Washington State Health Care Authority

Public Employees Benefits Board Meeting
Meeting Minutes

July 15, 2020
Health Care Authority
Meeting Held Telephonically
Olympia, Washington
1:00 p.m. – 4:15 p.m.

Members Present:
Sue Birch, Chair
Yvonne Tate
Harry Bossi
Tim Barclay
Elyette Weinstein
Tom MacRobert
Leanne Kunze

Members Absent:
John Comerford

PEB Board Counsel:
Michael Tunick, Assistant Attorney General

Call to Order
Sue Birch, Chair, called the meeting to order at 1:05 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.

Meeting Overview
David Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of today's meeting.

Approval of April 2, 2020 Meeting Minutes
Elyette Weinstein moved, and Yvonne Tate seconded a motion to approve the minutes as written. Minutes were approved as written by unanimous vote.

Follow Up From June 17, 2020 Meeting
Dave Iseminger: I have one update today. I like to use this time to give you COVID-19 updates. Many of the questions asked last meeting are embedded in future presentations. So, today I want to let you know the current status of how the plans are treating cost shares that are being waived for treatment of COVID. The plans had

various timelines. Under all the plans in the PEBB Program, waiver is occurring for member cost shares for COVID treatment through December 31.

PEB Board By-Laws Update

Dave Iseminger, Director, ERB Division. HCA is asking the Board to take action on updates to the PEB Board By-Laws. This is the same presentation as our last meeting with one modification. These updates are requested due to changes to statute. Specifically, there had been a K-12 non-voting member in statute that was removed effective January 1, 2020. There are also alignments with current law related to the Open Public Meetings Act and posting of agendas and minutes to modernize the By-laws. The Open Public Meetings Act hadn't recognized the internet until sometime in the last decade.

Slide 3 – PEB Board Action Required. There needs to be a two-thirds majority affirmative vote to amend the By-laws, requiring five votes versus the normal four. The proposed amendments are in the Appendix. I will highlight the one change made based on feedback. My recommendation is to approve the entire slate of proposed amendments in one vote.

Slide 4 – Feedback. One piece of feedback received resulted in a change to what was presented at the last meeting. It's a minor grammatical change to Slide 6, Article 1, Section 1 – Board Function in the Appendix. The red underlined portion is new language, red strike through is removed language. The phrase, “for higher education and State employees, State retirees, and school retirees” is how it will read if approved. The word “and” was added to the phrase “higher education and state employees.” In the prior version, we didn’t acknowledge the phrase “higher education” was also new. Beyond that, everything is as presented at the last meeting.

Sue Birch: Vote to approve proposed By-laws amendments as written.

Yvonne Tate moved, and Elyette Weinstein seconded a motion to approve the proposed By-laws as written.

Voting to Approve: 7
Voting No: 0

By-laws approved as written.

2021 PEBB Medicare Portfolio and Rate Resolutions

Tanya Deuel, ERB Finance Manager, **Sara Whitley**, Financial Services Division, and **Ellen Wolfhagen**, ERB Division.

Sara Whitley: Today is about Medicare. Slide 2 – PEBB Medicare Portfolio, is an overview of the current PEBB Medicare portfolio. We’ll also discuss the new proposed plans for 2021 to be offered via UnitedHealthcare. HCA’s current portfolio includes Kaiser Washington and Kaiser Northwest Medicare Options. Kaiser Washington offers a Medicare Advantage plan, as well as an original Medicare Coordination of Benefits plan. Each is offered in various counties throughout Washington and enrollees are able to select each plan from the county in which they live. Kaiser Northwest offers a Senior

Advantage or a Medicare Advantage option as well. All three Kaiser options include creditable drug coverage, which is drug coverage administered by the plan that is at least as rich as Part D drug coverage offered via Medicare.

The Uniform Medical Plan or UMP Classic Medicare option is our self-insured formation of benefits plan. Original Medicare fee for service pays primary on medical claims and UMP pays secondary. Our UMP Classic plan also includes creditable drug coverage, however, UMP pays primary on all pharmacy claims. There is no coordination of benefits with Medicare on the drug portion of the benefit.

The Premera Medicare Supplement Plans F and G are supplemental, or Medi-gap plans available for Medicare eligible enrollees, both retired and disabled. Supplement Plans quite literally help Medicare enrollees fill the gaps in Original Medicare coverage. They're not all-inclusive Medicare plans and do not include drug coverage.

The United MA-PD plans are proposed for 2021. These are employer group Medicare Advantage - Plus Prescription Drugs or Part D coverage plans. They include a national PPO network of providers with no difference in cost share for members being in or out of network care. As long as the provider accepts Medicare, they are considered in network for these plans. The United MA-PD plans offer lower premiums and out-of-pocket costs. These are not individual market plans, so there are no restrictions for enrollment, additional costs, or benefit restrictions for enrollees with preexisting conditions.

HCA has established contracts with United for this employer group plan, as we do with all of our carriers - Kaiser, Regence, Premera - in order to manage our member experience and ensure high plan performance. Our contracts include extensive performance guarantees with financial penalties linked to the management of operations, reporting, customer service, etc.

Slide 3 – History of Medicare Advantage. Medicare Advantage or Medicare Part C are managed care plans. Carriers establish at-risk contracts directly with CMS to administer Medicare Advantage plans. Based on that contract, CMS then pays the plan a risk adjusted capitated subsidy calculated on an annual basis that's intended to cover the cost of administering and covering all of Original Medicare, which is Parts A or hospital inpatient coverage and Medicare Part B, which is professional medical coverage.

Medicare Advantage Plans that include Part D drug coverage, or MA-PD plans, receive additional subsidies for administering the Part D benefit. In combination, these are intended to cover around 75% of the cost of the benefits. Managed care plans in Medicare were established around the 1970s and 1980s to address the rising costs of Medicare, which originally only included HMO plan options. As the plans evolved and enrollment increased, PPO options became available and national offerings have evolved to offer additional provider access to enrollees.

Medicare retirees have unique care needs and there are many clinical programs that offer coordination of care in the Medicare Advantage space that provides a means for increasing the quality of care that Medicare enrollees receive, as well as containing the costs associated with that care. Both Kaiser plans are Medicare Advantage plans,

include clinical programs, as well as the United plan, that are aimed at increasing the value and quality that's provided to our Medicare enrollees. These clinical programs are investments in the whole person health of a retiree with a goal of ensuring the plans are taking better care of our retirees, and over time, trends in hospitalizations and the cost of care decrease.

Slide 4 – PEBB Medicare Portfolio Development. Prescription drug costs in UMP Classic Medicare drive the cost of the plan and represent about 60% of the total plan cost, with that trend increasing over time. This is a function of UMP paying primary on drug costs, rather than secondary, as we do with coordination of benefits on the medical side. The plan absorbs the full impact of these costs.

The majority of that 60% of plan costs can be attributed to specialty drug spend. Specialty drug spend in 2019 represented about 1.4% of the total prescription counts but represented 57% of the total Medicare costs in our UMP plan. Many of the specialty drugs are in protected drug classes, which make it difficult for us to manage. Prescription drug prices are set at a certain rate, and because they're in protected drug classes, there is not much HCA can do to drive costs down. Historical increases in this trend has led to increases in premiums year over year for our retirees.

After stakeholdering and listening to retiree feedback on premium increases, we've utilized our purchasing powers with the state to procure lower cost, sustainable, high-value plans that maximize federal resources to help stabilize member premiums, while still providing high-value benefit options to our enrollees. Because UMP is a self-insured plan offering, HCA can't obtain the same federal resources as private carriers can by contracting directly with CMS.

