

School Employees Benefits Board

June 3, 2021

School Employees Benefits Board

June 3, 2021

9:00 a.m. – 12:00 p.m.

Attendance by Zoom Only

Health Care Authority
Sue Crystal A & B
626 8th Avenue SE
Olympia, Washington

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TAB 1

School Employees Benefits Board
June 3, 2021
9:00 a.m. – 12:00 p.m.

Aligning with Governor's Proclamation 20-28
all Board Members and public attendees
will only be able to attend virtually

TO JOIN ZOOM MEETING – SEE INFORMATION BELOW

9:00 a.m.*	Welcome and Introductions		Lou McDermott, Chair	
9:05 a.m.	Meeting Overview		David Iseminger, Director Employees & Retirees Benefits ERB) Division	Information
9:10 a.m.	Approval of: March 4, 2021 Meeting Minutes	TAB 3	Lou McDermott, Chair	Action
9:15 a.m.	Follow Up from May 5, 2021 Meeting		David Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information/ Discussion
9:25 a.m.	2022 Annual Procurement Update	TAB 4	Lauren Johnston, SEBB Program Procurement Manager, ERB Division	Information/ Discussion
10:05 a.m.	SEBB Medical Plan Appeals Process	TAB 5	Selena Davis, Senior Account Manager, ERB Division	Information/ Discussion
10:25 a.m.	Public Comment			
10:40 a.m.	Transition to Executive Session			
10:45 a.m.	Executive Session			
Noon	Adjourn			

***All Times Approximate**

The School Employees Benefits Board will meet Thursday, June 3, 2021. Due to COVID-19 and out of an abundance of caution, all Board Members and public attendees will attend this meeting virtually.

The Board will consider all matters on the agenda plus any items that may normally come before them.

Pursuant to RCW 42.30.110(1)(l), the Board will meet in Executive Session to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session will begin at 10:45 a.m. and conclude no later 12:00 p.m.

No "action," as defined in RCW 42.30.020(3), will be taken at the Executive Session.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

Direct e-mail to: SEBboard@hca.wa.gov.

Materials posted at: <https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program>
by close of business on June 1, 2021.

Join Zoom Meeting:

<https://zoom.us/j/93934682796?pwd=MXFiK040Z2hjbVhaMXBISUg1VDVkJz09>

Meeting ID: 939 3468 2796

Passcode: 414370

One tap mobile

+12532158782,,93934682796# US (Tacoma)

+13462487799,,93934682796# US (Houston)

Dial by your location

+1 253 215 8782 US (Tacoma)

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+1 301 715 8592 US (Washington DC)

+1 312 626 6799 US (Chicago)

+1 929 205 6099 US (New York)

Meeting ID: 939 3468 2796

Find your local number: <https://zoom.us/u/ajgly2xON>

SEB Board Members

Name	Representing
Lou McDermott, Deputy Director Health Care Authority 626 8 th Ave SE PO Box 42720 Olympia, WA 98504-2720 V 360-725-0891 louis.mcdermott@hca.wa.gov	Chair
Kerry Schaefer 1405 N 10 th ST Tacoma, WA 98403 C 253-227-3439 kerry.schaefer@hca.wa.gov	Employee Health Benefits Policy and Administration
Pete Cutler 7605 Ostrich DR SE Olympia, WA 98513 C 360-789-2787 Pete.cutler@hca.wa.gov	Employee Health Benefits Policy and Administration
Dawna Hansen-Murray 9932 Jackson ST Yelm, WA 98597 C 360-790-4961 dawna.hansen-murray@hca.wa.gov	Classified Employees
Dan Gossett 603 Veralene Way SW Everett, WA 98203 C 425-737-2983 dan.gossett@hca.wa.gov	Certificated Employees

SEB Board Members

Name

Representing

Katy Henry
230 E Montgomery AVE
Spokane, WA 99207
V 509-655-2350
Katy.henry@hca.wa.gov

Certificated Employees

Terri House
Marysville School District
4220 80th ST NE
Marysville, WA 98270
V 360-965-0010
terri.house@hca.wa.gov

Classified Employees

Wayne Leonard
Assistant Superintendent of
Business Services
Mead School District
608 E 19th Ave
Spokane, WA 99203
V 509-465-6017
wayne.leonard@hca.wa.gov

Employee Health Benefits Policy
and Administration
(WASBO)

Alison Poulsen
12515 South Hangman Valley RD
Valleyford, WA 99036
C 509-499-0482
alison.poulsen@hca.wa.gov

Employee Health Benefits Policy
and Administration

Legal Counsel

Katy Hatfield, Assistant Attorney General
7141 Cleanwater Dr SW
PO Box 40124
Olympia, WA 98504-0124
V 360-586-6561
Katy.Hatfield@atg.wa.gov

2/23/21



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue SE • P.O. Box 45502 • Olympia, Washington 98504-5502

SEB BOARD MEETING SCHEDULE

2021 School Employees Benefits (SEB) Board Meeting Schedule

The SEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501.

January 28, 2021 - 9:00 a.m. – 4:00 p.m.

March 4, 2021 - 9:00 a.m. – 2:00 p.m.

April 7, 2021 - 9:00 p.m. – 2:00 p.m.

May 5, 2021 - 9:00 a.m. – 2:00 p.m.

June 3, 2021 - 9:00 a.m. – 2:00 p.m.

June 24, 2021 - 9:00 a.m. – 2:00 p.m.

July 15, 2021 - 9:00 a.m. – 2:00 p.m.

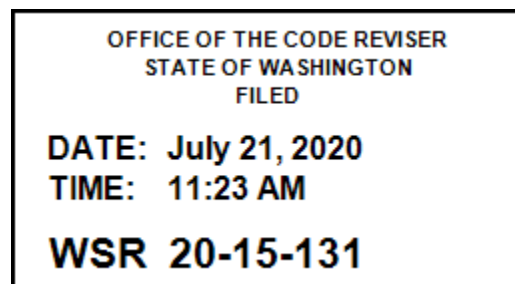
July 22, 2021 - 9:00 a.m. – 2:00 p.m.

July 29, 2021 - 9:00 a.m. – 2:00 p.m.

*Meeting times are tentative

If you are a person with a disability and need a special accommodation, please contact Connie Bergener at 360-725-0856

6/12/20



TAB 2

SCHOOL EMPLOYEES BENEFITS BOARD BY-LAWS

ARTICLE I

The Board and Its Members

1. **Board Function**—The School Employees Benefits Board (hereinafter “the SEBB” or “Board”) is created pursuant to RCW 41.05.740 within the Health Care Authority; the SEBB’s function is to design and approve insurance benefit plans for school district, educational service district, and charter school employees, and to establish eligibility criteria for participation in insurance benefit plans.
2. **Staff**—Health Care Authority staff shall serve as staff to the Board.
3. **Appointment**—The members of the Board shall be appointed by the Governor in accordance with RCW 41.05.740. A Board member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.
4. **Board Composition**—The composition of the nine-member Board shall be in accordance with RCW 41.05.740. All nine members may participate in discussions, make and second motions, and vote on motions.
5. **Board Compensation**—Members of the Board shall be compensated in accordance with RCW [43.03.250](#) and shall be reimbursed for their travel expenses while on official business in accordance with RCW [43.03.050](#) and [43.03.060](#).

ARTICLE II

Board Officers and Duties

1. **Chair of the Board**—The Health Care Authority Director or his or her designee shall serve as Chair of the Board and shall conduct meetings of the Board. The Chair shall have all powers and duties conferred by law and the Board’s By-laws. If the regular Chair cannot attend a regular or special meeting, the Health Care Authority Director may designate another person to serve as temporary Chair for that meeting. A temporary Chair designated for a single meeting has all of the rights and responsibilities of the regular Chair.
2. **Vice Chair of the Board**—In December 2017, and each January beginning in 2019, the Board shall select from among its members a Vice Chair. If the Vice Chair position becomes vacant for any reason, the Board shall select a new Vice Chair for the remainder of the year. The Vice Chair shall preside at any regular or special meeting of the Board in the absence of a regular or temporary Chair.

ARTICLE III

Board Committees **(RESERVED)**

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board’s duties. All Board meetings shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW, but the Board may enter into an executive session as permitted by the Open Public Meetings Act.
2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser’s Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.
3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.
4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.
5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 24 hours prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. An audio recording (or other generally-accepted electronic recording) shall be made of each meeting. HCA staff will provide minutes summarizing each meeting from the audio recording. Summary minutes shall be provided to the Board for review and adoption at a subsequent Board meeting.
6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board members in the minutes.

ARTICLE V
Meeting Procedures

1. Quorum—Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.
2. Order of Business—The order of business shall be determined by the agenda.
3. Teleconference Permitted—A Board member may attend a meeting in person or, by special arrangement and advance notice to the Chair, by telephone conference call or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the SEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at Board meetings may also occur in conjunction with a public hearing or during the Board’s consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.
5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Board members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .
6. Representing the Board’s Position on an Issue—No Board member may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.
7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the Chair, or upon request of a Board member, a roll call vote may be conducted. Proxy votes are not permitted, but the prohibition of proxy votes does not prevent a temporary Chair designated by the Health Care Authority Director from voting.
8. State Ethics Law and Recusal—Board members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW. A Board member shall recuse himself or herself from casting a vote as necessary to comply with the Ethics in Public Service Act.
9. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert’s Rules of Order Newly Revised. Board staff shall ensure a copy of *Robert’s Rules* is available at all Board meetings.
10. Civility—While engaged in Board duties, Board members conduct shall demonstrate civility, respect, and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

ARTICLE VI
Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The SEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.
2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public’s health, safety, and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

TAB 3

School Employees Benefits Board
Meeting Minutes
DRAFT

March 4, 2021
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 1:30 p.m.

The Briefing Book with the complete presentations can be found at:
<https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program>

Members Present via Phone

Lou McDermott, Chair
Wayne Leonard
Katy Henry
Dan Gossett
Pete Cutler
Terri House
Dawna Hansen-Murray
Alison Poulsen

SEB Board Counsel

Katy Hatfield

Call to Order

Lou McDermott, 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 telephonic only and will address only those topics necessary and routine to complete the regular cycle of activity in our Board season.

Meeting Overview

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

Today we are starting a new tradition for Board meetings. At the start of each meeting, when I go over the agenda, I'm going to take the opportunity to highlight different parts of the state and share information about the communities we serve in that region or county. Throughout the meeting, HCA staff presenters will have an image from that part of the state as their Zoom background. It's an opportunity to share information and elevate awareness about the communities, including potential health disparities and

health metrics for the populations we serve, as well as highlighting the natural beauty of our state.

Today we highlight Chelan County. The image you will see during presentations, and behind Chair McDermott, is a natural image from near Leavenworth, Washington. The most recent census for Chelan County shows about 76,000 residents, with about 38,444 of those residents in the SEBB Program. About 5% of the county population is served by SEBB. Similarly, for the PEBB Program, another 5% of the population is served through PEBB benefits. The Health Care Authority also administers the Apple Health Medicaid Program, which serves an additional 35% of the population in Chelan County. Between Medicaid, PEBB, and SEBB about 44% to 45% of county residents are served by the programs that the Health Care Authority administers.

Chelan County has a 9.5% uninsured rate, which is higher than the statewide average, a higher uninsured population, and relative to state averages, the County has higher unemployment.

Looking at the region of Chelan, Douglas, Grant, and Okanogan counties, cancer-related deaths are lower and better than the statewide average on incidents of low birthweight and opioid addiction. There are fewer instances of opioid addiction and higher performance overall in providing opioid treatment to patients with those opioid addictions.

Confluence is one of the largest hospital systems in the area. Initially, as HCA began working on value-based purchasing, we struggled to get all parts of the state to engage, embrace, and expand value-based purchasing. I'm happy to remind the Board that as of January 1, 2021, Confluence joined the UMP Plus Puget Sound High-Value Network. That is one of our hallmark value-based purchasing products within our HCA commercial portfolio. Headway has been made in expanding value-based purchasing, and more importantly, all major hospital CEOs have been engaged with HCA on various designs with a willingness to explore, support, and participate in future value-based purchasing efforts.

In a similar vein, as HCA continues to promote inclusivity and awareness in general, I'm going to finish my opening comments with a Land Acknowledgement statement related to tribal lands. Our meeting is being supported physically in Olympia, on the traditional territories of the Coast Salish people, specifically the Nisqually and Squaxin Island peoples. Olympia and the South Puget Sound region are covered by the Treaty of Medicine Creek, signed under duress in 1854. We want to acknowledge the Tribal governments and their roles today in continuing to take care of those lands.

Approval of April 2, 2020 Meeting Minutes

Terri House moved, and Dan Gossett seconded a motion to approve. Minutes approved as written by unanimous vote.

Approval of May 7, 2020 Meeting Minutes

Katy Henry moved, and Wayne Leonard seconded a motion to approve. Minutes approved as written by unanimous vote.

Approval of June 4, 2020 Meeting Minutes

Dan Gossett moved, and Dawna Hansen-Murray seconded a motion to approve. Minutes approved as written by unanimous vote.

Approval of June 24, 2020 Meeting Minutes

Terri House moved, and Dan Gossett seconded a motion to approve. Minutes approved as written by unanimous vote.

Approval of July 16, 2020 Meeting Minutes

Pete Cutler moved, and Katy Henry seconded a motion to approve. Minutes approved as written by unanimous vote.

Follow Up of January 28, 2021 Retreat

Dave Iseminger, Director, ERB Division. I have one follow-up not integrated in other presentations today. Terri House asked a question about SmartHealth and incentive earning for 2020. 17% of the population earned the \$50 incentive distributed in January 2020, which is just under 24,000 individuals. This year, the incentive escalated up to \$125. As we launched the program, the first iteration of the wellness incentive was \$50 applied to either the deductible of the plan or deposited into a health savings account.

2021 Legislative Session

Cade Walker, Special Executive Assistant, ERB Division. To date, the legislative session has been relatively slow for us. Not a lot of legislation directly impacts the PEBB or the SEBB Programs. However, HCA has been very busy with a tremendous amount of legislation regarding behavioral health. Our Division is monitoring that legislation given the crossover it could have with our carriers.

Slide 2 – Number of 2021 Bills Analyzed by ERB Division. This slide shows the breakdown of the bills the Employees and Retirees Benefits (ERB) Division is either the lead on or supporting. If it impacts the ERB Division, we are the lead and responsible for the overall agency analysis for legislation. When we are in the support role, we provide the Division's perspective to the agency's lead analyst. We also determine if the bill is a high priority bill or a low priority bill. A high priority bill is anticipated to have a financial impact greater than \$50,000 to the program or could require amending HCA rules or policies. To date, the ERB Division completed 100 bill analyses for the 2021 legislative session.

