

School Employees Benefits Board Meeting

July 23, 2020

School Employees Benefits Board

July 23, 2020

9:00 a.m. – 11:00 a.m.

Health Care Authority

Sue Crystal A & B

626 8th Avenue SE

Olympia, Washington

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TAB 1

School Employees Benefits Board
July 23, 2020
9:00 a.m. – 11:00 a.m.

All Board Members will be attending by telephone.

All attendees should attend telephonically.

To attend telephonically:

Call-in Number: 1-866-374-5136

Participant PIN Code: 60995706#

[Join Skype Meeting](#)
(visual only, no audio)

| 9:00 a.m.* | Welcome and Introductions | | Lou McDermott, Chair | |
|------------|---|-------|--|---|
| 9:05 a.m. | Meeting Overview | | David Iseminger, Director Employees & Retirees Benefits Division (ERB) | Information |
| 9:10 a.m. | Approval of January 27, 2020 and March 5, 2020 Draft Meeting Minutes | TAB 3 | Lou McDermott, Chair | Action |
| 9:15 a.m. | Follow up from July 16 Meeting | TAB 4 | David Iseminger, Director Employees and Retirees Benefits Division | Information/ Discussion |
| 9:20 a.m. | Vision Benefit Design Resolution | TAB 5 | Lauren Johnston, SEBB Program Procurement Manager ERB Division | