MEMO TO: Finance, Administration and Communication Committee

FROM: Nicole Bruce, Sr, Human Resources Analyst

DATE: August 28, 2018

SUBJECT: Benefits and Wellness Update – Potential Plan Changes for 2019

I. PURPOSE

☐ For Info Only ☒ Potential Agenda Item ☐ Scheduled for Council Action

II. RECOMMENDATION

To provide the FAC Committee with an update on the potential benefit plan changes for the 2019 plan year.

III. DEPARTMENT CONTACTS

Mellody Matthes, Human Resources Director – (425) 556-2122
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IV. DESCRIPTION/BACKGROUND

The Red-Med Plan is the self-insured medical plan that is provided by the City for employees, spouses, state registered domestic partners, and eligible dependents. A third-party administrator and a healthcare broker assist with management and administration of the plan. Any changes to Red-Med benefits are incorporated into a Summary Plan Description, which is the definitive description of the benefits that are covered by Red-Med.

Periodically, the City's third-party administrator, pharmacy benefits manager, and broker recommend plan changes. In addition to ensuring that the Plan is legally compliant, these recommendations address evolving treatment options and protocols, as well as other issues and benefit clarifications that these parties deem necessary. When these recommendations modify benefits, they are reviewed with Council and approval is obtained. These changes are negotiated with bargaining units before they are incorporated into the Summary Plan Description as plan amendments.

Proposed changes in benefits are reviewed and discussed with the Employee Benefits Advisory Committee (EBAC) and any recommendations will be brought forward to Council for their approval at the October 2, 2018 meeting.

The EBAC has also been monitoring and analyzing the benefit reserve fund. The City's Medical Self Insurance Reserve is in a very healthy state with excess funding. The EBAC will likely bring forward a recommendation to reallocate some of these "excess" reserves for a one-time use. One of the top recommendations that has been vetted is that of an HRA VEBA account for employees.

What is the HRA VEBA Plan?

The HRA VEBA Plan is a funded health reimbursement arrangement (HRA) offered by HRA VEBA Trust. Created in 1990, HRA VEBA Trust is a non-profit, tax-exempt health and welfare benefit trust. HRA VEBA Trust currently provides benefits to 50,000+ public employees and retirees from more than 500 governmental employers in the Northwest (Washington, Oregon, and Idaho). Participating employers include cities, counties, ports, public utility districts, fire districts, water and wastewater districts, and other types of special purpose districts.

What does "VEBA" stand for?

"VEBA" stands for voluntary employees' beneficiary association. VEBAs are a type of trust instrument used to hold plan assets for the purpose of providing employee benefits. VEBAs are authorized by Internal Revenue Code section 501(c)(9). HRA VEBA Trust offers a health reimbursement arrangement commonly known as the HRA VEBA Plan.

What is an HRA?

A health reimbursement arrangement (HRA) is an account-based health plan that can used, after becoming claims-eligible, to reimburse qualified out-of-pocket medical care costs as defined by the IRS. Common qualified expenses include co-pays, deductibles, prescription drugs, retiree insurance premiums, etc. An HRA is not an insurance plan, and employees/employers do not pay a premium. The account is funded with contributions from employers. Employer contributions, investment earnings, and withdrawals (claims) are tax-fee. Contribution amounts will not be included on Form W-2, and a Form 1099 is not required for earnings or withdrawals (claims).

A. Analysis

The EBAC has been working with our benefits broker Gallagher to explore potential plan design changes as well as the reserves strategy. The EBAC meets monthly and reviews options as well as the financial impacts of each plan design modification. Members of EBAC then communicate to their respective groups to get feedback and to gauge interest level in the potential changes. Some of the changes (considered) for 2019 are as follows:

- Removing the reimbursement feature from retail prescriptions and charging for the member cost at the point of sale rather than the member having to wait for reimbursement. This is an administrative change, but could have some cost impacts because to implement this change it has also been recommended that we remove the separate out-of-pocket maximum for mail order prescriptions and have one out-of-pocket maximum for all medical and prescription costs.
- Adding MDLive telehealth service. With MDLIVE, members can access a doctor from home, office, or on the go - 24/7/365. Board Certified doctors can visit with members either by phone or secure video to help treat any non-emergency medical conditions. Doctors can diagnose symptoms, prescribe medication, and send prescriptions to members pharmacy of choice.
- Adding a LASIK benefit to the vision plan.
- Unbundling Dental and Vision benefits and allowing employees to choose each plan separately. This will likely increase enrollment in these plans.
- Adding coverage for non-surgical obesity treatment.
- Creating an HRA VEBA plan and funding the account using excess reserves.

V. TIME CONSTRAINTS

In order for Plan Changes to take effect at the beginning of a new plan year (January 1, 2019), the recommendations will need to be approved at the October 2, 2019 meeting to allow for appropriate lead time for the Plan Administrator to make adjustments for an effective date of January 1, 2019.

VI. LIST OF ATTACHMENTS

No attachments