Slide 3 – 2021 Legislative Session – ERB High Level Lead Bills. We are past the second cut off when bills need to be out of the fiscal committees. The next cut off is March 9, when all legislation not necessary to implement the budget has to be out of the originating chamber. If a piece of legislation had originated in the House, it must be passed out to the Senate by March 9 for that legislation to continue moving forward. There are exceptions, such as legislation required for the implementation of the budget, or otherwise known as necessary to implement the budget. There's additional flexibility with that legislation.

Of ERB's high priority lead bills, currently four are continuing to move through the process. We'll continue to track those throughout the remainder of the session, which ends April 25. All signs indicate session will end on time.

Slide 4 – Upcoming Session – Agency Request Legislation. The one piece of agency request legislation submitted by the Health Care Authority is an ERB related: Senate Bill 5322, Prohibiting Dual Enrollment between the SEBB and PEBB Programs. It was introduced by Senator Robinson. It's merely a technical bill to legislation passed last year, ESSB 6189, a dual enrollment prohibition, specifically section (4). It requires enrollment in a single program for either your medical, dental, or medical, dental and vision benefits. The original legislation in 2020 restricts enrollment to a single coverage type but did not make it clear it should be within one program or the other. This caused significant programming and implementation hurdles to overcome. In fact, it is almost technically impossible for us to have facilitated that sort of a dual enrollment.

HCA requested this legislation to allow us to implement the dual enrollment prohibition intended by the Legislature. It comes with a cost savings due to simplifying the technical requirements to put in place a dual enrollment prohibition. This is not to say implementation will be easy.

Dave Iseminger: This bill is moving along in House Appropriations and is scheduled for a hearing.

Cade Walker: It's a Senate introduced bill and now in House Appropriations. It has flown through without a single vote of objection in the committees and on the floor of the Senate. It moved straight to House Appropriations. We expect this to pass.

Slide 5 – HB 1052 – Group Insurance Contracts. This is an important piece of legislation for the work we do. It aligns the insurance code with industry practice and with what HCA currently does in having performance guarantees, or performance standards, which is the language used in the bill to hold carriers accountable for performances. HCA puts performance guarantees in all of our contracts with our carriers. The topics of those performance guarantees range from customer service metrics: how quickly calls are answered, number of dropped calls; claims processing, how timely they are, how accurate those processed are. It's a part of our stewardship of being good benefit providers.

Slide 6 – Topical Areas of Introduced Legislation. All but two of the bills on this page did not make it past the cut-off point, the Fiscal Committee of the originating chamber. Engrossed Second Substitute Senate Bill 5097 is still active. It is adjusting the eligibility, different requirements and benefits of the Paid Family and Medical Leave Program that went into effect. It has nominal impact on our work. However, because our long-term disability benefit does bookend with the parameters and availability of Paid Family and Medical Leave, we are keeping an eye on it to determine if adjustments are needed in the future.

Senate Bill 5195 – Opioid Overdose Medication is also still active. HCA anticipates a minor fiscal impact for the programs with this bill.

Dave Iseminger: Cade, House Bill 1073 – Paid Family & Medical Leave is still active and traveling through the legislative process. Remove the strike out on that bill.

Cade Walker: Thank you for catching.

Slide 7 – Topical Areas of Introduced Legislation (*cont.*). Three bills are still active under Provider/Health Care Services. Senate Bill 5018, Acupuncture and Eastern Medicine Services, which has been introduced in the past, continues to move. House Bill 1196/Senate Bill 5326 – Audio-only Telemedicine. Both versions of that bill are currently moving forward. Senate Bill 5313 - Health Insurance Discrimination, primarily regarding trans medical services, continues to move.

Under the Open Public Meetings Act, House Bill 1056 – Public Meetings/Emergencies continues to move. There are potential minor implications for Board meetings and how they are conducted.

The budgets have not been released. We anticipate those budgets coming out from their respective chambers around the time the March budget forecast is released later this month.

K-12 Non-Medicare Retiree Risk Pooling Update

Molly Christie, Fiscal Information and Data Analyst, Financial Services Division. Slide 2 – Legislative Report. HCA submitted a report to the Legislature in January 2019 analyzing the most appropriate risk pool for disabled and retired school employees. The health insurance industry uses risk pools to calculate premiums for a group of people with different medical risks and the different associated costs because of those risks. Under these arrangements the cost of members who use more benefits are typically offset by members who use fewer benefits. And then, you have a single premium assigned to the entire risk pool. There's some subsidizing going on between these different groups.

Slide 3 – Current Risk Pool Structure. There are three current risk pools in the PEBB and SEBB Programs. All school retirees are currently covered under the PEBB Program. The PEBB non-Medicare risk pool includes SEBB non-Medicare school retirees, state employees, and state retirees. Medicare eligible school retirees are grouped under the PEBB Program Medicare risk pool with state Medicare retirees. Only school employees are covered under the SEBB Program risk pool. Again, non-Medicare retirees benefit from lower premiums because they're included in the same risk pool as state employees and state employees tend to be younger and healthier. HCA refers to this in the PEBB Program as the implicit subsidy. School districts pay a fee. It's the K-12 remittance to the PEBB Program to account for this subsidy. The K-12 remittance also accounts for a premium subsidy for our Medicare eligible school retirees. The remittance is now built into the SEBB Program funding rate.

Dave Iseminger: Molly, in the K-12 world, what we refer to as the remittance is often referred to as the carve out.

Molly Christie: Perfect. Slide 4 – 2019 Report Recommendation. In consultation with both Boards back in 2018, HCA recommended in its report to create a new non-Medicare risk pool under the SEBB Program that would include SEBB Program school employees and school retirees who are not yet Medicare eligible.

Slide 5 – Impacts. In doing this analysis, HCA's primary consideration was member experience and plan choice. Under the recommended risk pool scenario, our newly

retiring school employees not yet eligible for Medicare would be able to select from the same SEBB plans they had available to them while employed as school employees. Non-Medicare school retirees already in the PEBB Program would likewise remain in the PEBB Program for continuity of benefits. They wouldn't have to switch plans between the two risk pools. All retirees, as is current practice, would continue to move into the PEBB Medicare risk pool once they're Medicare eligible.

The recommended risk pool scenario would result in a gradual increase of up to 1% on SEBB Program non-Medicare bid rates and a decrease of a similar magnitude on the PEBB Program side for the PEBB non-Medicare risk pool because, on average, retirees have higher medical costs. Most of these costlier retirees are going to age into Medicare probably over the next three to five years. This will lower the risk profile and associated claims' costs in the PEBB Program non-Medicare risk pool.

On the SEBB Program side, new non-Medicare school retirees, once this is implemented moving forward, will slowly enter the new SEBB Program non-Medicare risk pool. This will cause a minor increase in overall costs in that risk pool. Put simply, current school retirees will slowly leave the PEBB Program as they turn 65, which will cause a decrease in the rates for that risk pool because they're not going to be replaced with new school retirees. Those new school retirees will enter the SEBB non-Medicare risk pool, causing a minor increase in the bid rates for that risk pool.

Employees pay a percentage of bid rates based on the employer contribution established under collective bargaining. So, in practice, any impacts to employee premiums under this recommended risk pool scenario would be very minimal, possibly even zero.

Slide 6 – Considerations & Next Steps. While preparing for implementation, HCA identified statutory changes required to make modifications to the PEBB and SEBB Programs' risk pools (RCW 41.05.022). HCA originally anticipated these changes could be made in the 2021 legislative session, which appears unlikely given everything that has happened in the last year. We look to move forward as quickly as possible in the future. We will keep the Board updated on the new anticipated implementation date once we confirm those statutory changes have been made.

Dave Iseminger: HCA had hoped implementation would be January 1, 2022. During this year, we are constantly reprioritizing work, like all of our employers in both of our programs. With statutory changes needed, our hope and intent is to have something ready for the 2022 legislative session, leaning forward with an implementation of January 1, 2023.

Wayne Leonard: You mentioned in the previous slide, the carve out or the remittance subsidy. Does that go to subsidize all retirees or just Medicare retirees?

Molly Christie: The remittance is paid specifically for school retirees, with about 20% attributable to the implicit subsidy, which is this risk pool subsidy of having school retirees included in the same risk pool as state employees. About 80% of that is the premium subsidy and the premium subsidy is for Medicare retirees specifically. The way I think about the implicit subsidy, and why that would be paid by K-12 districts, and there's not a specific remittance for PEBB Program members, is because they're paying

that as they're employed through this implicit subsidy. When they retire, they benefit from it. Because school employees aren't included in that risk pool when they're working, there's that associated cost the school districts pay once they're retired.

Wayne Leonard: So, right now that subsidy goes to the PEBB Program. When we create this new risk pool, it will go to the SEBB retirees, is that correct?

Molly Christie: What we anticipate happening is that the remittance won't go away completely because we still have all Medicare eligible retirees move into the PEBB Program. We're not changing the Medicare risk pool, and 80% of that remittance is for the Medicare explicit subsidy, the premium subsidy. What we will see though, is the implicit subsidy portion of the remittance will slowly decrease as school retirees in the PEBB Program non-Medicare risk pool start to age into the Medicare risk pool. Once they reach 65, they can no longer be in the non-Medicare PEBB Program risk pool. They're moving into Medicare, so, there's no reason to continue paying that implicit subsidy portion of the remittance for those retirees.

Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP) 2021 Leniency

Leanna Olive, Senior Account Manager, ERB Division. Slide 2 – Overview lists what will be discussed.

Slide 3 - Salary Reduction Plan. Per RCW 41.05, the Health Care Authority is authorized to offer and implement these benefits. The salary reduction plan makes it possible for employees to reduce their salary through payroll deduction in order to participate in tax advantaged benefits. Two such benefits are available: the medical health care Medical Flexible Spending Arrangement (FSA), whereby employees can deduct from their paychecks up to \$2,750 for 2021, which can be used for eligible out-of-pocket medical costs. The participant's entire annual deduction is available the first day of the plan year, and funds can be incurred and spent through the grace period extending into March of the next plan year.

The Dependent Care Assistance Program (DCAP) works in a similar way with key differences. It comes with a \$5,000 annual maximum election that can be used for eligible dependent care expenses. The \$5,000 maximum has not changed for this benefit since the late 80s. The account must be used by December 31 of the plan year and has no grace period. Funds are pre-funded, and they can be used only after they are contributed through payroll deduction. Traditionally, the amount of the participants annual election is determined during open enrollment and locked in with no opportunity to change without a qualifying event such as birth, adoption, or divorce that precipitates that special open enrollment.

Slide 4 – COVID-19 in the 2020 Plan Year. Last year, the pandemic hit tax advantage accounts quite hard, including a statewide suspension of elective surgeries, closures that kept people from health care settings, and it changed the childcare marketplace, even though people still needed childcare services. This naturally impacted participants' ability to utilize their tax advantage accounts, making member losses possible.

Slide 5 – COVID-19 in the 2020 Plan Year (*cont.*). The chart depicts SEBB Program members' FSA claims by month last year. The year gets off to a quick start as people see their providers, incur their deductible charges, and submit claims against the FSAs in February. In March, just as the closures go into effect, there's a drop, followed by steeper drops in April and May. The closures ended late May and people started seeing health care providers again causing an increase in claims, only to drop again as the winter months brought surges and additional public restrictions to curb them.

Slide 6 - COVID-19 in the 2020 Plan Year (*cont.*). January was low because billing hadn't occurred yet. February through April, bills were coming in from January through March and in May the pandemic was having its effects. Things opened in June and July and declined over the summer as they're teachers. Claims escalated when the school year began again in September, with claims coming in October through November, and a slight drop in December for winter break.

Slide 7 – Federal Actions Addressing FSAs. COVID had quite an impact on benefits. Realizing this, the IRS issued a memo last year allowing for certain leniency provisions to reduce the significant impacts of COVID on certain benefits. HCA created a limited open enrollment allowing members to open new DCAP and FSA accounts, or to raise or lower their annual elections prospectively. SEBB Program participants took over 2,000 individual actions pertaining to their accounts. To address the same problem this year, the COVID Relief Bill, passed in December by Congress, created more perspective leniency opportunities.

Slide 8 – Actions for SEBB Participants. HCA is implementing new opportunities for plan year 2021. They are: 1) an extended 12-month grace period for DCAP accounts. Account holders can claim unspent 2020 funds using 2021 eligible expenses. Unspent 2020 funds will not be forfeited until after January 31, 2021. 2) Terminated employees can continue to incur costs throughout the plan year in which they were terminated without electing COBRA. 3) The eligibility age for children in dependent care will increase from 12 to 13 years old. 4) Subscribers can make perspective annual election changes in their DCAP or FSA accounts without a qualifying event three times in 2021, by the end of March, June, and September. Each district sets their own deadline within those months.

Dave Iseminger: There are 295 school districts and over 300 SEBB Organizations. HCA is very aware of the payroll and timeline differences that exist throughout the state with so many school districts, so we try to allow flexibility whenever we can. This is an example of one of those times where it wasn't necessary for HCA to set a specific date. The IRS flexibility allowed us to decentralize the deadline in that specific instance.

Leanna Olive: Slide 9 – 2021 Communications. The majority of our communications went out in February. HCA received the notice of the leniency provisions in December 2020. On February 9, Benefits Administrators were notified of the leniencies via GovDelivery, February 16 updated forms and enrollment guides were posted to Navia's website, and on February 17 HCA's website was updated to announce the leniencies. February newsletters were distributed February 17 and 18 to notify members of the changes. Navia Benefit Solutions, our third-party administrator, will continue to send emails to participants reminding them of this benefit. The first email goes out the end of this week with a reminder email the first of each month employees can make changes.

Slide 10 – Final Insights. HCA anticipates these changes will reduce forfeitures to subscriber accounts. HCA polled SEBB Benefits Administrators to see if they preferred to allow monthly or quarterly election changes and the majority preferred quarterly at most.

SEBB participants in tax advantaged accounts are experiencing two exceptional years, when the traditional rules are made more lenient mid-year. HCA will communicate the relaxation of benefit rules is not because they're now enrolled in SEBB, but because SEBB's first and second years coincided with the COVID-19 pandemic.

Dave Iseminger: Leanna's last statement is a very real concern for HCA that the flexibility under the cafeteria plan for these benefits will be interpreted as a benefit of having been consolidated into the SEBB Program when it's just coincidence. It is another reason, in conversations with Benefit Administrators, we went with three changes this year. The rules allow for many changes. You could change daily, in theory, under the IRS rules, but we wanted a nod towards flexibility without setting the expectation that the benefit really is a free-for-all prospectively. There will be a day soon where the more stringent rules will be enforced by the IRS. It's important to highlight that point because the change is due to COVID, not SEBB consolidation.