Slide 5 – Characteristics of UMP Classic Medicare. Total plan costs are borne by the state. One of the advantages of having a self-insured plan is that we manage the benefit design and own any changes that take place in UMP Classic Medicare. It is a coordination of benefits, or COB plan, with original Medicare fee for service. Again, for medical claims, Original Medicare pays primary, UMP pays secondary. For pharmacy, UMP pays primary, there's no coordination of benefits.

Ellen Wolfhagen: Slide 6 – Original Medicare COB with UMP Classic, is an illustration only. If the provider's charge is $150, first look at the Medicare amount allowed based on a set fee schedule set by CMS which is the same for those same kinds of services. Medicare pays 80%. In the illustration, the Medicare amount allowed is $100, so Medicare would pay $80. UMP looks at the remaining $20 and determines how much the amount allowed would be, which is the same as the Medicare amount allowed. The UMP Classic benefit is 85% of that allowed amount, which is $85. $85 is greater than remaining $20; and therefore, UMP Classic would pay the $20 and the retiree will pay zero out of pocket.

Slide 7 – UMP Classic Medicare & UHC MA-PD Structure. This is just an illustration of some of the crossover between UMP Classic and the new MA-PD plans. Under UMP Classic, the retiree pays a coinsurance. Under MA-PD, the retiree would pay a copay.

Slide 8 – June 17 – Follow Up. The structure of UMP Classic and the MA-PD plans is very different. Because the costs are handled differently, it's difficult to make one-to-one comparisons. But the co-pays are set fees and are predictable. The coinsurance

amount is a percentage of what is allowed, so they're hard to predict because those costs may not be known by the retiree at the time of service. A lot of thought goes into individual plan selection usually driven by individual needs and circumstances, both economic and clinical, as well as preferences for kinds of facilities, treatment options, and providers. It's important to note that the provider access under MA-PD is exactly identical to UMP. Any provider a retiree is currently seeing in UMP is in network for the MA-PD plans.

Slide 9 – June 17 – Follow Up (*cont.*). Since the percentage of cost may not be known up front, it's hard to forecast what the actual coinsurance costs would be. With co-pays, those fees are set so it is possible to determine those costs. With these cost uncertainties in mind, HCA looked to provide a rich benefit design where most things are covered fully in order to protect against extreme costs.

Slide 10 – June 17 – Follow Up (*cont.*). This Slide is an illustrative scenario to look at an episode of care involving a cancer diagnosis. Again, this is just an illustration. Although it's hard to detail an episode of care, Dr. Transue, HCA's Medical Director, confirmed this is a reasonable summary for cost comparison purposes. We're looking at five visits of primary care, four visits of specialty care, a three-day inpatient hospital stay, six chemotherapy infusions, and a 90-day supply of specialty chemotherapy maintenance drugs. The difference between the infusions and the maintenance drugs is the infusions tend to be in a hospital or clinical setting and the specialty maintenance drugs tend to be oral medications that can be taken at home.

Dave Iseminger: I want to draw attention to two pieces of information on Slide 10. The first is the timeframe that Ellen's referring to in this illustrative scenario is January, which is important because that sets the stage that the deductible has not been met. For this scenario, we're pretending this is the first episode for seeking care in the plan year. It gets much harder to have an illustrative example adding in the variable of how far and how much out of pocket or deductible has been met. The second piece is the note at the bottom of Slide 11, which attempts to estimate the member cost for UMP and MA-PD plans because the nature of the question asked at the last meeting was specific comparing UMP and MA-PD. That is why we haven't included a further analysis of the rest of the portfolio.

Elyette Weinstein: I didn't hear exactly what you said about in-home infusion versus hospital infusion.

Ellen Wolfhagen: I was saying infusions are usually done either in a hospital or clinical setting as opposed to the maintenance drugs, which are usually oral drugs, which can be taken at home.

Slide 11 – Illustrative Comparison. This slide walks through the charges based on the information on Slide 10 and provides an estimated out-of-pocket cost. Estimated total medical costs for UMP Classic is the $250 deductible, no out-of-pocket medical for PEBB Complete, and a $500 admission charge for PEBB Balance, plus the specific co-pays for the specialty visits, and primary care visits for $635. The estimated total pharmacy costs are $225, $300, and $300. The estimated total costs does not equal those two boxes at the bottom because it includes the premium that has to be paid, which is the line at the top of the chart. We rounded the numbers at the bottom to make

round numbers. I also want to note that all Medicare enrollees pay a Part D premium, which we didn't include in this illustration.

Slide 12 – Additional Follow-Up Topics. There are no enrollment restrictions or additional costs for retirees who enroll with preexisting conditions. Customer service concerns are addressed through performance guarantees and reporting, and include measures such as time to answer calls, the percentage of calls resolved in one call, and call abandonment, or hang ups. There will be a dedicated call center for the PEBB plans.

Part D for prescription appeals come from denials of prior authorizations. About one in four members with a prior authorization denial pursue an appeal, and of these, the vast majority become approved. Prior authorization denials can be due to a lack of provider response or incomplete information, failure to respond to CMS requests timely, etc.

Sara Whitely: Slide 13 – 2021 Medicare Rates. Slide 14 – Retiree Premium Calculation is an overview of how a retiree premium is calculated. The equation is: Total Bid Rate – Medicare Explicit Subsidy = Retiree premium.

Slide 15 – State Medicare Explicit Subsidy – Illustration. Plan Premium – State Medicare Explicit Subsidy = Retiree Premium. For 2021, the Medicare explicit subsidy is proposed to be set at $183, or 50% of the premium, whichever is less, to arrive at our retiree premium. There are two illustrations, Plan 1 and Plan 2. The Plan 1 premium is $400. We then calculate the state Medicare explicit subsidy to be $183, or 50% of the premium, whichever is less. In this case, $183 is less than 50% of the premium, which is $200. $400 less $183 brings us to our retiree premium of $217 for Plan 1. In the case of Plan 2, the total plan premium is $200. When we calculate the state Medicare explicit subsidy, 50% of the premium, or $100, is less than $183. $200 less $100 brings us to a retiree premium of $100. These examples are for informational purposes.

Slide 16 – Medicare Retiree Rates and Slide 17 – Medicare Retiree Premiums lists the information for our senior advantage / Medicare plans.

Slide 18 – Impact of State Medicare Explicit Subsidy UMP Classic Medicare, compares Plans Years 2016 through 2021.

Sue Birch: Vote – Premium Resolution PEBB 2020-08 – Medicare Subsidy

Resolved that, the PEB Board endorses the calendar year 2021 monthly Medicare Explicit Subsidy of $183 or 50% of the premium, whichever is less.

Tom MacRobert moved, and Harry Bossi seconded a motion to adopt.

Voting to Approve: 7
Voting No: 0

Sue Birch: Premium Resolution PEBB 2020-08 passes.
Sue Birch: Vote – Premium Resolution PEBB 2020-09 – KPNW Medicare Premium

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of the Northwest Medicare plan premiums.

Yvonne Tate moved, and Tom MacRobert seconded a motion to adopt.

Voting to Approve: 7
Voting No: 0

Sue Birch: Premium Resolution PEBB 2020-09 passes.

Sue Birch: Vote – Premium Resolution PEBB 2020-10 – KPWA Medicare Premiums

Resolved that, the PEB Board endorses the Kaiser Foundation Health Plan of Washington Medicare plan premiums.

