 2 – What is COBRA Subsidy? The American Rescue Plan Act of 2021 (ARPA) was the Covid relief bill passed by the federal government in March. Essentially, the federal government will pay COBRA premiums for eligible individuals, with tax credits for employers. The intent was to help people who lost health coverage during the pandemic regain that coverage.

Slide 3 – Subsidy Denials. If they're no longer in their window for federal COBRA, which is typically 18 months, the PEBB Board Resolution 2020-01 extended continuation coverage benefits until two months after the state of emergency ends, but the subsidy would not apply to that extended period. Federal guidance on the subsidy states that individuals who are enrolled in extended continuation coverage, even with extensions issued by federal regulations, are not eligible for the COBRA premium subsidy, highlighting the COBRA only requirements in subsidy eligibility. Denial letters sent to applicants contain appeal rights, which are handled by HCA, not the individual employers.

Slide 4 – Why Would Someone's Subsidy End?

Slide 5 – 2021 COBRA Subsidy Statistics. If someone's subsidized COBRA ends, that doesn't mean they can't access continuation coverage that they pay for out of pocket.

Slide 6 – 2021 COBRA New Enrollees. Individuals not previously enrolled in COBRA were allowed to enroll in subsidized COBRA during the subsidy period. 152, or 82%, of those who enrolled in the COBRA subsidy were new to PEBB continuation coverage. 64, or 18%, were previously enrolled in PEBB continuation coverage and opted into the subsidy. That's 3% of our total PEBB continuation coverage population prior to the subsidy.

Slide 7 – Retro-coverage on the COBRA Subsidy. PEBB continuation coverage extended election periods can begin either during the extended election period or be

retro enrolled back to the original date coverage was lost. Because of this, American Rescue Plan extended election period recipients were given this option with one caveat. In order to retro enroll, the outstanding balance must be paid by the subscriber in full to unlock the earlier date of coverage. Otherwise, they would be enrolled only in the subsidy period that began April 1, 2021. Thus far, none of our PEBB COBRA subsidy enrollees chose to exercise this option.

Slide 8 – Continuation Coverage Utilization Trends includes both COBRA and COBRA-like continuation coverage authorized by the Board. Our full continuation coverage population is slightly larger than the federally authorized COBRA population due to the board-related extensions on continuation coverage like Resolution PEBB 2020-01 discussed earlier, and others. Continuation coverage trends between 2020 and 2021 are similar within SEBB, with a marked increase in continuation coverage utilization in 2021.

Slide 9 – Next Steps

Sue Birch: Does the plan that they select or that they were carrying over, do they have a choice of that? Like, if it was a CDHP?

Kat Cook: If they are newly enrolled in COBRA, they have a choice of what they're going to select. While they could select the CDHP, it would not be a good rational decision in most cases. Those that weren't in COBRA before can select whatever plan they had the ability to select when they were an employee; but if they were currently enrolled in COBRA, the federal law said they could not get a more expensive plan than they already had. They have to keep the plan they already had in COBRA.

Dave Iseminger: At the beginning of next Board season, we plan to do a wrap of what happened after we're able to do the full postmortem. Regardless of when the subsidy ends, if it gets extended, we do something after the initial election period. We're still in that adjudication process, so we will add that level of insight on plan selection into the future presentation.

Leanne Kunze: I may have misunderstood, so I want to ask a clarifying question with a hypothetical scenario. If somebody left employment involuntarily in February, at the time they could not afford COBRA. At this point, would they still have the opportunity, within that six-month look back window to then go back and get COBRA now that this subsidy is there? Or do we have a responsibility, any employer, to inform people who may have been in a situation where this subsidy wasn't known?

Kat Cook: Let me make sure I understand those questions, Leanne. Your question is if someone had lost coverage prior to the subsidy due to an involuntary termination, would they be able to access subsidized COBRA coverage either during the window, or retro back to their employment loss date? Is that what you're asking me?

Leanne Kunze: Correct.

Kat Cook: Perfect. They would have the option to do either, as long as they were deemed eligible for the subsidy. If they had huge medical expenses in March after they lost their coverage, they could choose to retro back to February 1 when they lost

coverage. They would pay those back premiums, which would then mean that they could then be reimbursed for later medical expenses if they were allowable. Or if they don't want to pay the back premiums because of the cost benefit analysis they did of their expenses between February 1 and April 1, they could start the subsidized coverage April 1 and there would be no financial outlay from them for their premiums.

Leanne Kunze: Okay. Thank you very much.

Kat Cook: I just want to make sure it's clear that they would have to be eligible for the subsidy. They would have had to involuntarily terminated or lost hours.

Leanne Kunze: Correct. Thank you.

Dave Iseminger: Leanne, that's what you saw in Kat's report that we notified 26,000 people, but we've only received like 500 forms back. The net had to be cast wide to ensure those eligible would receive the notice.

Sue Birch: Do you have any information on why, out of the 26,000, we only had 500 respondents? Why people weren't taking us up on it.

Kat Cook: We've been discussing it, but because we're still in process, we don't have firm answers. We have theories but they're not substantiated at this point.

Sue Birch: What are your theories, Kat?

Kat Cook: We cast an incredibly wide net due to federal regulations to make sure we didn't miss folks. The original net was anybody who lost benefits from a certain date forward. People lost benefits for various reasons. They left and got another job, and then they wouldn't be eligible because they have other coverage. They retired and they have retiree coverage. They were fired. Any reason like that would mean that we cast a much broader net than what was probable, but that was better than the alternative of not notifying those that qualified. Not only would that be federally irresponsible, ethically irresponsible.

Sue Birch: Great. Thank you.

Dave Iseminger: Sue, there's that short window for the required notification. We all learned of it in March and had to mail things by the end of May. Even as we tried to, because it's not as typical data element within our system of record, about why somebody loses benefits we have that pitstop over into the employers, but we weren't able to get that employer data element before we had to send the notifications. HCA wasn't able to cull the requirements of our data pool for notification by even a reasonableness check with the employer about who likely might not have met the eligibility requirements. So, some of it is the timing aspect, further exacerbated by the legislation passed in mid-March. A model notice needed to be produced by a trifecta of governmental entities that didn't get produced until late April, early May, with a Memorial Day mailing date. It was better for us to go broad. But then you get, on the backend, 26,000 versus 500.

Public Comment

None.

Next Meeting

July 21, 2021

Starting at 1:00 p.m.

Preview of July 21, 2021 PEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the July 21, 2021 Board Meeting.

Meeting adjourned at 12:47 p.m.