Lou McDermott: The next agenda item is Annual Benefits Planning Cycle presented by John Partin, the new Manager of our Benefits Strategy and Design Section. This is John's first Board Meeting, so Dave, please introduce John?

Dave Iseminger: The Board has had many presentations by Marcia Peterson. Marcia retired at the end of August and John is the new Marcia! John has been with us at the Health Care Authority since January 1, 2021. You will see him before the Board in the similar capacities that you had presentations and interactions with Marcia. John came to us from Regence and was part of the provider contract negotiations with Regence. One of the main parts of that portfolio included the Uniform Medical Plan, so he has a lot of insights on providers, thoughts, strategies, and negotiations related to expanding value-based purchasing strategies and is very aware of those provider negotiation dynamics that play out for us as the payer. That in no way does full justice to John's experience, but a highlight of his most recent duties.

Annual Benefits Planning Cycle

John Partin, Benefits Strategy & Design Section Manager, ERB Division. Slide 2 – SEBB Benefits Cycle is a portrayal of what the cycle and timeline look like. Generally done annually, it takes between 18 and 24 months for this process from generating new ideas for consideration, reviewing and developing those ideas, submitting proposals where appropriate, for operating budget evaluation. We then bring the resulting proposals back for refinement, Board review and approval, and then to implementation planning and execution. It's a fairly formal, detailed process and fairly involved from getting the ideas generated and included in the operating budget, and then getting them ready for implementation.

The slide shows the process start date of March 2021. Ideas for new or enhanced benefits can come from a variety of sources, the Board being an important one. HCA gets information from customer service, our payers, the carriers through their claims' analysis, and larger book of business reviews. We also hang on to ideas the Boards

have generated in previous iterations. HCA gets things from market and industry monitoring. We like to start with the Board given your awareness of the groups and employees you represent. The Board is an integral part of this process.

Because the process takes 18 to 24 months from start to finish, keep in mind as we brainstorm ideas today, the earliest they would take affect is for the 2023 benefit year. I want to encourage us to consider both ideas that are born from our experiences working through and managing through the pandemic, as well as those we believe have potential value as we move out of the current crisis into a working, social, and more personal norm by 2023. They both have value.

Dave Iseminger: We talk about it being a two-year cycle. Currently, we're in year two of the cycle that began last year. Last spring, we talked about the challenging state budget environments and brought you a spreadsheet of options generated and provided to the Office of Financial Management. All state agencies and programs were asked to put forward potential budget reduction options, which HCA did for both the PEBB and SEBB Programs. HCA put a pause on a lot of new activity related to the 2022 benefit design. That is the status as we begin brainstorming. We will pick up those ideas from last year as part of the initial analysis.

John Partin: Slide 3 – Discussion. I'd like to hear any new or enhanced benefit ideas you believe are important to the groups and employees you represent.

Katy Henry: I have requests for more information for the Board to determine whether we want to look at different benefits. One that has come up is the massage/chiropractic benefit and the limits. Could we find out how many people actually hit their limits for that benefit, how many appeals there were, and how many appeals were granted? That would help us better understand if that's something we should look at. Another interest in terms of the pandemic, across the nation we've seen health equity highlighted. For HCA, are there things the pandemic has highlighted that we should be looking at regarding treatment or access? My final question is about maternity health outcomes. We know this is an issue across lots of our populations. Is there anything that we could do related to health benefits that could work to address this disparity or this issue?

John Partin: Katy, appreciate your calling those out. Two of those are already on our radar screen. Those are all reasonable questions.

Dan Gossett: Let me add what Katy said. When it comes to treatment limitations, not only massage, but we should probably look at chiropractic, acupuncture, and then that fourth box, which is OT, PT, ST, etc., and see what those numbers are. Not only would I like to have the raw numbers, but I'd like to have the percentages.

John Partin: To clarify, you want to see the total number of requests that fall into each of those categories, the breakouts, and then as a percentage of the total population?

Dan Gossett: Exactly.

Dave Iseminger: Dan, I just want to reassure you when I hear acupuncture, I assume CAM. When I hear massage, I assume CAM. When I hear Chiro and acupuncture, I

assume CAM. They all go together based on the historical conversations from the Board.

Wayne Leonard: I've had a couple questions from some staff members about having a better vision benefit similar to PEBB. I don't know the differences between our vision benefits and PEBB's. I assumed they were the same but maybe they're not. And then some questions about the managed dental care plan. I think the number of providers in the Spokane area is limited, like 12 dentists. The wait times are pretty long. Is it possible to add additional providers?

To follow up on Dan and Katy's comments, the last couple years we've received correspondence from staff members with rare conditions. I am curious about what the appeal process is. I don't want to be involved in the appeal process because I'm not a medical professional. But there doesn't, from the correspondence we've had, seem to be an appeal process if someone has a condition that has some medical necessity for additional treatments beyond what SEBB currently offers. Obviously, some of these benefits have to be limited because the goal is to provide coverage for more people, rather than fewer people. I'm curious about the appeal process for those situations.

John Partin: To clarify on that last piece, it's specifically related to things like the CAM, Chiro, and the PT, OT question, correct?

Wayne Leonard: That was the latest example in the correspondence we received. But last year, we received correspondence with some rare circumstances. It's not specific to the CAM benefit, but in general, what the appeal process would be.

Dave Iseminger: We can work on a presentation for this Board season about the medical plan appeal process, but there is a multi-level appeal process. Sometimes it really gets into which part of the certificate of coverage is being appealed. Sometimes there is no medical necessity override for a specific course of treatment being pursued. Whereas other parts of the certificate of coverage, the benefit may have a medical necessity override. It can get very granular into the exact piece of coverage being appealed. I don't want any Board Member to walk away today believing there is no medical necessity override at all within, for example, the Uniform Medical Plan, because there are instances of medical necessity override. It can be very benefit specific. We will create a presentation to elucidate more about the medical appeal process.

Terri House: I'd like to add my name to the list of Wayne, Dan, and Katy questions. My other question focuses on if we can look at some enhanced mental health benefits.

Dave Iseminger: Terri, do you have specific areas of behavioral health services, specific examples, that might help us?

Terri House: We have a lot of employees with children distance learning, and I know teenagers especially have had some ill effects from this. Suicide attempts are on the rise. I see us coming out of this needing more than just a few limited visits. I'd like to know if we can plan better coming out of this.

John Partin: I appreciate that comment, Terri. Here is what I heard you say. Let me know if I'm too far afield. One is around when we think about pediatrics, realizing

pediatrics can run up to, and in some cases beyond the age of 18, related to some of the issues with COVID, and the remote learning and isolation, the lack of opportunities to socialize. That then bifurcates into things related to depressive results, as you mentioned suicide attempts. It can also be a myriad of other mental health diagnoses that are a result of that feeling of isolation. It's really twofold. What I heard was, is there anything else we could do other than increasing access for those types of treatment plans, anything more innovative, as we come out of the pandemic? But also, specifically, is there anything we can do on the benefit number of visits that are available? And start thinking about access, because in general, access for kids is a little more difficult in many of the areas in Washington than it is for adults. Is that what you're asking?

Terri House: Yes. I think you're right there.

Dawna Hansen-Murray: I want to reiterate again on the vision plan. It definitely is substantially more out of pocket for a lot of people compared to what we used to have. Also, the dental. A lot of us were used to 100% for crowns, minimum 70%. Now we're paying 50%. So, possibly a richer dental plan than the Uniform Dental plan.

John Partin: It's comparing it to what there was before the inclusion in SEBB.

Dawna Hansen-Murray: Yes.

Dave Iseminger: HCA is aware of that area of the benefit design that if you accessed and utilized your preventive services, your out-of-pocket cost shares were reduced on a year-over-year basis. HCA has continued to look at and analyze that since the beginning of the program knowing it is something the Board would be interested in evaluating at some point. A lot of work has been done internally to be able to come back to the Board at some point with a proposal. Given the nature of the state budget recently, we're focusing on cost neutral proposals. We can ease the last part of the benefit cycle of legislative funding to try to mitigate some of the concerns that might happen in that part of the cycle. Work is being done on dental incentive benefit design models.

Wayne Leonard: Terri's comment reminded me, prior to SEBB, most school districts had an Employee Assistance Plan (EAP). We talked about the difficulty in providing the statewide plan. We're beginning to look at a private, or a separate EAP, because as you said with the FSA, the implementation of SEBB occurring at the same time with the global pandemic, we've experienced a huge increase in the requests for services, and what the kinds of things our old EAP would have covered. Part of that is mental health, but there are other things covered with that as well. I don't know if an EAP is something the SEBB Program could revisit, or if it's too problematic for a statewide plan.

Dave Iseminger: We will take that back, Wayne, to look at those pieces. We'll have to think about where that falls within the hierarchy of the optional benefits statute that was passed last session.

John Partin: Wayne, when you say other services, are those non-medical services?

Wayne Leonard: Yes, they could be smoking cessation, financial counseling, alcohol counseling, other kinds of mental health issues.

Eligibility & Enrollment Policy Development

Stella Ng, Senior Policy Analyst, and **Emily Duchaine**, Regulatory Analyst, Policy, Rules, and Compliance Section, ERB Division.

Stella Ng: Emily and I will introduce nine proposed resolutions today. Slides 2, 3, and 4 are the RCWs outlining the Board's authority as we review the resolutions. Slides 5, 6, and 7 – Introduction of Proposed Resolutions. The first resolution being proposed deals with amending a passed resolution approved by the Board in 2018. The next eight resolutions deal with dual enrollment prohibition that will work in conjunction with Senate Bill 5322 in this legislative session. Once these policy resolutions are introduced, we would like your initial insight as we prepare these resolutions for action at the next Board Meeting.

Slide 8 – Proposed Resolution SEBB 2021-01, Amending Resolution SEBB 2018-25 – When the Employer Contribution for SEBB Benefits End. Resolution SEBB 2018-25 was passed in July 2018. The original SEBB 2018-25, as well as SEBB 2018-32, and SEBB 2020-02 are included in the Appendix for your reference. This proposed resolution expands to Slides 8-10, and they are the technical way of enacting the proposed changes. Slides 11-13 is the resolution with the proposed changes.

SEBB 2018-25 addresses situations when the employer contribution for SEBB benefits may end earlier than the end of the school year. The original resolution includes three categories. First, the SEBB Organization terminates the employment relationship. Second, the school employee terminates the employment relationship. Third, the school employee's work pattern is revised such that the school employee is no longer anticipated to work 630 hours during the school year. It doesn't address staff returning from approved leave without pay or late hire situations. HCA is recommending amending the resolution to include additional categories to address these situations. The additional categories are written in such a way to align with the policy resolutions previously passed by the Board regarding establishing eligibility for SEBB benefits.

The first new category added to Resolution SEBB 2021-01 addresses the employee returning from approved leave without pay who maintained or established eligibility under SEBB 2020-02, who subsequently had a change in work pattern, such that the school employee will no longer work the minimum hours required to meet SEBB eligibility criteria. In this case, eligibility for the employer contribution ends as of the last day of the month, in which the change is affective.

The second new category addresses the 9- to 10-month school employee hired late in the year and who is eligible for the employer contribution under SEBB 2018-32, who subsequently had a change in work pattern such that the school employee is no longer anticipated to be compensated for at least 17.5 hours a week in six of the last eight weeks, counting backwards from the week that contains the last day of school. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective.

The last two new categories address the 12-month school employee hired late in the year and eligible for the employer contribution under SEBB 2018-32, who subsequently had a change in work pattern such that the school employee is no longer anticipated to be compensated for at least 17.5 hours a week in six of the last eight weeks counting backwards from the week that contains August 31, the last day of the school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is effective; or the school employee hired later in the year, and eligible for the employer contribution under SEBB 2018-32, who is no longer anticipated to work 630 hours the next school year. In this case, eligibility for the employer contribution ends as of the last day of the month, in which the change in anticipation occurs.

There are no changes to the five examples presented to the Board in 2018 when the Board adopted Resolution SEBB 2018-25. Those examples are included in the Appendix. Slides 14-16 are three new examples describing the effect of the proposed amendments of when the employer contribution for SEBB Benefits end.

Slide 14 - Example 6. Jan is a certificated school employee (teacher) originally hired at the beginning of the 2020-2021 school year who goes out on approved leave. She returned from leave in March 2021 and decides to change from full time to quarter time effective May 14, 2021. She is no longer anticipated to work the minimum hours required to meet SEBB eligibility criteria. The employer contribution for SEBB benefits would end May 31, 2021.

Slide 15 - Example 7. Bob, a classified school employee (bus driver) and a 9- to 10-month school employee has a revised work pattern such that he is no longer be anticipated to be compensated for 17.5 hours per week. Bob was hired on April 5, 2021, is anticipated to work 630 hours the next school year, to be compensated for at least 17.5 hours per week for at least six weeks in the last eight weeks before summer break on June 21, 2021 and is receiving SEBB benefits. On May 14, 2021, he notifies Sequim School District he will only be working 10 hours per week effective May 24, 2021. The employer contribution for SEBB benefits ends May 31, 2021.

Slide 16 - Example 8. Nancy, a classified school employee (bus driver) will no longer be anticipated to work 630 hours the next school year. She is a 9- to 10-month school employee hired on May 4, 2021, is anticipated to work 630 hours the next school year and compensated for at least 17.5 hours a week for at least six weeks in the last eight weeks before summer break on June 21, 2021. She is receiving SEBB benefits. On June 22, 2021, Kent School District notifies her she will no longer be working the next school year. Nancy's employer contribution for SEBB benefits ends June 30, 2021.

Dawna Hansen-Murray: I'm looking at Example 8, Nancy, the 9- to 10-month employee who's a bus driver. It basically looks like she's getting laid off at the end of the school year. That's the effective date, which means they would probably cash that person out, even though they would normally get paid throughout the summer. And that's why the benefits would stop. Am I correct? It wouldn't be effective at the end of that contract year? Our bus drivers are paid yearly. They're paid through the summer. Their pay is spread out and our effective dates are usually at the end of August.

Dave Iseminger: We'll take your question back and provide insights at the next Board meeting. I want to make sure we understand the question fully. You're pointing out that the contract itself ends on August 31 and how does that fact relate to this example?

Dawna Hansen-Murray: Our employees are paid through August. Even though they only work the 10 months, it's spread out over 12 months. They get their paychecks during August and benefits are paid for July and August as well. It could be in this case they're terminated or laid off and they would not get a paycheck for those three months. They would probably get their pay from the district they're owed and then they would lose their benefits. And for us normally, it goes until the end of August.