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Premium Resolution PEBB 2020-10 passes.

Sue Birch: Vote – Premium Resolution PEBB 2020-11 – UMP Medicare Premium

Resolved that, the PEB Board endorses the Uniform Medical Plan (UMP) Medicare plan premiums.

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Premium Resolution PEBB 2020-11 passes.

Sue Birch: Vote – Premium Resolution PEBB 2020-12 – UHC Medicare Premiums

Resolved that, the PEB Board authorizes the UnitedHealthcare Medicare Advantage plus Prescription Drug (MA-PD) plan premiums.

Harry Bossi moved, and Tim Barclay seconded a motion to adopt.

Elyette Weinstein: I'd like to speak to this. I believe the Health Care Authority when it reiterates that it will not propose shutting down UMP Classic health care plan options. HCA doesn't have to do that. The proposal before us would push us further down the private corporatization path, which will cause UMP Classic to die, slowly, by a thousand cuts. All you need to do is sit back and watch as adverse selection does the job for us.

The private health care corporations will continue to trot out shiny new low-cost plans that will mostly attract younger and healthier state retirees who don't need high-cost specialty drugs and services -- yet. Meanwhile, the Legislature may decrease or eliminate UMP's Medicare drug subsidies. Over time, it is likely that only those retirees who need special, costly treatments, or medication will remain in UMP Classic. This will drive premiums up even more and eventually no one will be able to afford them.

The death of UMP Classic would eliminate competition for the private health care corporations. I don't trust them to safeguard the public health and welfare. They're not evil but private corporations are not designed to prioritize public health and welfare over the profit of their shareholders. Their main duty is to maximize shareholder return. Unions and advocacy groups knew this and they fought tirelessly for government employer sponsored health care over decades and decades. They knew that government employers were best suited to provide adequate and reliable health care absent a single payer government model.

On the other hand, a look at the behavior of America's private corporate sector, which was supposed to be protecting us, provides a sobering view of how private corporations prioritize profits over public welfare, especially during a period of lax government oversight since 1980, which can also result from cuts in state funding, which are increasing, and state funding is falling. Public subsidies though go to companies too big to fail.

Sadly, even though they worked for and earned adequate medical coverage, our state retirees who are old, poor, people of color - this is an economic justice issue - will pay a price while health care privatization and corporatization prosper. We are on our way toward fulfilling the prophecy of the New York Times opinion writer who predicts that, "The future holds fewer choices for expendable Americans such as retired state workers, while it enriches corporate investors and executives."

I cannot join other PEB Board Members who march towards this unjust future. With the support of my retiree Executive Board, I will vote no.

Tim Barclay: One bit of feedback on your comments, Elyette. I would say that the potential for adverse selection to create what you called a slow death for the UMP program, I don't necessarily agree with you on that, in that it's certainly within, I think, the Health Care Authority's purview to create a risk adjustment mechanism similar to what we do in the active employees' plans if we felt such a selection bias was starting to happen. With the actives, the risk adjustment that takes place in the rate setting mitigates and offsets that potential selection that can take place where the healthy people migrate to the CDHP versus the people who stay in UMP Classic. If we saw that sort of selection bias taking place in Medicare, we could similarly implement a risk adjustment, which would then not penalize the sicker people for being sicker and congregating in one particular plan. I would point out that one issue I think we have within our power going forward is to make sure we don't unfairly ratchet up the premiums on the people who stay in the UMP plan if we choose to do that.

Leanne Kunze: While I wholeheartedly agree with the concerns that are listed, with Member Weinstein's comments, I see that as looking at the current status of health care in our country. It feels like this particular motion, the scope is much more narrow than

that level of policy. And while I want to, of course, demonstrate support for the need for better policy on the national level, I do believe that we have the opportunity to demonstrate more like what Tim was saying. I, at this point, would likely be voting yes and at the same time wanting to recognize the larger concerns from policy that we likely need to be working on at a federal level.

Tom MacRobert: I share the concerns that were just expressed. I'm very fearful that Medicare Advantage plans by demand are profit motivated and are beholden to their shareholders. I have a great deal of concern about moving in that direction. I look at that comparative chart and realize it's very hypothetical. But nonetheless, if UnitedHealthcare has the richness of benefits that were described to us, and I look at the cost of Uniform Medical and the cost of UnitedHealthcare's plan, it's packed. I could, based on just kind of what we have discussed, get the same quality of benefits for half the price. What's to stop a stampede of people moving from Uniform Medical to UnitedHealthcare if they save 50% of their costs while the benefits are "the same." What are the hidden costs that we are not aware of?

Sue Birch: Is that a question to a particular staff, Tom, or is that just a comment?

Tom MacRobert: It's a comment.

Elyette Weinstein: First of all, while -- and Tim, I really respect your expertise and integrity, as you know, but I am not totally sure that government, which Pierson and Hacker has said in their books about government, they're political scientists at Berkeley, "Government at all levels, including the state, is in a time of drift." If you look at how the government has even handled the COVID crisis, we are all over the map. Without the help of the federal government, I don't know where we're going to be at, and I'm not sure our state will continue to have the will to provide help to UMP. We may have a new governor. We may have a new Legislature. We may have a whole new scene. This is a time of great uncertainty.

The other thing I would like to mention is that, whether we like it or not, federal funds, as well as federal policy, does trickle down to the state level. We are not a bulwark, as the Confederacy found of the federal government. Especially since a conflict of laws, rules, and federal policy can have a great deal of effect on state policy. That concludes my comments.

Voting to Approve: 4
Yvonne Tate
Harry Bossi
Tim Barclay
Sue Birch

Voting No: 3
Elyette Weinstein
Tom MacRobert
Leanne Kunze

Sue Birch: Premium Resolution PEBB 2020-12 passes.

Sue Birch: Vote – Premium Resolution PEBB 2020-13 – Premera Medicare Premiums

Resolved that, the PEB Board endorses the Premera Medicare Supplement plan premiums.

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

Voting to Approve: 7
Voting No: 0

Sue Birch: Premium Resolution PEBB 2020-13 passes.

2021 Rates Overview

Tanya Deuel, ERB Finance Manager, Financial Services Division. I will walk through the Plan Year 2021 active employee and Non-Medicare retiree rates.

Slide 3 – Calculating the State Index Rate. We've walked through this illustration quite a few times now, but it's a great reminder for this presentation specifically. This is an illustrative example of how we calculate the state index rate, which is the employer contribution towards medical benefits. It is a percentage established in the Collective Bargaining Agreement for health care, which says the state will contribute 85% of the weighted average projected health care costs.

There are three plan bid rates as examples: Plan A, Plan B, and Plan C. Plan A shows a $550 bid rate, Plan B shows a $500 bid rate, and Plan C shows a $450 bid rate. Plan A shows three adult units enrolled in that plan, Plan B shows one, and Plan C shows six. If you multiply that down, the $550 plan bid rate for Plan A, times three adult units, equals a monthly cost for that plan of $1,650. Follow that math across Plan B and Plan C. Now add the total monthly cost for all three plans, which were multiplied by the number of adult units enrolled, to get a total cost of $4,850. Divide that by the total 10 adult units that were enrolled in those three plans to get a weighted average of $485. The state index rate, which is the employer's contribution towards health care is set at 85%. Take that total weighted average, times 85%, to get an employer contribution of $412. Keep that $412 in mind as we go to Slide 4.

Slide 4 – Determining Employee Premiums. On this slide, you see the three plan bid rates for Plans A, B, and C, which were on Slide 3. The $412 calculation as the employer's contribution towards health care is then subtracted from each of those three plans. Regardless of the plan costs, the state is going to contribute the same average amount for each of those plans, meaning the employee contribution is the difference. The $550 minus $412 means those three employees each would pay $138. In Plan B the bid rate is $500, the state would again contribute the same $412. So that one employee enrolled in Plan B would contribute $88. Same math for Plan C.

Slide 5 – Determining Employee Premiums by Tier. This Slide shows the Tier structure in the PEBB Program. For Plan A, the single employee contribution we just calculated on the previous slide was $138. For the single tier, Tier1, would pay $138. For Tier 2, an employee and their spouse or state registered domestic partner, would be times two, add the $10 spouse charge, to get a contribution of $286. Tier 3, employee and child or

children, regardless of the number of children enrolled in your plan, multiply the single subscriber amount of $138 times 1.75 to get a contribution of $242. For Tier 4, the full family tier, multiplies by 2.75, plus the $10 spouse charge, to get a total cost of $390. That same multiplier would be for each of the plans across the top of the slide.

Slide 6 – Employee / Employer Premium Contributions. This is the first preview into the employer and employee premium contributions for Plan Year 2021. The plan names listed are sorted by carrier, followed by the Proposed 2021 Employee Contributions (Single Subscriber) and the state index rate (employer contribution for Plan Year 2021) at $581. As we just discussed, the $581 is the same amount regardless of plan. And then you'll see the total composite rate listed. The equation is the total composite rate minus the state index rate ($581) to show the remainder which is what the employee pays.

Elyette Weinstein: I'm not clear – the employee does not pay the composite rate?

Tanya Deuel: No. The composite rate is the bid rate the plans proposed during negotiations as their total cost for that plan for a single employee. For example, UMP Classic, the total rate we developed says it would be $686 to cover, on average, the single person in UMP Classic. Subtract the $581 that the state's going to contribute, again, that's that weighted average amount set in the Collective Bargaining Agreement. The remainder of $105 is what the employee would pay.

Elyette Weinstein: Thank you.

Tanya Deuel: Slide 7 – Employee Contributions by Tier. This slide walks through each of the employee contributions by tier. The plans are listed in the same order as the previous slides, then comparing Plan Year 2020 with proposed Plan Year 2021 rates by tier. You will find the comparisons for subscriber, followed by the subscriber and spouse, the subscriber and children, and finally the subscriber, spouse, and children tier. The last column shows the 2020 to 2021 change in subscriber rates. This percentage and dollar change is a single subscriber tier (first two columns). The average composite increase on the employee premiums is 2.4%. When you look here, we saw average increases on the total bid rate, not just the employee portion, of about 1.5% to 5% this year. When we get to the Non-Medicare slides next, you will get a good sense of plan by plan, where those plans bid rates fell. Due to the nature of the state index rate, and how the calculation works, the percentages here might look larger than the total average bid rate increase. When you have an increase on a smaller number, you're going to get a larger percent increase than the total bid rate.

Slide 9 – Non-Medicare Retiree Rates by Tier. This slide is structured similar to the slides we just saw but is for Non-Medicare retirees who do not receive a contribution from the state towards their health care costs. Instead, the benefit Non-Medicare retirees see is eased by being rated with active employees. Their rates are typically lower than they would be if they were on their own.

The last column on this slide is the 2020 to 2021 change in subscriber rates, which is close to what you would see as the total bid rate change, plan by plan. The numbers look a lot smaller than we saw on the previous slide and are well within range of the typical increase we see year over year, typically between a 3% and 5% increase. Quite

a few are on the lower end of increases. The Non-Medicare retirees pay the full bid rate plus a self-pay administrative charge ~$5, which is included in the premium shown.

Tim Barclay: Can you remind me how many people are actually in the Kaiser Northwest CDHP plan on the Non-Medicare side?

Tanya Deuel: On the active employees?

Tim Barclay: Yes.

Tanya Deuel: We will have someone in the room pull it up.

Tim Barclay: Just keep that in mind. The next question, which you don't have to answer now, but I'm curious. My assumption is that the number is very small. I just want you to go back and look and tell me how much that rate increase is based on the experience of that small cohort of people. It's just surprising to me that their CDHP jumped out of whack with Kaiser Washington and the UMP plans. I'd like to better understand how they got there.

Tanya Deuel: They definitely have a smaller amount of enrollment in that plan. Their bid rate did increase within the 3% to 5% range I described. It was at the top of that increase on just the bid rate. Before this meeting, I looked over the last four years, specifically, on Kaiser Northwest CDHP. They've had some significant decreases in employee contributions on a percentage and their bid rates themselves actually increased on the lower end of percentages the last few years versus some of the other plans in the portfolio. With the state index rate only increasing a little less than 2% this year, and their bid rate increasing 5%, we're seeing that increase in the employee contribution. Since most of the enrollment is in UMP Classic, it really drives up state index rates.

Dave Iseminger: The combined member enrollments of both subscribers and dependents is approximately 580 members as of last month.

Tim Barclay: I guess that makes sense. The question to think about is, does it really make sense to have one of our three CDHP plans priced significantly different than the other two? Is there justification for that rate differential? Again, I don't expect you to answer that off the cuff now. It's something I'd like you to ponder before we meet next.

Tanya Deuel: We can do that. Slide 10 – Dental, Life, and Long-Term Disability. Slide 11 – Dental Premiums, which are 100% employer paid for active employees. This slide compares Plan Year 2020 rates to Plan Year 2021 rates for the Uniform Dental Plan, DeltaCare, and Willamette Dental Group. Our fully insured Dental Care and Willamette plans are in a rate guarantee, as well as our administrator for the Uniform Dental Plan. The rate guarantee for the Uniform Dental Plan on the administrative piece stays flat. However, this is a self-insured dental plan and we do look at claims, so the rate will slightly increase for Plan Year 2021.

Slide 12 – Life, AD&D, and LTD Premiums. Again, these are employer funded and have no rate changes for Plan Year 2021. Optional Life and LTD are paid by the employee. There is no rate change for Plan Year 2021, however, if a member does

change their waiting period, or their age band changes, they may experience a rate change for those optional benefits.

Slide 13 – Proposed Premium Resolutions. These resolutions are carrier specific, not plan specific. There is a resolution for each of the carriers, meaning if you didn't want to have one of the plans within the carrier, all of the plans would not be passed through.

Proposed Premium Resolution PEBB 2020-14, Non-Medicare Premiums. The PEB Board endorses the Kaiser Foundation Health Plan of the Northwest employee and Non-Medicare retiree premiums. Next would be the same resolution but for the Kaiser Foundation Health Plan of Washington (Proposed Premium Resolution PEBB 2020-15 – Non-Medicare Premium), followed by Proposed Premium Resolution PEBB 2020-16 for the Uniform Medical Plan. At our July 22 meeting we will bring these resolutions back to the Board for action and provide any stakeholder feedback we receive. And I will bring back information specific to Tim's question on Kaiser Northwest CDHP.

Sue Birch: Thank you for that thorough presentation. I'm guardedly optimistic that these rates are looking relatively flat. I have to say for the years of all of this work, I feel like we're starting to get traction on making things more affordable and/or to reduce the increases that we've seen. Let's hope we're going to move in a downward direction for the years to come.