Dave Iseminger: I've got to pare it back to make sure that I'm understanding the question. The question is regarding the difference between a termination and the number of months an employee is paid and how that relates to this specific example.

Dawna Hansen-Murray: Basically, it's when is that termination date? When is their last paycheck?

Dave Iseminger: We will follow up to ensure what we say on the record is correct.

Terri House: As a follow up to Dawna's, I'm a classified employee. If I get laid off at the end of the school year, which effectively would be June, my contract would still run through August 31. So, if I'm being paid until then, wouldn't my benefits be extended until then?

Katy Hatfield: This resolution is addressing somebody who was initially not eligible for benefits because they were never anticipated to work 630 hours during the school year. They were given benefits only under the Board's more generous late hire rule. That late hire rule required two things: it required they work 17 and a half hours per week in six of the last eight weeks before summer break; and it also required that they be anticipated to work 630 hours for the next school year. If either one of those two things disappears, they lose their benefits effective the first day of the following month. So Dawna's question of this person, Kent School District could have notified the person that they're not going to be coming back the next school year, and they could still be continuing to pay them all the way through August, but they no longer would have met the criteria required for the more generous late hire rule of being anticipated to work 630 hours the next year, which is one of the requirements.

Dave Iseminger: Thanks, Katy, for that additional context, or the initial insight about these questions. We will definitely bring back any final insight to both of those interrelated questions.

Wayne Leonard: I think Terri's and Dawna's comments are pretty indicative of almost all school employees who are benefits eligible, have their pay spread out over 12 months. But even if someone's terminated in June, I'm not sure if that termination is handled the same way from district to district. If Dawna mentioned that person in her district would be cashed out of as of June 30, it's also possible that employee could be paid through August. Whether their benefits would continue to be provided is probably another question. I do think those are important points to think about.

Emily Duchaine: The next eight resolutions address dual enrollment prohibitions that will work in conjunction with Senate Bill 5322 in this legislative session. Slide 18 – RCW 41.05.742 Single Enrollment Requirement. Under the current statute, individuals are already limited to a single enrollment in medical, dental, and vision plans among SEBB and PEBB plans. These resolutions were developed to implement the requirement that an individual be limited to a single enrollment in medical, dental, and vision plans in either the SEBB or PEBB Program, as set forth by Senate Bill 5322.

Slide 19 – Senate Bill 5322f: Refining the Dual Enrollment Prohibition. Senate Bill 5322 amends RCW 41.05.742 by striking through language that allows individuals to be enrolled across different types of plans in both PEBB and SEBB Programs, and adds language specifying that an individual is limited to a single enrollment in either the SEBB or PEBB Program. Slides 20 and 21 are RCW 41.05.740(7) and RCW 41.05.050 (4)(d)(i) are included for your information as you consider the policies we'll discuss.

Slide 22 – Resolving the Issue of Dual Enrollment in PEBB and SEBB Benefits. Issues needing resolution are the challenges and limitations, language used throughout the presentation, examples of dual enrollment, what school employees can do to resolve their dual enrollment, guidelines and principles for resolving dual enrollment on behalf of the employee, and recommended policy resolutions.

Slide 23 – Challenges and Limitations in Implementing the Requirements of Resolving Dual Enrollments. As these resolutions were being developed, we had to consider the limitations and challenges we faced, like member engagement, what is our current technology capable of, Board authority, HCA staff time and effort, outreach and training needs, federal requirements, and IRS rules, to name a few!

Slide 24 – Language Used Throughout This Presentation. This slide provides definitions of words used throughout the resolutions.

Slide 25 – Examples of Current Dual Enrollment in the PEBB and SEBB Programs, identifies dual enrollment scenarios members find themselves and their dependents in under the current rules. There are many other scenarios not addressed here that are even more complicated than these.

Dave Iseminger: As a proxy for the number of dual enrollments in the system now, our best estimate is around 5,000. This is a complex issue for a relatively small piece of the entire population. In medical coverage, for example, between both programs, we have 650,000 lives. It's a very small percentage of the entire population, but it's a very complex, important area to get right.

Emily Duchaine: Slide 26 – Examples of Future Dual Enrollment in PEBB and SEBB Programs. These are enrollment scenarios our members could potentially find themselves and their dependents dealing with as the result of becoming newly eligible for one program when they're already enrolled in another program, or because a school employee and an employee enrolled them in both as a dependent. For example, a school employee spouse is enrolled as a dependent in SEBB medical coverage. The spouse gets a job at the Secretary of State's Office and they waive PEBB medical coverage but they remain enrolled in PEBB dental.

Slide 27 – How Will School Employees Know What to Do? This slide gives you an overview of how HCA intends to inform the school employees how they can resolve any dual enrollment situations before the start of plan year 2022 through newsletters, enrollment guides, on our HCA website, through GovDelivery notices, etc. Separate notices will go to members informing them how they can resolve their current dual enrollment during the annual open enrollment period. This information will be integrated into our customer service and outreach and training efforts as well.

Slide 28 – What Can School Employees Do to Resolve Current Dual Enrollment? During the November 2021 open enrollment period, for plan year 2022, school employees currently dual enrolled can choose either the SEBB Program or the PEBB Program for their medical, dental, and vision plans for themselves and their covered dependents.

Slide 29 – What Can School Employees Do to Avoid Dual Enrollment? School employees who become newly eligible for the employer contribution towards SEBB benefits, or who experienced a special open enrollment and are already enrolled in PEBB benefits, can choose to enroll in SEBB benefits, or they can waive their enrollment in SEBB and maintain their enrollment in PEBB. They must make their decision within 31 days of gaining or regaining eligibility, or within 60 days of a special open enrollment.

Slide 30 – What If the School Employee Does Not Act to Resolve Dual Enrollment on Their Own? HCA will attempt to contact the member. If they do not respond and take the necessary steps to resolve the matter of dual enrollment, the SEBB Program will act on behalf of the school employee by auto-enrolling them into one program and auto-disenrolling them from the other program. Resolutions were written to establish policies that enable the member to prevent and/or resolve any dual enrollment issues or permits HCA to act if the subscriber does not. HCA will follow certain guidelines and principles.

Slide 31 – Guidelines/Principles for Resolving Dual Enrollment. This is a list of the guidelines and principles used in developing our resolutions for resolving dual enrollment when the school employee does not act.

With these new resolutions, there will be lessons learned and situations that may arise that we didn't anticipate, but hopefully we have effective solutions in these resolutions to help make this transition as easy and successful as possible for our staff, but more importantly for our members.

Slide 32 – Proposed Resolution SEBB 2021-02, Amending Resolution SEBB 2018-53 School Employees May Waive Enrollment in Medical. The original SEBB 2018-53 resolution is included in the Appendix for your reference and was passed in December 2018. This resolution shows the technical way of enacting the proposed change.

Slide 33 – Proposed Resolution SEBB 2021-02, Amending Resolutions SEBB 2018-53 School Employees May Waive Enrollment in Medical. This resolution enables school employees to waive SEBB dental and SEBB vision, which is not currently allowed, only when they waive SEBB medical for PEBB medical on the condition they also enroll in a PEBB dental plan. Although the SEB Board cannot make policy on behalf of the PEBB Board, it can set the requirements for waiving SEBB medical. This amendment is

intended to resolve the current issue of a school employee who waives SEBB medical for PEBB medical but would still be enrolled in SEBB dental and SEBB vision. A school employee will not be allowed to waive SEBB dental and SEBB vision for any other reason.

Slide 34 – Proposed Resolution SEBB 2021-03 SEBB Benefit Enrollment Requirements When PEBB Benefits Are Waived. Assuming the PEB Board passes the prior resolution when presented to them, we recommend the SEB Board pass this resolution. An employee who waives PEBB medical and PEBB dental, or SEBB medical, must be enrolled in a SEBB dental and SEBB vision plan. If necessary, they will be automatically enrolled in the associated subscriber's SEBB dental and SEBB vision plans. This resolution requires that an employee who has waived PEBB medical and PEBB dental to enroll in SEBB medical, SEBB dental, and SEBB vision. The SEB Board also, has the authority to set enrollment requirements for SEBB medical. HCA's intent is for both the SEB Board and PEB Board to enact these policy resolutions.

Slide 35 – Proposed Resolution SEBB 2021-04 Resolving Dual Enrollment When A School Employee's Only Medical Enrollment is in PEBB. If the school employee is enrolled only in SEBB dental, SEBB vision, and PEBB medical and no action is taken to resolve their dual enrollment, the school employee will remain in their PEBB benefits and will be auto-disenrolled from the SEBB dental and SEBB vision plans. The school employee's enrollment in SEBB life, AD&D, and LTD will remain.

Slide 36 – Proposed Resolution SEBB 2021-04 – Example #1. Jane, a teacher at Olympia High School, is currently enrolled in SEBB dental and SEBB vision as a school employee. She waived SEBB medical. Her spouse Bob is an employee at the Department of Ecology. Jane is enrolled in PEBB medical as a dependent under his account. Neither Jane nor Bob act on attempts from HCA asking them to choose which plan Jane stays in. The intent of this resolution is to keep the individual in the program where they receive their medical benefits. In this example, the school employee is not enrolled in SEBB medical, only SEBB dental and SEBB vision. Jane, a school employee, will remain in PEBB as a dependent because that is where she is enrolled in medical. She will be auto-disenrolled from her SEBB dental and SEBB vision plans. By keeping Jane in PEBB, she will also need to be enrolled in PEBB dental.

Slide 37 - Proposed Resolution SEBB 2021-05 - Resolving Dual Enrollment Involving Dual Subscriber Eligibility. This resolution is to resolve the issue of dual enrollment for a school employee who is enrolled in both PEBB medical as an employee and SEBB medical as a school employee; or they're not enrolled in medical under either program but have PEBB dental, SEBB dental, and SEBB vision because they're dual eligible for both PEBB and SEBB.

Slide 38 - Proposed Resolution SEBB 2021-05 – Example #1. Mary, custodian at Ballard High School and the University of Washington has worked for UW since 2001 and enrolled in PEBB benefits as an employee the entire time. Mary became eligible for SEBB benefits in 2020 at Ballard High School. She enrolled in SEBB medical as a school employee and is currently enrolled in both PEBB medical as an employee and SEBB medical as a school employee.

Slide 39 - Proposed Resolution SEBB 2021-05 – Example #1 (*cont.*). Mary does not act in response to attempts from HCA asking her to affirmatively choose enrollment in either the PEBB Program or SEBB Program. Although Mary is both a PEBB Program eligible employee and a school employee, she has been enrolled in PEBB benefits longer than she has been enrolled in SEBB benefits. Because she took no action, she was kept in PEBB and auto-disenrolled by HCA from SEBB. She will also be auto-disenrolled from her dental and vision plans.

Slide 40 - Proposed Resolution SEBB 2021-05 – Example #2. Paolo is a facilities manager with the Department of Transportation. He also teaches at Timberline High School. Paolo waived medical in both programs because his wife works for Boeing and he is enrolled in medical under her plan. Because he is eligible for both the PEBB Program as an employee and the SEBB Program as a school employee, he enrolled in PEBB dental, SEBB dental, and SEBB vision. He has worked for DOT since 2015 and became eligible for SEBB benefits in 2020.

Slide 41 - Proposed Resolution SEBB 2021-05 – Example #2 (*cont.*). Paolo did not respond to HCA requests to choose his coverage. Although he has been enrolled in PEBB dental longer than he has been enrolled in SEBB dental and SEBB vision, he will be kept in the SEBB Program so he doesn't lose his SEBB vision coverage. He will be auto-disenrolled from PEBB dental.

Dave Iseminger: As a reminder, PEBB Program vision coverage is embedded in the medical benefit. That's why you see this special situation to ensure there's not a loss in vision coverage. Vision is separate in the SEBB Program, but embedded in medical in the PEBB Program, which has an extra layer of complexity in this resolution. It will come up again, but it's rooted in the fact that vision is embedded in PEBB but standalone in SEBB.

Emily Duchaine: Slide 42 - Proposed Resolution SEBB 2021-06 - Resolving Dual Enrollment Involving a SEBB Dependent With Multiple Medical Enrollments. This resolution is to resolve the issue of dual enrollment for a school employee's dependent who is enrolled in SEBB benefits and also enrolled in PEBB medical because they are a PEBB eligible employee. If no action is taken by either the school employee or the dependent to resolve the dependent's dual enrollment, the dependent will remain in PEBB benefits and be auto-disenrolled from the school employees SEBB medical, dental, and/or vision plans.

Slide 43 - Proposed Resolution SEBB 2021-06 – Example #1. Linda is an employee with the Washington State Department of Health and her spouse Julie is a bus driver for Salish Middle School. Linda is currently enrolled in SEBB dental and SEBB vision under Julie as a dependent. She's also enrolled in PEBB medical as an employee. Neither Linda nor Julie act in response to attempts from HCA asking them to affirmatively choose enrollment for Linda in either PEBB benefits or SEBB benefits.

Slide 44 - Proposed Resolution SEBB 2021-06 – Example #1 (*cont.*). Linda is kept in PEBB benefits because that is the medical program she's enrolled in as an employee. She was auto-disenrolled by HCA from SEBB dental and SEBB vision.

Slide 45 - Proposed Resolution SEBB 2021-06 – Example #2. Charles is an employee with the Department of Commerce. His spouse Maria is a receptionist at Salish Middle School. Charles is currently enrolled in SEBB medical under Maria as a dependent, and also enrolled in PEBB medical as an employee. Neither Charles nor Maria act in response to attempts from HCA asking them to affirmatively choose enrollment for Charles in either PEBB benefits or SEBB benefits.

Slide 46 - Proposed Resolution SEBB 2021-06 – Example #2 (*cont.*). Even though Charles is enrolled in medical in both programs, he will remain in PEBB medical because he is only enrolled in SEBB medical as a dependent and enrolled in PEBB medical as an employee. He was auto-disenrolled by HCA from SEBB benefits.

Slide 47 - Proposed Resolution SEBB 2021-07 - Resolving Dual Enrollment Involving A Member With Multiple Medical Enrollments As A Dependent. If a school employee's dependent is enrolled in both PEBB medical and SEBB medical as a dependent and has been enrolled in PEBB benefits longer than in SEBB benefits and no action is taken to resolve the dual enrollment, the dependent will remain in PEBB benefits and auto-disenrolled from the school employee's SEBB benefits. If a school employee's dependent is not enrolled in any medical but enrolled only in PEBB dental and SEBB vision (with or without SEBB dental) as a dependent, the dependent will be kept in SEBB benefits and auto-disenrolled from PEBB dental. Exception: If there is a National Medical Support order or a court order in place, enrollment will be in accordance with the order.

Slide 48 - Proposed Resolution SEBB 2021-07 – Example #1. Carl works for the Office of Financial Management and his wife Melanie is a school employee at Roosevelt Elementary School. They have one child, Cooper, enrolled in medical on both their plans. He's been a dependent in PEBB medical longer than he has been enrolled as a dependent in SEBB medical. The intent is to keep the dependent in the medical program they've been in the longest.

Slide 49 - Proposed Resolution SEBB 2021-07 – Example #1 (*cont.*). Neither Carl nor Melanie responded to HCA's request for action. Even though Cooper is enrolled in medical in both programs, he will remain in PEBB medical because he has been enrolled in PEBB benefits longer than he has been enrolled in SEBB benefits. He will be auto-disenrolled from SEBB benefits. Exception: If there is a National Medical Support order or court order in place, the dependent must be kept in the coverage of whichever parent the order decrees.

Slide 50 - Proposed Resolution SEBB 2021-07 – Example #1 (*cont.*). If one parent or legal guardian responds to HCA's notice to resolve the dependent's dual enrollment and the other parent or legal guardian does not, the SEBB Program will perform the action requested by the responding parent or legal guardian. If both parents or legal guardians give conflicting responses, the SEBB Program will work with the parents or legal guardians to determine which plan the dependent child will remain in. A National Medical Support order or court order is still the exception. The dependent has to be kept in the coverage of whichever parent the order decrees.

Slide 51 - Proposed Resolution SEBB 2021-07 – Example #2. Frank works for the Secretary of State and his wife Deborah is a school employee at Capitol High School.

Their daughter, Ella, is currently enrolled on their plans. Ella is not enrolled in either PEBB medical or SEBB medical, however, she is enrolled in PEBB dental, SEBB dental, and SEBB vision as a dependent. She has been enrolled as a dependent in PEBB benefits longer than she has been enrolled as a dependent in SEBB dental and SEBB vision. The intent of this resolution is to keep the dependent in their SEBB vision when they're not enrolled in medical in either plan.

Slide 52 - Proposed Resolution SEBB 2021-07 – Example #2 (*cont.*). Even though Ella has been enrolled in PEBB dental longer than she has been enrolled in SEBB dental and SEBB vision, she will be kept in SEBB so she doesn't lose her vision coverage. She will be auto-disenrolled from PEBB dental.

Slide 53 - Proposed Resolution SEBB 2021-08 - SEBB Benefit Automatic Enrollments When PEBB Benefits Are Auto-Disenrolled. This resolution is to resolve the issue of a dependent who is a PEBB eligible employee and is auto-disenrolled from benefits in the PEBB Program and kept in the SEBB Program but may need the equivalent coverage in the plan in which they were kept. This issue arises if the dependent is kept in SEBB medical coverage and auto-disenrolled in PEBB medical coverage but does not have vision and dental. The dependent would need to go on a school employee's vision, if they were not already enrolled, since vision is separate from medical in the SEBB Program. They would also need to go on the school employee's dental since a condition for waiving enrollment in PEBB medical and dental for SEBB is to also enroll in SEBB dental.

Slide 54 - Proposed Resolution SEBB 2021-08 – Example #1. Bruce works for HCA. His husband Steve is a school employee at Tumwater High School. Bruce is currently enrolled in SEBB medical under Steve as a dependent. He's also enrolled in PEBB dental as an employee. He is not enrolled in PEBB medical because he affirmatively waived medical when he became eligible for PEBB benefits. The intent of this resolution is to resolve the issue of a SEBB dependent who is also, a PEBB benefits eligible employee and who stays in SEBB medical and would therefore need dental and vision coverage.

Slide 55 - Proposed Resolution SEBB 2021-08 – Example #1 (*cont.*) Bruce remains in SEBB benefits because he's enrolled in SEBB medical. He would be auto-disenrolled from PEBB dental and automatically enrolled in SEBB vision. If he wasn't already enrolled in SEBB dental, he would automatically be enrolled in SEBB dental.

Slide 56 – Proposed Resolution SEBB 2021-09 - Enrollment Requirements When A School Employee Loses Dependent Coverage In PEBB Benefits. This resolution addresses a school employee who waived SEBB benefits, enrolled in PEBB benefits as a dependent, and is dropped by their spouse. Because we only allowing a school employee to waive SEBB medical, SEBB dental, and SEBB vision to be enrolled in PEBB medical and PEBB dental, the school employee would need to return from waive status and enroll in SEBB medical, SEBB dental, and SEBB vision. The school employee could still waive SEBB medical if they had Medicare, TRICARE, or other employer sponsored coverage, but they would still need to enroll in SEBB dental and SEBB vision since waiving SEBB dental and SEBB vision is only allowed if the school employee is waiving for PEBB medical.

Slide 57 – Guidelines/Principles Recap. In developing these resolutions, HCA prioritized medical over non-medical, subscriber status over the dependent status, and longevity of enrollment. Is there a National Medical Support order or court order? HCA will respect the default requirements in place for each program to ensure no member has a gap in coverage.

Dave Iseminger: This is an extraordinarily complex area. It's one of the most complex presentations we've put together for the Board recently. After hearing this, if you go back and identify questions, please send them to me and I will get them to the team for response.

I think districts might question if someone is disenrolled from SEBB medical, does the district still pay the funding rate for them, as if a waiver had occurred? With the current funding model and how the funding rate is built, even when someone waives, the school district is still charged for that individual. None of these resolutions change that right now.

After the initial dual enrollment transition occurs at the beginning of the next calendar year, HCA can determine if people were migrating more to one program or the other. We can look to see if there's a way in the funding rate model to build in an adjustment, like a waiver assumption we proactively account for in the funding rate mechanism. HCA will also look at the impact of dual enrollment and the dual enrollment prohibition as part of what we call the variable funding rate waiver report due to the Legislature at the end of this year.

Wayne Leonard: On most of your examples and on your guiding principles, you reach out to the employee to try to resolve these issues. I'm wondering if there's a chance to, at the same time, reach out to the School District Benefits Administrator to help the employee resolve the issues. Emails from one agency or another may be ignored. If there was an opportunity to work with the Benefits Administrator, you could preemptively get a resolution prior to going through your decision tree.

Dave Iseminger: This presentation is about the policy implications and there's a policy decision of how the Health Care Authority would implement when someone doesn't act. I recognize there's not a lot of detail in the presentation about what that outreach will look like and what the exact mechanism will be for individuals to convey their intent. You're right. We know the district will be interested in engaging to be able to support school employees.

The interesting thing here to remember, because all of these people are a dual enrollment situation, they could be heading towards the PEBB employer where the account is registered. Or they could be coming over to the school district account. We're still working toward a very detailed explanation of a preferred pathway for conveying this choice given there are so many doors that individuals could choose. There are 800 employers with at least several hundred combinations of employment between the two programs. There will be a very descriptive way to convey that choice. I do think there's going to be some collaboration with all employers, the school districts, the PEBB employers, state agencies, and higher education. I'm light on those details because we're still building parts of that operational engine to be able to describe it but

there will be systemic outreach. HCA's goal is to apply auto-disenroll/auto-enroll rules as little as possible.

Wayne Leonard: Typically, when an employee receives an email, their first call is to the district office Benefits Administrator. It'd be helpful if we knew what they received from HCA, but I wasn't sure if it was protected information.

Dave Iseminger: HCA will have to be able to communicate to both the PEBB employer and the SEBB employer, because, in the familial situation where they're crossing programs, which is inherently what this issue is, they could go to either. HCA will need to determine the best way to convey whatever level of detail we can without violating any privacy statute. At the same time, there could be a fair amount of detail that can go because it's facilitating the enrollment. There could be some exceptions to the privacy rules. There will be coordinated communication that both the PEBB employers and the SEBB employers are apprised of and can help understand what the employee, on both sides, will need to do, and how to do it.

Emily Duchaine: Slide 58 - Next Steps. HCA will incorporate Board feedback into the proposed policies, send the proposed policies to stakeholders. and bring recommended policy resolutions to the Board for action at the April 7, 2021 Board Meeting.

Dave Iseminger: Over the entire SEBB Program launch, Barb Scott or Rob Parkman would have been the presenters on this topic. Rob Parkman retired since our last Board meeting, but I'm pleased with Stella and Emily's work in presenting to the Board. I want to acknowledge Rob's retirement, his contributions to the SEBB Program launch, and formally welcome the new guard, so to speak.

For the next presentation on Long-Term Disability Insurance, HCA had email server problems last night when we sent supplemental slides related to this presentation, which didn't get sent until in the evening. If you haven't seen that email, there is a copy of the updated slide deck in your emails, as well as it being posted on the SEB Board website in the updated Briefing Book. Additional examples were added to the slides after we received some questions.

Long-Term Disability Insurance

Kimberly Gazard, Contract Manager, Employees and Retirees Benefits Division. Slide 2 – Overview of presentation.

Slide 3 – Proposed Employee-Paid LTD Benefit. This slide is a summary of the proposed LTD redesign. The 60% default plan mirrors the current 60% coverage that exists in the portfolio today, with 60% of the first \$16,667 of insured earnings with a maximum monthly benefit of \$10,000. The minimum monthly benefit is \$100, or 10% of the LTD benefit before deductible income, whichever is greater. The benefit waiting period is the greater of 90 days, period of sick leave, and/or the period of the Washington Paid Family & Medical Leave. Subscribers can opt-out at any time with the cancellation effective the first day of the following month.

The 50% buy down plan is almost identical to the 60% default plan, except for the monthly benefit amount. It is 50% of the first \$16,667 of insured earnings with a maximum monthly benefit of \$8,333. The minimum monthly benefit and the benefit

waiting period is going to be the same as the 60% default plan. Subscribers can also opt-out of both plans at any time with the cancellation effective the first day of the following month.

Slide 4 – Employer-Paid LTD Benefit will remain the same with a maximum monthly benefit of \$400 before deductible income. Any school employee who declines the employee-paid LTD insurance will remain enrolled in the employer-paid LTD insurance. Going forward, Basic LTD is referred to as employer-paid and Supplemental LTD referred to as employee-paid because HCA feels the term “Basic coverage” gives the impression that it's adequate coverage should an employee become disabled and need to utilize the LTD benefit. “Employer-paid” and “employee-paid” are better descriptions of what the benefit is providing.

Slide 5 – Implementation Timeline. Should the Board approve the LTD redesign, The Standard would begin updating the policy language with their Office of the Insurance Commissioner's filing, and HCA will begin drafting a comprehensive communication work plan. HCA will utilize an existing communication work plan used in last year's LTD opportunity modifying that comprehensive work plan to fit with this LTD redesign for later this year. Our intent is to set up the SEBB Organizations for success with this redesign by providing them resources and information to communicate with employees.

Slide 6 – Proposed Opt-out Employee-Paid LTD Starting January 1, 2022. New hires would be auto-enrolled in the 60% default plan, with coverage effective the first calendar day of the following month their hire date. They would receive a letter indicating they had 31-days to opt-out.

Subscribers can opt-out at any time, but they would be subject to evidence of insurability (EOI) if they choose to re-enroll in the future. Any cancellation coverages after the 31-day new-hire period would be effective the first day of the month following the cancellation date by utilizing SEBB My Account or by submitting a paper form to their Benefits Administrator.

Slide 7 – Proposed Opt-out Employee-Paid LTD Starting January 1, 2022 (*cont.*). For existing subscribers, they would be sent a letter in Fall 2021 letting them know they're being auto-enrolled in the 60% default plan with coverage effective January 1, 2022 and notified of their option with adequate time to opt-out prior to their first payroll deduction. After January 1, 2022, subscribers can opt-out at any time, with the cancellation effective the first day of the month following the cancellation date. Evidence of insurability would be required if existing subscribers choose to re-enroll in employee-paid LTD coverage in the future.

Slide 8 – Opt-out Communication Strategy. The ERB Division's Outreach and Training Unit will provide training to SEBB Program Benefit Administrators and forwardable email messages for communicating with employees. Ongoing information will be provided through our SEBB newsletter and GovDelivery emails. HCA will have a targeted letter mailed to SEBB Program subscribers not currently enrolled. The letter will also be emailed to those subscribers who have enrolled in the electronic version. HCA will provide an FAQ and a fact sheet, and HCA web pages are available 24/7, which will be updated as information is available regarding the transition.

Slide 9 – Proposed Preliminary Employee-Paid LTD Rates. These rates and the overall plan design plan is subject to Washington State Office of the Insurance Commissioner’s approval. When comparing the proposed rates with our current rates, the 60% default plan rate is reduced about 21% and the 50% buy down plan rate is reduced about 52%. It’s a great option for subscribers who are looking for a lower rate, with only insuring 10% less of their monthly salary, compared to the 60%.

Slide 10 – Similar Situated Employer with Opt-out Design. The Standard provided insight on a similar situated employer who launched an opt-out design for LTD for approximately 110,000 lives. They had a default 60% coverage for an employee-paid benefit. The employees could choose a cheaper 50% coverage plan opt-out entirely. Prior to implementing their auto-enroll design, they had 45% participation, with 35% specifically in the 60% plan and 10% in the 50% plan. After implementing their auto-enroll, approximately 22% opted-out of coverage entirely. It gave HCA insight on another opt-out design for a similar situated employer.

Slides 11 -13 – Employee-Paid LTD Premiums & Benefits. These slides show how to calculate the employee-paid LTD premium. The calculation is the same whether you are enrolled in the 60% default plan or the 50% buy down plan and has examples of different salary levels, providing a range from \$31,000 to \$81,000.

Slide 14 – Proposed Resolution SEBB 2021-10 – Employee-Paid Long-Term Disability (LTD) Insurance. Effective January 1, 2022, SEBB 2018-39 is rescinded and the SEBB Program will instead offer the following employee-paid LTD design:

Two separate employee-paid LTD insurance choices including: (a) coverage at 60% or (b) coverage at 50%. Both choices will have the following features:

- The following Benefit Waiting Period (the longer of): 90 days; the period of sick leave (excluding shared leave) for which the employee eligible under the employer’s sick leave, paid time off (PTO), or other salaried continuation plan; or the end of Washington Paid Family and Medical Leave Law for which the employee is receiving benefits
- No Choice Sick Leave
- Choice Pension
- A Maximum Monthly Bbenefit of \$10,000 for the 60% coverage and \$8,333 for the 50% coverage

Slide 15 – Resolution SEBB 2018-39 – Employee-Paid Supplemental Long-Term Disability. HCA proposes rescinding this resolution effective December 31, 2021.

Slides 16 – 17 – Proposed Resolution SEBB 2021-11 - Employee-Paid Long-Term Disability (LTD) Insurance Enrollment Procedures outlines the process for enrolling subscribers.