2020 Uniform Medical Plan (UMP) Preferred Drug List (PDL)

Ryan Pistoresi, PharmD, MS, Assistant Chief Pharmacy Officer, Clinical Quality and Care Transformation (CQCT) Division. I am providing an update on the 2020 UMP Preferred Drug List (PDL). Slide 2 – UMP Formulary Update. This slide lists what was reviewed at the January 2020 Retreat. HCA provided information on how our members were accessing Moda for questions, the call times and wait times. Today I'll provide an update on that for the first quarter of 2020 to give you a more complete picture. At the January Retreat, we shared some data around the number of members who were being proactive and requesting an exception request so they could have a smooth, seamless transition for 2020. However, January was too early to present any type of comprehensive result around the PDL.

Slide 3 – Ongoing Pharmacy Management. Today's update is in the context of the overall pharmacy management. HCA continues to evaluate, update, and manage the 2020 PDL. We continue to bring drug classes to the Washington State Pharmacy and Therapeutics and to Moda P&T Committees to evaluate new drugs and new cost management strategies, to solicit new rebate offers and to update those rebate offers to get better deals as drug prices continue to increase. We continue to update, review, and create clinical policies to ensure the appropriate use of prescription drugs within the plan, and that this 2020 update is really a new tool we haven't had before that helps us direct members to the highest value drugs on the PDL, while still allowing access to these non-covered drugs when medically necessary and appropriate for their condition. Slide 4 – Preferred Drugs vs. Non-Preferred Drugs. This slide is a longitudinal analysis provided to help understand how members have been switching from preferred drugs to non-preferred drugs. I want to alert you to the two lines. The upper line is the preferred alternative, when members switch from one drug to another they're switching to a preferred drug. From 2016 to 2020, it appears relatively flat. It also shows the cost per day of the medication per 1,000 members. If you take one tablet once a day, that represents a day. If you take four tablets a day, those four tablets would equal one day.

A day's supply is a standard measure used in pharmacy to better estimate utilization to account for that variation in different amounts of tablets, or different amounts of insulin, or other types of drugs. The cost for one of these days of a preferred drug is $1.15 and the cost per day for the non-preferred drug in this analysis was $39.68. There is a stark difference between the preferred and non-preferred drugs and we're trying to use this tool to help direct our members to these preferred alternatives first. In the case they aren't medically appropriate or there are other issues, they're still allowed the access to the non-preferred drug.

Slides 5 and 6 - Preferred Drugs vs. Non-Preferred Drugs (*cont.*) These two slides are a more in-depth look, but for the most part, these are the trend lines over the last five years. 2020 covers only January through April. The top line on Slide 5 has adjusted the scale to focus in on what we see as change. There has been a steady increase year over year, but for 2019 to 2020, we've seen about a 3.8% increase, which is about 962 days per 1,000 members. In 2020, we are already seeing there has been an increase in the rate which members are switching to a preferred alternative from their previous drug.

Slide 6 shows the graph on the non-preferred drugs. There was a shift in 2016 to 2017, going from 558 to 266, which reflects insulin changes made back then, and relatively flat from 2017 to 2019. We are starting to see a decrease in 2020, but we're only 142 days in. The relative change is much more significant at 58.4%, a decrease from 243 days to 101 days.

Elyette Weinstein: You cut out when you were discussing how you calculate the average pill usage per day. I couldn't hear everything you said.

Ryan Pistoresi: The way we like to standardize drug utilization in pharmacy is to look at a measure known as the day's supply. Someone may use one tablet a day, another person may use three tablets a day. They're the same prescription, they're getting the same kind of benefit. But rather than looking at how many tablets are dispensed, or how many vials, or syringes, we use a calculation that looks at how much drug was used per day so we can standardize. Everyone has 365 days in a year, but they may not be using the same number of tablets or units of drug. This is just a measure for this analysis. If you looked at the number of tablets in a specific drug like Lisinopril, a blood pressure drug, you could compare someone using tablets of Lisinopril to milliliters of insulin, to Albuterol inhaler administrations. This is a way we can standardize across all different drug types into a single measurable unit.

Elyette Weinstein: Thank you.

Ryan Pistoresi: Slide 7 – When Non-covered Drugs are Requested. The non-covered drugs are the main change with the 2020 PDL. We created a mixed classification for Tier 3 drugs which are now some of the non-covered drugs. When members are requesting the coverage for non-covered drugs, two options can occur. The request could be approved, which happens when it is determined that a member is unable to use the appropriate formulary alternative and the requested non-covered drug is covered at a Tier 2. These were drugs previously in Tier 3 so the cost share for these members was a 50% cost share on the drug. If it was a specialty drug, it was capped at $150 per 30-day supply, so the concession made when we were moving forward with

this was wanting to help the members, because we realized these drugs are medically necessary and they have exhausted their lower-cost, higher-value alternatives. We wanted to let them have a lower cost share. For some members who are using certain types of diabetes medications or inhalers, they were having to spend $200 to $300 a month because it was a 50% cost share. Now they're paying at Tier 2, which is capped at paying $75 a month. This helped members who were approved for these requests.

For members who were denied, Moda discovered, there were preferred alternatives available to the member and Moda would provide that list to the member so they could discuss it with their prescriber. Different plans have different preferred drugs. It can be confusing. We wanted to help the members and providers to have this information so that they could review to see if any of the drugs on the list were appropriate alternatives. The member could then switch to a PDL alternative or appeal the determination based on special circumstances, which could help expedite it. Or they could obtain the requested medication that was denied using the Washington Prescription Drug Program or if they are a resident of Oregon, the Oregon Prescription Drug Program discount card. The discount card is offered through the Northwest Drug Consortium. There is a specific discount card for the residents of Washington and one for the residents of Oregon. It helps members buy drugs similar to how the Consortium for Washington and Oregon would purchase the drugs, and at the same rate that UMP is purchasing the drugs.

Slide 8 – Exception Requests. This slide compares the number of request statistics for 2019 and 2020. In 2019, 449 Tier 3 exception requests were received. Some were members using a Tier 3 drug and requesting a Tier 2 cost share. The requests listed for 2020 include exception requests starting on October 1 of 2019 and going through June 15, 2020. There have been ten times the number requests, and as such, a higher approval rate. This indicates a number of members in UMP who would be using these Tier 3 drugs and who could have qualified for this reduced cost share, didn't know the process or have the opportunity to apply for the reduced cost savings. Because we put that as a highlight in our member communications for open enrollment, we received a lot of questions from members. We saw a significant increase in the amount of approvals, which is helps our members because they are going from Tier 3 cost share down to Tier 2 cost share. Some members went to the alternative drug. Members are not going without their drugs, they're able to see what other alternatives there are.

Slide 9 - 2020 PDL Exception Requests: Top Requested Drugs. The drugs listed have had at least 75 requests and the conditions they treat. These are the brand name versions.

Slide 10 – Customer Service Calls per 1,000 Members (2018 – 2020). This slide is the update from the customer service perspective. The chart shows the member experience around open enrollment. The January, February, and March information is updated to show how the member experience changed. The call volume increased through open enrollment, which isn't surprising. We usually see an increase in calls in January, but not in 2020. It was a delayed increase in calls per 1,000 members. This may be attributed to members going to the pharmacies with questions or due to COVID-19. To avoid trips to the pharmacy, did members have other options?

Slide 11 – Customer Service Wait Time Average (2018 – 2020). The goal was 30 seconds or less. There was an increase in January. January 2020 is also when the

SEBB Program went live for UMP, too. There are approximately 93,000 more members in UMP. There were a lot of calls to the pharmacies which increased the wait time. Moda does offer a call-back service for members who don't want to wait on hold. They are placed in the queue and will receive a call back from the representative when they are next in line.