Dave Iseminger: In Proposed Resolution SEBB 2021-11, the first bullet says, “during an enrollment period established by the Health Care Authority in 2021.” HCA is confident the enrollment period would align with the fall general open enrollment. An

actual date was not described in the resolution leaving open the possibility of starting this benefit election period earlier than the traditional annual open enrollment.

Slide 18 – Proposed Resolution SEBB 2021-11 – Example #1. Ashley is a 41-year-old current paraprofessional on SEBB benefits, making \$31,000 annually, who did not previously enroll in supplemental employee-paid LTD in the SEBB Program. During the fall 2021 enrollment period set by HCA, Ashley does not convey an election to opt-out or decline employee-paid LTD insurance under this new LTD opt-out enrollment process. Effective January 1, 2022, Ashley would be automatically enrolled in the employee-paid LTD at the 60% coverage level and the employer-paid LTD.

Slide 19 – Proposed Resolution SEBB 2021-11 – Example #1 (*cont.*). On January 31, 2022, Ashley sees a deduction of \$8.26 on her pay stub. She calls her school district and asks about the deduction. She then submits an election request to opt-out entirely from the employee-paid LTD insurance. The cancelation is effective February 1, 2022. There is no refund due Ashley because the change in coverage is prospective.

Slide 20 – Proposed Resolution SEBB 2021-11 – Example #2. Shawn is a newly hired paraeducator starting January 15, 2022. He is determined to be eligible for the employer contribution for benefits on that same day. For the employee-paid LTD, Shawn submits an election request on February 12 to enroll at the 50% buy down coverage level. Based on his hire date of January 15, 2022, his request would be timely if submitted by February 15, 2022. His employee-paid LTD would start February 1, 2022. LTD premium refunds would depend on the SEBB Organization's payroll timelines. The process is the same as for premiums associated with the SEBB medical default enrollment process.

Slide 21 – Proposed Resolution SEBB 2021-11 – Example #3. Jamie is a new teacher hired who is determined to be eligible for the employer contribution for benefits on September 2, 2022. For this example, the first day of the district school year is September 7. For the employee-paid LTD, Jamie submits an election on October 1 opting-out of all employee-paid LTD insurance. Based on her hire date, the last date to submit a timely election would be October 3, 2022. Her SEBB benefits, including employee-paid LTD benefits, would start September 2, 2022. A premium refund would depend on the SEBB Organization's payroll timeline, but it's the same process for LTD as it is for the medical plan default enrollment.

Slide 22 – Proposed Resolution SEBB 2021-12 - Amending Resolution SEBB 2018-54 Relating to Default Enrollments. This slide identifies the changes made to Resolution SEBB 2018-54 to create Proposed Resolution SEBB 2021-12

Slide 23 – Proposed Resolution SEBB 2021-12 - Amending Resolution SEBB 2018-54 Relating to Default Enrollments. This slide is the track changes version of the new proposed Resolution SEBB 2018-54 Relating to Default Enrollments. Basic long-term disability is changed to "employer-paid long-term disability" and "enrollment in employee-paid long-term disability insurance at the 60% coverage level" is added.

Slide 24 – Proposed Resolution SEBB 2021-13 - Amending SEBB 2018-38 – Employer-Paid Basic Long-Term Disability. The proposal is to change the title to "Employer-Paid

Long-Term Disability Insurance” striking the word “basic” and inserting in the first bullet the words “the period of sick leave (excluding shared leave) for which you are eligible under the employer’s sick leave, paid time off (PTO), or other salaried continuation plan (excluding vacation leave)”.

Slide 25 – Proposed Resolution SEBB 2021-13 - Amending SEBB 2018-38 – Employer-Paid Long-Term Disability Insurance. This slide is the track change version of the proposed changes.

Dave Iseminger: What you see in the core of the benefit waiting period is how the plan currently works. The goal was to shift the language from the word “basic” to focus on employee-paid and employer-paid to help reshape underlying assumptions that come with the word “basic.” When we looked at the underlying resolution from 2018, we realized that although we described the three prongs of the benefit waiting period, the resolution presented to you included words for only two of them. The plan had been implemented with all three as was presented. While bringing the resolution back to amend the title to shift away from use of that word “basic” from a marketing perspective, we want to clean this piece up from how the benefit was launched based on the prior presentations in 2018. This is codifying what was described before, what we should have put before you in 2018, while recommending the title change.

Kimberly Gazard: Slide 26 – Next Steps. HCA will incorporate Board feedback in the proposed policies. The Rules and Policy team will send the proposed policies to stakeholders to get feedback. Recommended resolutions will come back to the Board for action at the April 7 Board Meeting.

Dave Iseminger: Slide 27 – Initial Stakeholder Insights & Questions. There are a variety of different stakeholder conversations to date. I want to highlight themes of some comments and answer a few of them upfront. These will be part of the stakeholder review process in April. This slide has two of the biggest questions that have come up with the entire original LTD benefit. There is a strong sentiment from all perspectives about the hope and need to focus on improving the employer-paid benefit instead.

This is the third iteration of ways we've presented to the Board about working on the LTD benefit. The first one was in the initial benefit launch context of there's \$2.10 in the funding rate that is used to pay for the employer funded benefit for LTD. Were there benefit trades within the rest of the portfolio to stay budget neutral but have a higher employer contribution? We went through a variety of proposals related to that and there was not a consensus from the Board about any benefits swaps that were tolerable. That approach didn't pan out.

The second approach was in 2019, focusing on the employer-paid benefit. We provided to the Board various costs associated with increasing the benefit level of the employer-paid benefit all the way up to a 60% benefit with various maximum monthly benefits that would be realized upon the point of claim. We sought insight from both Boards, which ultimately the agency used to put forward a decision package requesting additional funding in the 2022 supplemental budget process. Unfortunately, that did not gain traction. Then the pandemic hit. As we sit and look at the unlikelihood of additional funds coming in the employer-paid LTD benefit in the next two to four years, the next

couple of bienniums, this is where the third approach comes into play, looking at the other half of the offering, which is the employee-paid benefit.

If the Board adopts this proposed approach, it does not preclude future work on the employer-paid benefit. By keeping the employer-paid benefit, it leaves open the possibility of increased funding. It would be harder to establish a new employer-paid benefit than it would be to increase funding on an existing employer-paid benefit.

A lot of questions come to the Health Care Authority about comparing pre-SEBB LTD rates with SEBB LTD rates. There are a variety of differences and nuances between the plan design and the numbers people use. We've gone back and looked at some of the pre-SEBB benefits data and we see that the maximum benefit level had a wide range in school districts pre-SEBB. We saw insured amounts capped at \$5,000, \$6,000, \$6,600, \$7,500, \$8,000, \$8,300, and then \$16,667. The maximum benefit amount would clearly impact the rate and the amount of income that's insured under this proposal is \$16,667 per month.

Another key piece is the inverse of adverse selection risks. Over time, people who fail underwriting aren't allowed into the risk pool. When the SEBB Program LTD benefit launched, there was no evidence of insurability required. People who had been previously denied LTD coverage were able to get covered with no questions asked. Any employer who goes out for a new benefit and has an influx of individuals who previously were denied would see a premium impact differential compared when people who previously failed underwriting were not allowed entry into the risk pool again.

There are also benefit coverage differences listed on Slide 27. There are several differences in the duration of coverage that's allowed for mental health disorders, or substance abuse, or chemical dependencies. These are statements about *most* commercial products. HCA is aware of school districts that had similar pieces to what's proposed in the SEBB benefit. But by and large, in the commercial disability circumstances, there tend to be more lifetime limits rather than per disability incident limits like exists within the SEBB offering. There are other pieces of plan design variation, whether it's the benefit waiting periods of 60, 90, 120 days and whether there was mandatory or permissive enrollment.

The last point is the difference between a noncontributory plan versus a contributory plan design. Contributory means that an employee pays some or all of the premium. Noncontributory means the employer pays all of the premium. This impacts the taxing of the benefit when the claim is paid to the member. In a contributory plan, like SEBB's, where the employee is paying some of the premium, or all the premium, the ultimate benefit is not taxable. In a noncontributory plan where the employer fully pays the premium, the benefit that's realized by the member on the back end is taxable. Although, again, a wide variation within school districts pre-SEBB. HCA's understanding is there tended to be more noncontributory plans in the pre-SEBB world, whereas the SEBB plan is a contributory. These differences, and others, help explain why it is not a simple comparison of a premium dollar amount and a percentage of coverage allowed.

Slide 28 – Initial Stakeholder Insights & Questions (*cont.*). A question came up during public comments at the January Retreat whether the Board had the authority to make

this type of plan design. Yes, the Board does have the authority under statute RCW 41.05.740 to design that structure within any structure that conforms with state and federal law. It fits within the funding structure of the SEBB Program. That's where we get back to leaving the employer-paid benefit with the current contribution level that's in the funding rate. You can't spend money you don't have the authority to spend. As long as you're within funding authority and state and federal laws, you can design a plan as you want. You already have a situation where you have an automatic enrollment that impacts employees' paychecks. When a newly hired school employee fails to make a timely election, they're automatically enrolled into UMP Achieve 1 and they have an employee contribution. It's clear you have the authority to do mandatory enrollment when it comes to an employee contribution. Ultimately, with the parts of the portfolio the SEB Board has authority over, school districts are required to offer the benefits as they're authorized by the Board.

Are Board decisions for the two programs linked and are their rates connected? The answer is no. They're completely separate risk pools. HCA is presenting the same proposal to both programs. But if one passes it and one doesn't, that is a possible scenario of the end result. The resolutions are not intimately related to each other and the rates and rate pools are separate. There's no connection from a rate perspective.

Administrative concerns related to the timing of opt-out elections and premium collection. If you go back to SEBB Resolution 2021-11, you'll see examples. Depending on the timing of the new employees hire date, their eligibility determination for the employer contribution, and when they turn in their form juxtaposed with payroll deadlines, there'll probably be some instances where that happens. In many instances, school districts have already operationalized a way to collect the premium related to the default medical enrollment. When somebody turns in their paperwork at the very end of their enrollment timeline as a new hire, there's already processes that have been developed in various school districts to account for this. HCA anticipates the same logic would be similarly applied here. It doesn't mitigate the workload aspect.

There will be school employees who are automatically enrolled and will be frustrated about the default enrollment. When we look at these policy decisions at a high level, and our recommendations to you, we're trying to make proposals that benefit the majority of the population. The flipside of this frustration are those individuals who incorrectly believe the employer-paid basic benefit will be sufficient for their income replacement needs if they go out on a disability. For the PEBB Program, this low employer-paid benefit maximum payout has existed for decades. Even if these conversations aren't happening on a regular basis in the school district setting yet, they will if the current benefit design stands. It is very difficult for the Benefits Administrators, for payroll officers, for HR departments to have a conversation with somebody who has just had a devastating car accident, a stage four cancer diagnosis, a diagnosis of early onset Parkinson's disease, and to say to them your benefit is \$400 right when they are struggling with what their life is going to look like in the near term. They're suddenly faced with not having the type of coverage they thought they had. There are a couple things that actually exacerbate that in the SEBB setting, and one is we know that pre-SEBB there was a much more robust employer paid benefit. The inference from the pre-SEBB world to the current SEBB world for school employees really fosters that incorrect assumption. This felt like a good proposal to try to undercut that incorrect assumption and to set people up for success.

Does a school employee need to annually opt-out? No, this is not something that would require an annual process from the school employee. That would run counter to rate setting principles within disability insurance. You opt-out once.

The last item is a request to refine and help provide examples of how the benefit waiting period works. We'll put an example up at the next slide deck for April. But a quick example is if a school employee has 120 days of sick leave accrued and the benefit waiting period is 90 days, you simply compare 120 to 90 and 120 is greater than 90. On day 121 the waiting period has expired. It is not 120 days plus 90 days. You start counting with the longest benefit waiting period and then it's over.

Those are some of the initial questions received in the last few weeks. I wanted to highlight some of them rather than waiting until the final meeting. I have not gone over all the questions. We'll continue to get feedback and questions about the proposal. We will bring more back in April.

Dan Gossett: As I look at this, having no evidence of insurability, that's a plus. To have another option, that's a plus. That rates go down, that's always a plus. It really comes down to that opt-out or opt-in. Since people can opt-out at any time, and it takes effect the first day of the following month of termination, that's good. If you make this choice, you're not there forever. What I really like about the opt-out aspect is by not having long-term disability, and having the employee-paid part of it, you're taking a risk. If you're taking a risk, I really like it when people have to make a selection to show they're assuming the risk that they will not have a good long-term disability, a well-funded one.

Lou McDermott: Dan, that's a very interesting perspective. That's the first time I've heard anyone articulate it that way. I appreciate that. That is an interesting perspective, somebody making a conscious decision to take a step towards assuming the risk. So, thank you. I had never thought about it that way.

Wayne Leonard: I appreciate your historical context, but I would like to, at some point, have a comparison of a 100% employer-paid plan. The benefit levels, obviously, don't need to come up to where this is, but I know when we were first setting up the plans, Sean Corey was very adamant about improving that benefit. At that time, it seemed like our real focus was on medical and making it affordable. There was a lot of work getting the plans set up and in place. I think now there might be a different, more varied viewpoint on a 100% employer-paid plan. You mentioned the timing of the opt-out thing. That was one thing I've heard from people, that 31 days is a little quick given the differences and employee timing. A 60-day opt-out would be better, and hopefully avoid a lot of the appeals.

Finally, in terms of communication of this going forward, if this plan is to start at the next open enrollment period, or a plan like this in January 2022, I believe that's at the same time the state is instituting a new payroll tax for long-term care. That's a mandatory type thing. There may be a lot of confusion if people see a deduction of maybe \$30 a month for LTC and then see something else for LTD. That probably needs to be part of the communication as well

Dave Iseminger: Thanks, Wayne. Those are excellent points. I will make sure that we come back and talk about the alignment of the proposal with a 31-day election period. The proposal was to align it with all the other benefit elections that a new hire gets. It was to dovetail it with those specific pieces so it's not, "In your packet, here are the things you do at 31 days, at 60 days, retirement, and at 90 days." I have a feeling there are other reasons for a 31-day period. Maybe there are implications that it's greater than 31 days. I don't want to say that without confirming they do exist like I think they do. We'll make sure that we include that as part of the follow-up. The juxtaposition of the letter C and D is a very good point with regards to the timing of things happening this fall, independent of this proposal. I appreciate those pieces of feedback.

Dawna Hansen-Murray: I am hoping some of those examples you bring back will show how the Paid Family Leave Act comes into it, too. As somebody who tends to hoard her sick leave, I've got quite a bit of sick leave. I would have to exhaust all of it before I could take advantage of this?

Kimberly Gazard: That is correct, yes.

Dave Iseminger: It's about whether you have to actually exhaust your leave versus the time period associated with that leave. If you have a lot of leave on the books, say 120 days, and that's greater than 90, subtract family medical leave out of the equation for a moment, the benefit waiting period is 120 days. You don't actually have to burn that leave if you don't want to for whatever reason. You just have to wait the time equivalent to the leave that's on the books. We know there are instances in the PEBB Program with a similar policy that there are reasons why and circumstances under which the employee doesn't actually burn their leave. They wait the period equivalent of that leave. We will make sure there is a Paid Family Medical Leave example included.

Dawna Hansen-Murray: Thank you.

Public Comment

Mitch Thompson: Thank you, first of all, for allowing me the opportunity to speak to the Board. I am speaking today on behalf of myself, as well as the Washington Association of School Business Officials. We polled our membership on the long-term disability benefits proposal to ask opinions on whether or not the membership felt the benefit was a good thing. While the benefit may be a good piece, and it may be something everybody should have, a couple things came out of it. I believe the Board all got the communication from our WASBO Board President. This is a rehash of it. The big highlights are this is a supplemental long-term disability. It's a voluntary option and should remain a choice. It shouldn't be a mandatory thing. That's the first piece.

This does add extra burden to the Benefit Administrators. You're going to have a whole lot more issues of explaining to employees why something got pulled out of their check, as opposed to those who, you know, that their supplemental coverage is only \$400 a month. There's going to be more billing errors and more corrections. Even in the presentation, the piece was brought up about refunding members, and at what point in the payroll cycle we're at refunding the members.

Right now, the way that SEBB works is we have to report to SEBB what SEBB tells us, not what is actually true. Our school district, in particular, is floating the money so we

know what should be or shouldn't be. If we get a bill from SEBB that says the employee has to pay, let's say the default coverages, and we know that employee has opted-out, then we pay as a district. The next month when the credit comes, we get the credit from SEBB. So, there's a lot of extra work that comes to reconciling that bill. And mandating an opt-out, it'll increase the employee frustration with SEBB that already is not in favor of SEBB versus the pre-SEBB offerings.

So, to Dave's point, there are other programs that are mandatory options. With retirements, it's mandatory, you have to pick a retirement plan or you're defaulted in a retirement plan. This isn't the same as a retirement plan because this is an optional benefit. Regardless, whether it's a benefit to the employee or not, I personally believe the employee needs to make the choice and make the educated decision that this is for them, and this is what they need. Thank you.

Toni Thompson: A quick question. It's all about having an informed response and whether or not you respond. Are we depending on all passive response, like the assumption that if you don't respond, or you don't pick, you weren't interested? Or will you actively make sure that everyone has actually decided not to pick?

Dave Iseminger: Toni, I know you raised your hand during the dual enrollment presentation. Is your question about dual enrollment, LTD, or both?

Toni Thompson: Actually, both. The question is every aspect of this seems to be around people actively making a choice. My worry is that anything that I send out to people, there's a percentage that come back uninformed. No matter how I go about getting the address, regardless, something comes back. It bounces back. It's not received. And I didn't hear anywhere, in any of the parts of the different coverage changes, that there'll be any verification that someone actually received notification and they actively made a choice when they decided to opt-out. That was an active choice and not a passive choice, if they simply did not receive the communication. How much concentration is it about making sure that everyone does know that they must make a choice by this date and they have made a final choice?

Dave Iseminger: HCA typically, for public comment, receives feedback so we can then formulate a comprehensive response at the next meeting, if possible. What I'll highlight for you at this point, though, is we will do everything we can, with as many multiple communication streams as possible to ensure that people have the best opportunity of getting some or multiple communications about any benefit change. For the SEBB Program's initial Open Enrollment, HCA applied default enrollments for people who did not engage in the initial SEBB enrollment. It was less than 2% of the population (~1¾%). We always want everybody to make an affirmative choice. We never want to apply the automatic logic. But as you said, there will always be a subset of individuals, for whatever reason, their address of record is not up to date or in the PEBB Program there once was somebody in a coma for the entire enrollment period. If there are unique circumstances, we can evaluate that in the context of an appeal. But overall, we will always do multiple notifications to give everyone the best opportunity to tell us what they want to do. I'll talk to the rest of the team and see if there's additional context we can provide the Board.

Toni Thompson: Great, just one last thing. In speaking to the initial payments for coverage before people make their decisions, since it often does cross two pay periods, is it possible to push the payment out any further where it does not have to occur in the first month? Like, the first payment is spread over the next three months? Starting there so you can more accurately make the payment on the benefits that we need to charge the individual employees once they make their choices so we're not trying to float costs?

Dave Iseminger: Toni, what school are you from?

Toni Thompson: We're a standalone entity, Rainier Valley Leadership Academy.

Dave Iseminger: We'll reach out to you, because a lot of payroll cycles are so varied for individuals. I'll have our payroll team and/or accounting team reach out to you to answer specific options and flexibility that exists within the accounting procedures now.

Toni Thompson: Great, appreciate it. Thank you for the time.

Julie Salvi, Washington Education Association. Good afternoon. I have a couple things to touch on from the presentations today. First, I wanted to reinforce the benefit discussion that happened earlier. There were many good ideas offered that we are very supportive of. In addition to what was talked about, I would also raise the question about vision benefits and especially a second pair of glasses being covered, prescription sunglasses that bus drivers used to have covered in many of their plans. That is one thing we continue to hear about.

In terms of the eligibility proposals, I'll work through the stakeholder feedback on this but I want to ensure they reflect the policy of the Board that it is compensated hours not just worked hours. I'll look at that in detail for the next Board Meeting as you're gathering input.

On the LTD proposal, we value the access to a benefit without the evidence of insurability for this option that's being presented. We appreciate that there is the ability to choose between the 60% and the 50% and that the basic benefit is being maintained. We know that was not always part of the conversation. Like many, we would like to see the base benefit increased. But if that is not in the cards at this point, we appreciate the opportunity for employees to have access to coverage and then make an informed decision if they are choosing to not pay for that benefit. We do still view this as having a choice. I recognize the questions that have come up around making sure people are actively making choices. I would recommend we all spend some time talking about communication strategies, and multiple communication strategies, so employees will hear this in many venues from the Health Care Authority, from the districts, from their unions, and other resources as well.

The other thing I would add to that discussion is what we have seen in another voluntary benefit, the deferred compensation at the state level. When the state went to essentially opting people in and an individual had to take a step back to not make those additional investments for their retirement, the take up rate dramatically increased. That was a benefit that will help members over time. We see some parallels there and we would like to see members have better coverage than what many of them have today.

Finally, I just wanted to bring up going back to the discussion from last summer that we had about the two-year look back rule and how that's kind of broken during the pandemic with so many disruptions in the working schedules of individuals. I recognize that this is a backup eligibility provision. Most eligibility will be determined by someone's schedule. But in this pandemic, if that is a rule that an individual might have relied on for a safety net, or for consistency of application of benefits determinations between districts, that really is not likely going to be operational until 2023-24. You heard from substitutes last summer that it will also affect many more individuals in K-12 - paraeducators who have had hours cut, school bus drivers, and others. This may be a discussion, as we learn more about how benefits are being handled that comes up again before the Board, mainly in our interest of having consistent eligibility standards across the state. Thank you for your time today.

Next Meeting

April 7, 2021

9:00 a.m. – 2:00 p.m.

Preview of April 7, 2021 SEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the April 7, 2021 Board Meeting.

Meeting adjourned at 1:05 p.m.

TAB 4



2022 Annual Procurement Update

Lauren Johnston
SEBB Program Procurement Manager
Employees and Retirees Benefits (ERB) Division
June 3, 2021

Medical Procurement Work Plan

- Request for Renewal (RFR) released March 5, 2021
- RFR Responses returned April 5 and April 9, 2021
- Round 1 rates submitted April 30, 2021
- Preliminary negotiations May – June 2021
- First public presentation of rates mid-July meeting
- Final vote on results end of July 2021

Uniform Medical Plan

Uniform Medical Plan (UMP) 2022 Proposed Benefit Changes

Mental Health Parity

- Ensures compliance with federal parity laws for mental health/substance use disorder benefits and medical/surgical benefits
- Removes the coinsurance for mental health and substance use disorder inpatient professional services (i.e., physician services) in UMP Achieve 1, UMP Achieve 2, UMP Plus PSHVN, UMP Plus UW.
- No changes needed for UMP High Deductible

UMP 2022 Proposed Benefit Changes (*cont.*)

UMP Accumulators

- Currently when members switch plans during a plan year, their accumulators do not roll over with them when they switch to a different UMP plan
- HCA recommends allowing accumulator rollovers between UMP plans for member satisfaction and to align with how Kaiser's and Premera's plans apply rollovers

Proposed Resolution SEBB 2021-14

UMP Accumulators

Beginning January 1, 2022, when a subscriber enrolled in a Uniform Medical Plan (UMP) changes their enrollment to another UMP plan during the plan year (excluding Open Enrollment), the insurance accumulators (such as deductibles, out-of-pocket maximums, and benefit and visit limits) will transfer into their new UMP plan.

Uniform Medical Plan (UMP) 2022 Proposed Benefit Changes

UMP High Deductible IRS Change:

- Health Savings Account (HSA) annual maximum contribution increasing to \$3,650 for subscriber only and \$7,300 for all other tiers

Proposed Change to UMP Plus – Puget Sound High Value Network

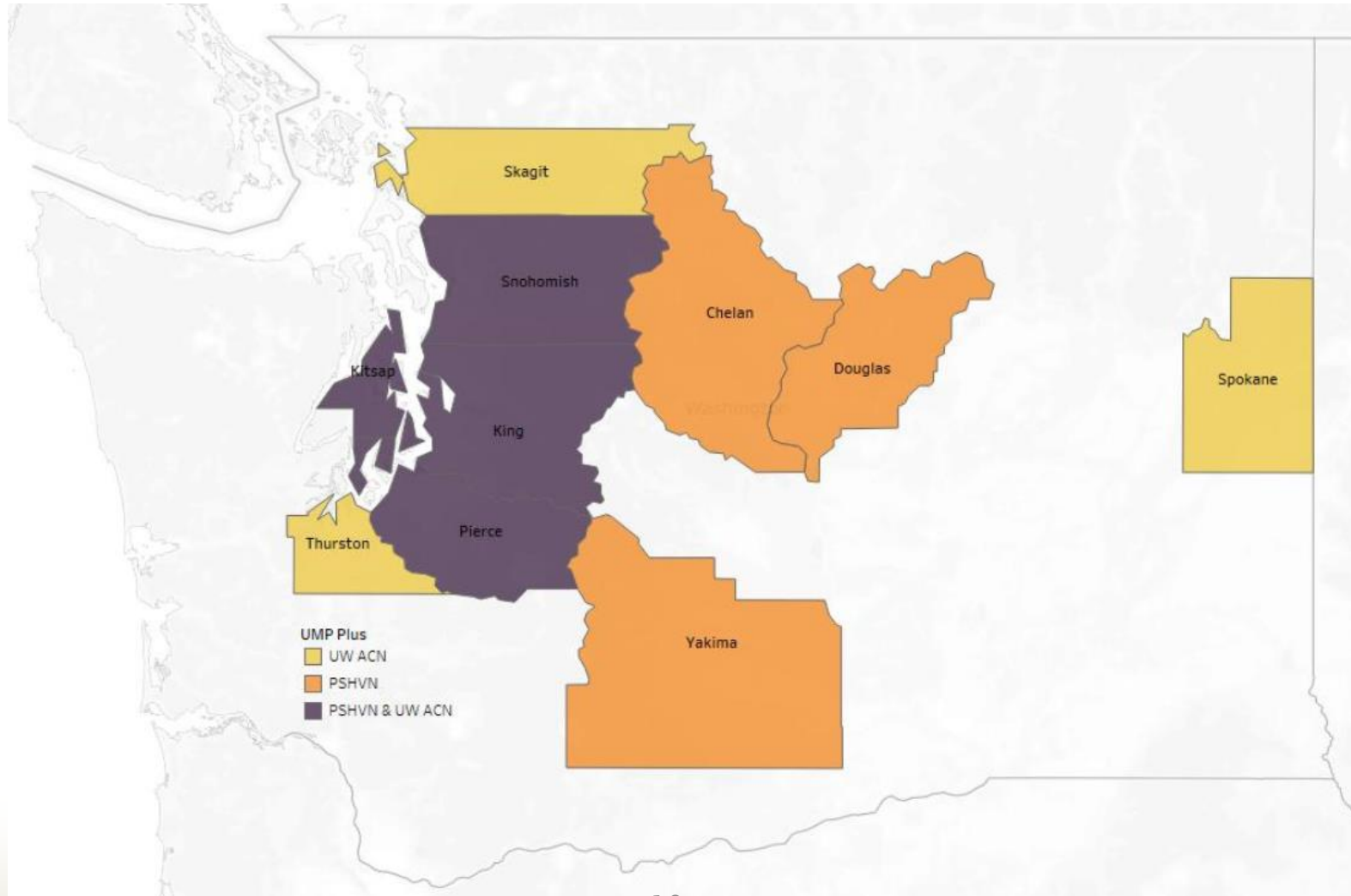
No longer in Thurston County

- Provider Contracts:
 - Adult primary care contracting challenges
 - Recent ownership relationships have shifted toward UW Medicine UMP Plus Network
- 77 impacted members