Slide 12 – Customer Service Abandonment (2018 – 2020). Moda measured the time a call came in and does not get to a customer service representative. The goal is less than three percent. Most months, the goal was met. It was higher in January, which can be attributed to the increase in the number of calls and the SEB Board Program going live, and slightly higher in February and March, but within the goal.

Slide 13 – COVID-19 Impact. Two actions were taken to assist our members in getting through COVID-19. One of the first actions taken was to postpone prior authorizations for maintenance drugs that would have expired in March, April, or May. Those authorizations were extended three months without requiring the member to go into the doctor's office to get labs drawn or other types of criteria for a reauthorization. This extension affected 2,802 members. Second, members are allowed early refills, up to a 90-day supply, to reduce trips to the pharmacies.

Slide 14 – Future Analyses. Current and ongoing analyses are: longitudinal analysis of member experiences, cost and savings analyses, and change in drug use within drug classes.

Sue Birch: Ryan, on behalf of the Board I want to thank you because everything we can do to try to get greater value for our members is much appreciated. You've shown us that we're moving in the right direction.

SmartHealth

Jenny Switzer, UMP Account Manager, ERB Division. Slide 3 – What is SmartHealth? SmartHealth is Washington State's voluntary and confidential wellness program. HCA contracts with Limeade, who administers the SmartHealth Program. It's an online mobile-friendly wellness program that supports employees and their well-being. It includes customized activities based on self-reported information and participants can earn rewards such as gift cards, their deductible, or HSA incentives.

Slide 4 – Incentive Eligibility. The following group subscribers can qualify for SmartHealth wellness incentives: employees enrolled in a PEBB medical coverage, employees not enrolled in Medicare Part A and B, COBRA subscribers not enrolled in Medicare A and B, and PEBB Continuation Coverage Unpaid Leave Subscribers. Spouses enrolled in PEBB medical coverage and employees that waive PEBB medical coverage have access to SmartHealth and can utilize it to better their well-being but are not eligible for the wellness incentive. Retirees who defer PEBB medical coverage do not have access to SmartHealth.

Slide 6 – Incentive Levels. There are three different incentive levels. Level 1 is completing a well-being assessment, a self-reported assessment of your overall well-being to earn 800 points and get a $25 Amazon gift card. Level 2 is a member who completes Level 1 and then earns 2,000 total points. They can receive $125 Wellness incentive applied to the next year's medical deductible or their HSA account. Level 3

employees complete Levels 1 and 2 and earn 4,000 total points and a wellness champion badge on the portal to encourage them to keep going and focus on their personal well-being.

Slide 7 – SmartHealth Incentive Details. The deadline for the $25 Amazon gift card is December 31 for all members. For the $125 wellness incentive, the Board voted last year to move the deadline from September 30 to November 30 to give our members more time to complete the levels, if you are in the PEBB Program prior to October 1. For members that enroll after October 1, they just need to complete Level 2 by December 31 to receive the $125 wellness incentive.

Slide 8 – 2019 Participation. Of 165,839 eligible members, 74,988 members registered in the SmartHealth portal. 2,818 spouses registered and 4,823 retirees registered to participate in the SmartHealth Program.

Slide 9 – Most Viewed Activities in 2019. This slide shows a highlight of some of our most viewed activities in 2019. We had an activity where people could learn about the Moda Diabetes Prevention Program, tracking steps that can be linked to a Fitbit or Garmin activity tracker, and then a video that highlighted SmartHealth stories. In 2019, we featured 398 unique activities for our members.

Slide 10 – Statewide Well-being Assessment. This slide is a quick overview of our statewide well-being assessment. The assessment highlights areas of strengths and opportunities for improvement for our organizations and as a full picture of the PEBB statewide look. They are available to organizations for their individual populations so that they can plan for the next year and know areas they can focus on as the statewide assessment reports. In 2019, our top scoring areas were smoke-free living, drinking moderately, and self-care. In the 2019 areas of opportunity were healthy weight, sleep, and back health. The PEBB Program areas of opportunity are very similar to Limeade's overall customer population.

Slide 11 – Well-being Assessment Trends 2016, 2017, 2018, and 2019. The well-being assessment trends are from people completing the self-reported well-being assessment. This tool is to see how effective our marketing campaigns are to our members, informing them of the assessment, and to track when people are most engaged with this part of the activities.

Slide 12 - $125 Incentive Trends 2016, 2017, 2018, and 2019. This slide shows the trend for the $125 incentive. HCA watches this trend graph to see how well our communications are working.

Slide 13 – 2020 WBA Percentage of Completion Same Period Previous Years. This slide shows the percentage of completion for the well-being assessment from 2016 through 2020. In 2018, there was a spike when the $25 Amazon gift card was new and heavily promoted by the wellness coordinators in each of the organizations. For 2020, almost 39% of the registered population has completed the well-being assessment.

Slide 14 – 2020 Most Viewed Activities. To date, for 2020, the activities viewed the most are listed. Tracking 5,000 daily steps was viewed the most, then Be Smart with Your Money, COVID-19: Learn the Facts, COVID-19 Resources, Learn About the Diabetes Prevention Program, to name a few.

Slide 15 – COVID-19 Crisis Response Activities. There were 20 activities to address health and wellness issues related to the COVID-19 pandemic, with more added each month.

Slide 16 – User Feedback on COVID-19 Activities. HCA received good feedback from members on the activities related to COVID-19.

Tim Barclay: Jenny, I'm wondering if the program has been in place long enough, and if there's data available, that at some point we can move beyond participation as our measure of success and start looking to see if people are really changing to healthier behaviors as a result of the participation in SmartHealth? Is there ever a way we can look and see what we're really achieving in terms of results instead of just participation?

Jenny Switzer: That is a topic we discuss all the time. How do we move into making it an intrinsic desire for people to be more engaged in all levels of wellness and well-being? That statewide well-being assessment gives us a picture each year how our members are rating, although it's a self-assessment. We do have a way of seeing how people are self-reporting their improvements, and maybe areas where they've gone backwards. We don't see it on an individual level. I don't have anything specific that I can give you, but we're in those conversations, and the well-being assessment does give us a pretty good picture of where we're seeing improvements.

Tim Barclay: I think that's one of the things we want to think about going forward, because as we talked extensively at our last board meeting, given the budget constraints we're faced with, this is one of the things we are spending real money on, both through the direct cost of the program and the incentives that go along with it that I would hope at some point we could start to produce something to support that investment, that it's really making a difference. I appreciate your comments.

Supplemental Long-Term Disability (LTD) Benefit Options
Jean Bui, Manager, Portfolio Management & Monitoring Section
Marcia Peterson, Manager, Benefits Strategy & Design Section
Paula Williamson, Protected Leave and Accommodation Manager, Employee Resources Division.

Slide 2 – Overview. The current Basic Long-Term Disability benefit is inadequate to cover the needs of PEBB Program subscribers. There is a very low likelihood that we will have the ability to improve the basic LTD benefit, both due to receiving no additional funding during the 2019-2021 biennium and with the current state fiscal challenges brought on by the COVID-19 pandemic. Although we offer supplemental employee LTD coverage, only 34% of PEBB Program subscribers have enrolled. This number increased after a special open enrollment event held in 2019.
Slide 3 – Three Types of Group Disability Coverage. How do we increase participation in supplemental coverage? Short-term coverage covers an employee's salary during a short-term disability. The disability would prevent the employee from their ability to work their usual job. This includes pregnancy, accidental injuries, and illness. The short-term disability has been replaced by the Washington State Paid Family and Medical Leave Program.