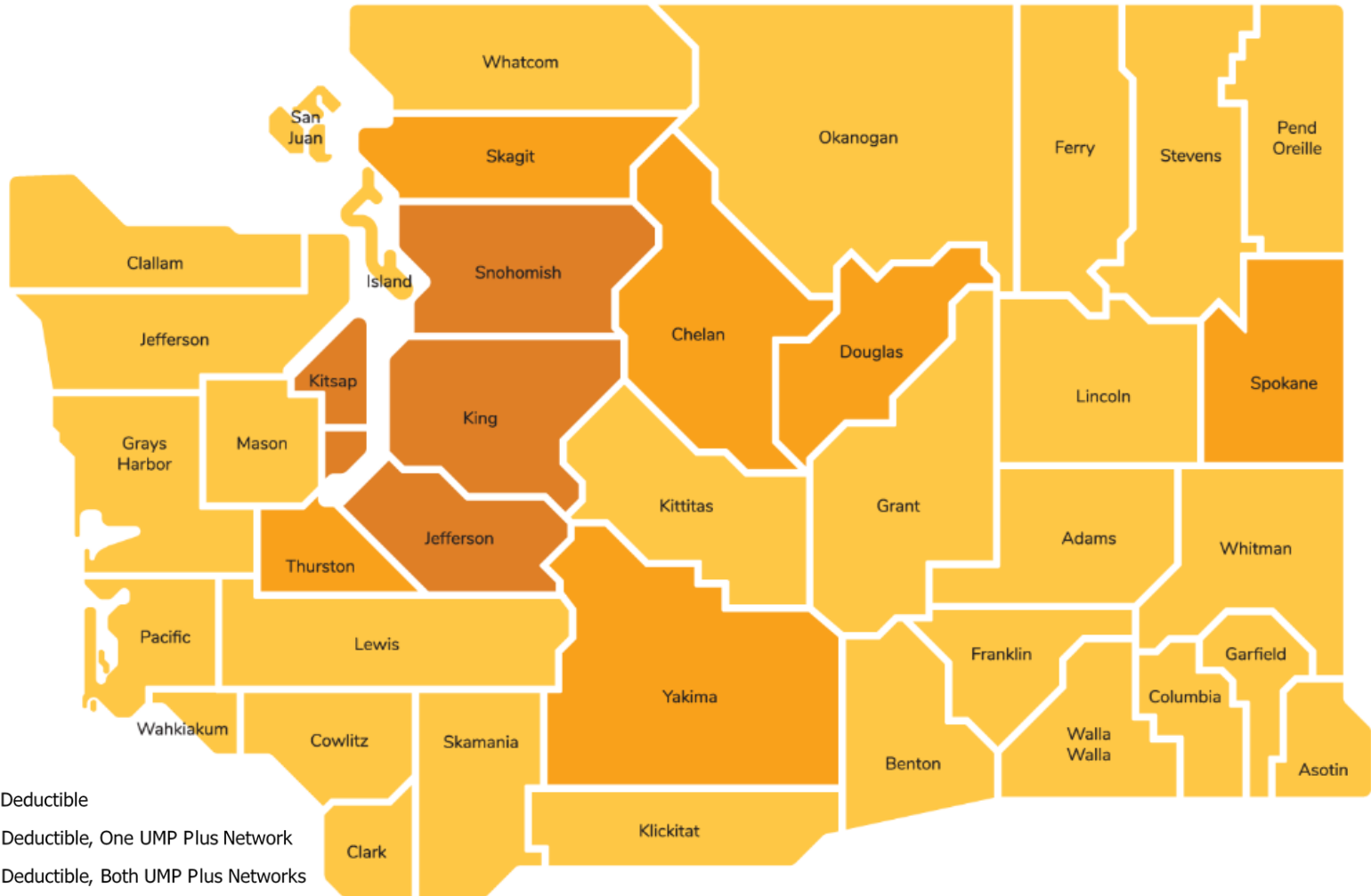
Proposed Change to UMP Plus – Puget Sound High Value Network (*cont.*)

- Communications plan:
 - Multiple notices to members from different sources (HCA/UMP, PSHVN, provider search/web notices, etc.)
- Plans in Thurston County (13)
 - UMP Achieve 1, UMP Achieve 2, UMP High Deductible, UMP Plus – UW ACN
 - Premera High PPO, Peak Care EPO, Standard PPO
 - KPWA Core 1, KPWA Core 2, SoundChoice
 - KPWA Options Access PPO 1, PPO 2, PPO 3

2022 UMP Plus Network Coverage



UMP Plan Coverage



Kaiser Foundation Health Plan of the Northwest (KPNW) & Kaiser Foundation Health Plan of Washington (KPWA) Proposed Changes

KPNW 2022 Proposed Benefit Changes

Naturopathy Benefits:

- Currently a specialty care benefit with a provider referral required changing to self-referred only
- Primary Care Copay, varies by plan
- No visit limit and no dollar max per plan year

KPNW 2022 Proposed Benefit Changes (*cont.*)

Acupuncture Benefits:

- Adding self-referrals
 - Physician-referred: Unlimited visits; Specialty care copay, varies by plan;
 - Self-referred: 20 visits per year; Specialty care copay, varies by plan

KPNW 2022 Proposed Benefit Changes (*cont.*)

Massage Benefits:

- Self-referrals allowed
- \$25 copay; 20 visits allowed per year
- No dollar limit maximum (currently combined \$1,000 with naturopathy)

KPNW 2022 Proposed Benefit Changes (*cont.*)

Rehabilitation Services:

- Allows self-referrals
- No longer requires a prior authorization
- Outpatient Physical, Speech, and Occupational Therapies will have a combined visit total of 60 visits per plan year
- Specialty care copay, varies by plan

KPNW 2022 Proposed Benefit Changes (*cont.*)

Dental Services for Potential Transplant Recipients:

- The member must be referred for a covered transplant evaluation and services authorized by KP's National Transplant Services team. This team approves transplant such as kidney, liver, bone marrow, etc
- Coverage adds routine dental services necessary to ensure the member is clear of infection prior to being placed on the transplant waitlist

KPWA 2022 Proposed Benefit Changes

For KPWA and KPWA Options, Inc., adding In-home Infusion Therapy To All Plans:

- Waives cost shares for administration of infused medication in a home setting
- Still a cost share for the associated prescription drug costs
- Out-of-network providers for home infusion will no longer be covered under the KPWA Options Access PPO plans

KPWA 2022 Proposed Benefit Changes (cont.)

For KPWA and KPWA Options, Inc., removing cost shares for two urine drug screenings:

- \$0 copay per plan year
- No diagnosis code restrictions
- Includes urine drug screenings for employment
- Not subject to deductible

KPWA 2022 Proposed Benefit Changes (*cont.*)

For KPWA Options, Inc., aligning with Premera and UMP by removing the annual out-of-network maximum out-of-pocket limit :

- Access PPO 1: \$9,000/Enrollee or \$18,000/family unit
- Access PPO 2: \$7,000/Enrollee or \$14,000/family unit
- Access PPO 3: \$5,000/Enrollee or \$10,000/family unit

KPNW & KPWA Provider Network Changes

- KPNW is adding PeaceHealth Southwest Medical Center as an in-network provider
- KPWA's contract with UW Medicine used for Core and SoundChoice plans expires May 31, 2021 (does not impact KPWA Options, Inc. plans)
- KPWA's contract with Kittitas Valley Medical Center for all plans will end on December 31, 2021

Premera Blue Cross Proposed Changes

Premera 2022 Proposed Benefit Changes

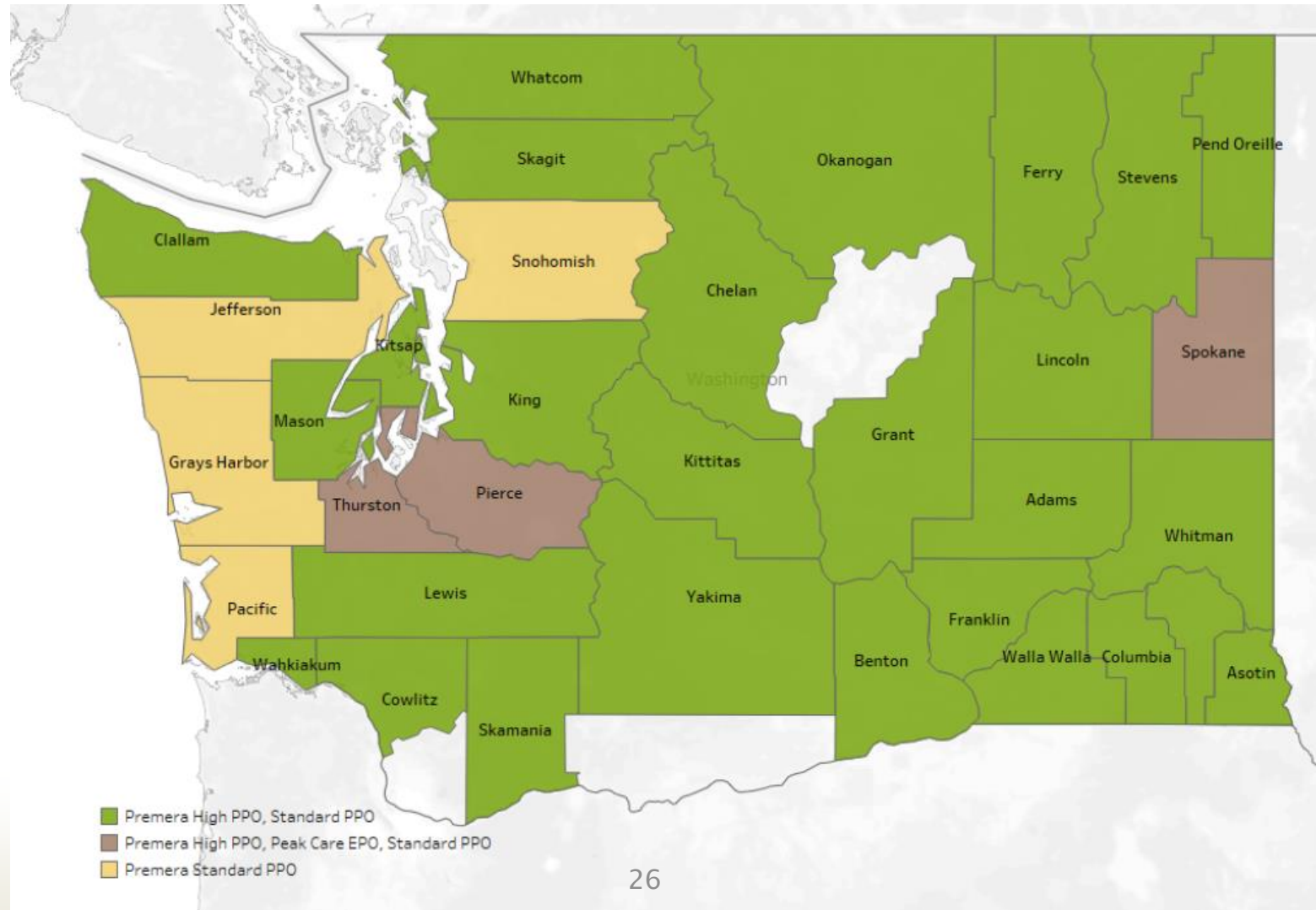
Adding a Quit for Life Program:

- \$0 cost share to members
- Unlimited Phone coaching
- Quit smoking medications
- Quit tools

Premera Service Area Expansion

- Premera proposes expanding offerings to Kittitas County
- School employees who live or work in Kittitas County would be able to enroll in either the Premera High PPO or Premera Standard PPO

Proposed Premera 2022 Service Area



Dental & Vision Benefit Offerings

No Proposed Benefit Changes for 2022

- Dental
 - DeltaCare Dental Plan
 - Uniform Dental Plan
 - Willamette Dental of WA
- Vision
 - Davis Vision
 - EyeMed Vision Care
 - MetLife Vision

Questions?

Lauren Johnston

SEBB Program Procurement Manager
Employees and Retirees Benefits Division

Lauren.johnston@hca.wa.gov

TAB 5



SEBB Medical Plan Appeals Process

Selena Davis, Senior Account Manager, UMP
Employees and Retirees Benefits Division
June 3, 2021

The General Appeals Process

- Follows state and federal law, generally all medical appeals follow the same process

This presentation will cover:

- Appeals process specific to UMP
- Different levels of appeals
- The appeals overturn rates by plan
- How members can submit an appeal

What is an Appeal?

- Request for reconsideration
- Can be made by the member or authorized representative, in writing or by phone
- 2 kinds of appeals: this presentation will focus on UMP medical appeals

Medical Appeal Examples

- Denial of preauthorization request
- Denial of claims payment or reimbursement
 - Not medically necessary
 - Experimental
 - Health care setting
 - Non-covered service

3 General Levels of Appeals

- Level 1: Denial of request
- Level 2: Internal appeal
- Level 3: External appeal to independent review organization (IRO)

General Appeal Process

Level 1 Appeal

- All must be filed within 180 days from date of notification
- All can be filed verbally or in writing
- All can be filed by the member or by an authorized representative
- These appeals go directly to the health plan for review

General Appeal Process

Level 2 Appeal

- Request for reconsideration of first level appeal
- Must be requested within 180 days from date of notification
- New evidence may be considered
- Different staff review

General Appeal Process Independent Review

- IRO is made up of outside medical and benefit experts
- Ensure the denial determination is following the law and Certificate of Coverage (COC)
- Must be requested within 180 days of notification of second level appeal determination
- No cost to the member
- Binding decision

Expedited Appeal

- All levels of appeals can be expedited in emergent situations
- No more than 72-hour response time
- Examples of emergent situations:
 - Denial of prescribed treatment or benefits
 - Usual appeal time is potentially life threatening
 - Hospital admissions

UMP PEBB** Appeals

Level*	2018	2019	2020
1*	1,327	1,326	1,805
2*	363	340	266
IRO*	100	92	71
Overtured	437	460	645

*Includes expedited appeals

**Non-Medicare

UMP PEBB Retiree** Appeals

Level*	2018	2019	2020
1*	122	148	202
2*	40	48	48
IRO*	10	10	20
Overtured	45	52	81

*Includes expedited appeals

**Includes Medicare

UMP SEBB Appeals

Level*	2020
1*	588
2*	91
IRO*	16
Overtured	249

*Includes expedited appeals

Regence: How to Submit an Appeal

- Online: sign into your Regence account, select Programs & Resources, and select Appeal Online

The screenshot shows a web browser window with the URL regence.com/member/members/member-appeals. The page header includes the Regence logo (BlueShield select counties of Washington) and the Uniform Medical Plan logo. The main content area is titled 'Appeals' and contains the following text: 'You have the right to appeal, or request an independent review of your coverage, benefits or services. You can submit your appeal online, by email, by fax, by mail, or you can call using our toll-free number. There are several levels of appeal, including internal and external appeal levels, which you may follow. Contact us as soon as you know you need to appeal.' Below this text are three options: 'Appeal online' (with a computer monitor icon), 'Appeal by mail or fax' (with an envelope icon), and 'Appeal by phone' (with a telephone handset icon). The 'Appeal online' option is highlighted with a red rectangular box, and a large blue arrow points to it from the right.

Regence: How to Submit an Appeal (*cont.*)

- Submit your written appeal by email, fax, or mail
Email: UMPMemberAppeals@regence.com
- Fax: 1 (877) 663-7526
- Call Customer Service to submit your appeal at 1 (888) 849-3681
- Mail your appeal to:
UMP Appeals and Grievances
Regence BlueShield
PO Box 91015
Seattle WA 98111-9115

Questions?

More Information:

<https://www.insurance.wa.gov/complaints-appeals>

Selena Davis, Senior Account Manager
Employees and Retirees Benefits Division

Selena.Davis@hca.wa.gov