Long-term disability covers an employee's salary during a longer-term disability. This is a situation in which the employee is unable to perform with reasonable continuity the duties of their job. The third bullet needs a correction and it should read: sickness, injury, or pregnancy after the benefit waiting period, usually 90 days, through the employee's maximum benefit period, which is specific to each claim. The slide deck will be corrected for the next meeting.

Slide 4 - Three Types of Group Disability Coverage (*cont.*). The third type of disability group is Social Security Disability, which results in the inability of the employee to engage in any substantial gainful activity. This is medically determined and could be the result of a physical or mental impairment. The disability is expected to last for at least 12 months or to result in death.

These three types of disability benefits, along with an employee's sick leave and vacation leave, are the income protection for employees facing a disability that makes them unable to work.

Slide 5 – Nationwide Disability Facts. One in four people now age 20 will experience a disability during their career. Only 20% of people have disability insurance. Approximately 50% of adults could not cover their salary for three months. And 40% of adults do not have enough cash on hand to cover a $400 emergency expense.

Slide 6 – Factors in Whether to Select Disability Insurance. Research shows that the disability product is not well understood, including what is considered a disability. Product descriptions aren't relatable. Later Paula will provide some real-world experience PEBB Program members have had related to disability. Often employees are unlikely to understand the incidence of a disability unless they personally have family or friends who have experienced one. LTD products are often complex and hard to understand, resulting in an employee defaulting to no choice at all, especially if the value is questionable. Or they rely on the employer selection as their default option, assuming that it would be adequate to cover their needs. In the case of the PEBB Program, that would be a maximum of $240 per month for the basic benefit.

Slide 7 – Current PEBB Program LTD Benefit. This slide compares the current PEBB Program basic and supplemental benefits. The basic benefit covers 60% of the first $400 of monthly income. It is $50 up to a maximum of $240 per month and is 100% employer paid. Supplemental covers up to 60% of the first $10,000 of monthly income, from $50 up to a maximum benefit of $6,000 per month and is 100% employee paid.

Marcia Peterson: Slide 8 – Comparison from 1977 to 2020. The basic LTD benefit for PEBB Program members hasn't changed since 1977 when the median household income in the United States at that time was $13,570. In Washington State in 2018, the median household income was $74,073, so a huge difference in income during that time. The basic benefit possibly covered more of a salary than it does today. While household income has increased over 400% during the last 43 years, the basic LTD benefit hasn't changed. And as was noted, only about 34% of PEBB Program subscribers have enrolled in that supplemental benefit. What we end up with is a vast number of employees, when faced with a disability and look to their disability benefit, if they haven't signed up for supplemental, realize their salary of $240 a month is what they're going to be living on during this time. This is one of the reasons we wanted

Paula Williamson to share her experience of dealing with employees in this type of situation.

Paula Williamson: Thank you for the opportunity to share this experience. Our long-term disability basic benefit is woefully inadequate, I find in working with staff in my role as the Protected Leave and Reasonable Accommodation Manager at the Health Care Authority. HCA has about 1,400 or so employees. Several times a year we have a staff member who is facing end of work life decisions due to a chronic condition or the sudden onset of a very serious health condition like a cancer, Parkinson's, Alzheimer's, or any of those conditions that we all can name. I'm the one they come to when they are trying to figure out next steps in their lives. When they ask, because they remember something about a long-term disability benefit, can we get that started? I will go into the system and look at their status and determine they only have the basic benefit. When they started with the state years and years ago, just as Jean was saying, people don't anticipate becoming disabled in their work lives. When they first start with the state, they are somewhat overwhelmed with so many decisions as far as getting enrolled into benefits, and PERS, learning a new job, and all the acronyms we have, that long-term disability isn't really on their radar. So, when they come to me, because they're really facing a decision to stop working because they are incapable of working anymore, I get to break the news to them, “Yes, you have the basic long-term disability which will pay you a maximum of $240 a month.” It's a very difficult conversation to have with someone and it breaks my heart every time.

In the private sector, we've seen this approach have a very positive impact on things like 401k plan participation. Anything we can do here at HCA to steer people in the direction of making a decision, whether it's a default decision to be enrolled in an optional buy up with the option to select out would be a beneficial so when they’re faced with no longer being able to work, I can look in the system and share with them, yes, after 90 days you have a meaningful benefit of 60% of your salary, up to $10,000 of that salary, for a total benefit of up to $6,000 per month. It's something that makes the next step in their life seem doable. So, I encourage you to really think about this as a possible option for us to help our employees throughout their work lives. Thank you.

Marcia Peterson: Slide 9 – Options to Improve Disability Coverage for PEBB Program Subscribers. Obviously, we would like to improve disability coverage for PEBB Program subscribers. There are a few options we've looked at. One is looking for a way to request funding for increasing the basic benefit so it would go to a maximum monthly benefit of $1,500. HCA finance staff estimated the annual cost to the state for the PEBB Program alone at about $12.8 million to bring it up to that level. To add the SEBB Program, it would be almost double that amount.

We could also increase the percentage who select that supplemental benefit by improving the communication regarding the value, which we are working on for the next open enrollment. HCA is working with The Standard to improve at least the way that it's communicated so people understand more about the benefit itself.

HCA offered a one-time open enrollment period in March 2019 for the supplemental plan, where we allowed people to sign up without evidence of insurability. Enrollment increased from 28% to 34%. That 34% we learned is pretty average for public sector employees for supplemental benefits. We can also look at an automatic enrollment with an option to opt out.

Slide 10 – Proposing Opt-Out Benefit for LTD Supplemental. HCA is proposing an opt-out benefit for LTD supplemental for all the reasons we've discussed today. We are unlikely to get additional funding in the near future to improve the basic benefit. Improving the communications, try as we might, only gets us so far. We are looking for Board feedback on this option of getting more members comprehensive coverage.

Slide 11 – Automatic Enrollment with Opt-Out. I want to talk about behavioral economics because this is a tool we're talking about using for this opt-out approach. Behavioral economics is a study of how people make decisions and research shows people don't always make the most rational choices that benefit us. We are subject to all kinds of influences when we make choices. An example is if you want people to eat healthy and you run the cafeteria, you put the fruit at eye level when people walk in the door, not the coconut cream pie. The fruit is the first thing they'll choose because that's the first thing they see. It's called giving a nudge, not mandating. It's not saying you can't have coconut cream pie, it's working on that subtle nudge. It makes it easier for people to make "good choices" and harder to make "bad choices."

One way to encourage people to make good choices in a benefit program is to automatically enroll them but give them that option to opt-out. That has been shown to be successful since people tend to stick with the default option because it's more work to change. It increases the percentage of people who take advantage of those employer benefits that are available to them who normally may not.

Slide 12 – Automatic Enrollment with Opt-Out (*cont.*). We are talking about mirroring the approach the Department of Retirement Systems has used. They utilize this opt-out approach in to increase the percentage of state employees who took advantage of the Deferred Compensation Program, which is a great retirement savings program. Thirty days after a new employee is hired, they receive a letter from the Department of Retirement Services regarding the Deferred Compensation Program enrollment, indicate they are automatically enrolled, and they have 30 days to opt-out of program. This has worked amazingly well. Over the last three years, they've maintained an approximate 90% retention rate. HCA would like to discuss a similar approach for supplemental LTD with the Board.

Slide 13 – Possible Opt-Out Supplemental LTD (Existing Employees). The proposal is to start in January 2022 and have all PEBB Program subscribers not already enrolled in supplemental LTD coverage receive a letter in the fall of 2021 letting them know they're going to be auto enrolled in supplemental LTD. They would have the option to opt-out at any time, depending on the design we're proposing. If they wanted to re-enroll later, they would be subject to evidence of insurability. Their first payroll deduction for this benefit would begin in January 2022.

Slide 14 – Possible Opt-Out Supplemental LTD (New Hires). Newly hired PEBB Program subscribers would be automatically enrolled. They would receive a letter letting them know they have their 31-day new hire period to opt-out, which is very similar to other benefits elections they have in our program. The coverage would be effective the first calendar day of the following month. If they opt-out and want to re-enroll later, they would be subject to evidence of insurability.

We've discussed this proposal with The Standard and they are excited to offer this option. That's as far as we have gone because we want Board feedback before going further.

Yvonne Tate: I want to compliment you all. I think it's very important, especially in this space and time, to make sure employees have all the long-term disability insurance possible. $240 a month is absolutely nothing to live on. I just appreciate that you all recognize that, and you're working hard to try and make things better.

Tim Barclay: Are you proposing to eliminate the basic benefit at the same time you do this opt out supplemental?

Dave Iseminger: It actually is part of the proposal right now. So just to summarize, it would be retiring the basic benefit, making the structure only a supplemental employee-paid benefit that is opt-out. The one piece that I think might have gotten missed. It's still up in the air, we're still working through this piece, and I would appreciate the Board's insight. There are a couple of options that can be evaluated. It could be opt-out at any point, and it's effective first of the next month, like many other changes that happen for PEBB throughout the year, or it could be opt-out once a year during annual open enrollment. If you were to ask us today, our recommendation would be to opt-out at any point, effective first of the next month.

Tim Barclay: I guess I would just add that while normally I'm not a fan of taking benefits away from members, I think if you leave the basic benefit in there, it adds more confusion than value. I think you'll have people turning down the supplemental and still relying on the basic, no matter how much you tell them it's almost worthless. I think it's a good thing to change direction at the same time and make it a supplemental only benefit.

Harry Bossi: Just a suggestion, and you probably already considered this, but rather for existing hires who would have to opt out, instead work with Standard to have another special open enrollment like there was two years ago. It might make it more palatable because that can turn ugly, unfortunately, especially with the communication campaign. For new hires moving forward, it would be the opt-out. That way existing employees aren't feeling like they're being forced into or out of something. New hires would understand that it is part of the benefits package. Those are my comments, but thank you for looking at other ways to achieve greater coverage for employees. Much appreciated.

Dave Iseminger: Harry, I want to give you one piece of context because we've had a variety of conversations with The Standard. This has been a multiyear process. I know we brought you and the SEB Board ideas about trading benefits within the portfolio. Then there was the request to the Legislature, and now we're here looking for another road to go down, which is where we are on this proposal. When we talked with The Standard about the concepts of open enrollment, I think it's important to know that when we did that one-time special open enrollment in March 2019, we got a 6% increase in net participation. I think it's important to know that the industry standard participation that exists for public sector large employers like ourselves does tend to be around 35%. There is a saturation point that happens when opting in no matter what you do. Our successful efforts of March 2019 got us to that typical place. But I think the type of

participation we could get from an opt out approach is double, or even triple participation. It would be significantly higher and offer a lot more protection. We will certainly talk with Standard to see if anything has changed on that front. But I did want to highlight that we have reached a typical average saturation point for participation of a public sector large employer.

Elyette Weinstein: I used to work for Department of Retirement Systems as an attorney, and then also the State Actuary working with the State Pension Benefit Board. What we ran into, I forget who discussed this, but there's a cliff argument, and it is that employees that got into PERS2 or TRS2 when they were new and didn't get the benefits that PERS1 or TRS1 got, were screaming, and yelling, and appealing all the time, especially if they had just missed the cliff. It isn't the people who way, "Well, I was new. I guess I can't opt out." No, they're like, "Well, that was an arbitrary date. Prove to me that date is based on anything economic." I'm just saying you're not going to stop people from arguing. I guess the point I'm trying to make is after about ten years with the retirement system, we saw cliff arguments all the time. These are 20 years after a person was into TRS2, and they would be screaming and yelling that they weren't allowed into TRS1. I think people are going to protest if they're to say, come in new, and the people that were already there weren't mandated in and they were. They're going to see it. I mean, they filed charges saying it's discriminatory.

Sue Birch: Thank you for those comments. I think at this point, we are going to let this issue ride, because we don't have any decisions to make today.

2021 PEB Board Meeting Schedule

Dave Iseminger: The PEB Board meeting schedule for 2021 is included behind TAB 10. We generally have the same weeks at the same point of the year. We always schedule three meetings in July, not knowing exactly how the rate season will go and which of the meetings we'll need. We always meet twice in July. We anticipate next Wednesday's meeting being the last Board Meeting of the season. As part of the Open Public Meetings Act, the meeting schedule will be filed with the Code Advisor's Office. The length of our meetings are determined by the agenda so mark your calendars with these dates.

Public Comment

No public comment.

Next Meeting

July 22, 2020
1:00 p.m. – 3:30 p.m.

Preview of July 22, 2020 PEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the July 22, 2020 Board Meeting.

Tim Barclay: Dave, let's suppose hypothetically that Tanya does not come back with good justification for KP Northwest CDHP rate differential? I noticed that the premium resolution is by carrier and not by specific product. What are our options as a Board if she doesn't come back with a good justification, and they are not willing to lower their premium to be consistent with the others? What are the Board's options to address that situation?

Dave Iseminger: Tim, I can think of at least two preliminary pieces. The first is, remember there was the resolution about the rate development process that was passed a meeting or two ago that talked about carriers can't submit anything unless the Board or agency requests it. We could always entertain exercising that right, either using the Board's request, or the agency's request, to ask Kaiser Northwest to present a bid rate option that does not include the high deductible health plan. If we get to a point where next week there's not satisfactory answers, and the Board wants to hold over that resolution for another week, we can get direction from the Board to engage with Kaiser Northwest. We could have a relatively short meeting on July 29 to finish up the rate-setting process with KP Northwest.

I'll remind all Board Members that all our carriers listen in on all of our calls. I suspect there'll be some conversations from KP Northwest as early as tomorrow, given the questions that were raised today so we can try to provide answers. But you could hold over the resolution for a week and give specific direction for the agency to engage with the carrier if that is the direction we all deem is the best option going forward.

Tim Barclay: Is there anything we can do for you today to make that process easier if they want to offer a more appropriate rate for that plan?

Dave Iseminger: It would be helpful if the Board wanted to give us the direction today that if KP Northwest wanted to adjust only their CDHP rate, you would entertain additional information on that CDHP rate. That would be helpful today. That way if we determine in conversations with KP Northwest that such an adjustment could be made, you would have already indicated on the record your willingness to entertain that. I would encourage you, if you want to go down that path, to be very specific about what you would or wouldn't allow. I don't think you need a formal vote, but I'd like you to have a straw poll if that's the direction you want to go.

Tim Barclay: I would certainly support it.

Yvonne Tate: I support it.

Harry Bossi: I have some concerns about the CDHP, in particular, because of the low enrollment and wondering if it's just a drag. Thank you.

Sue Birch: We'll have our next meeting on July 22. I wish for you all to be well, wear your masks, stay safe, and be socially distant.

Meeting Adjourned: 3:41 p.m.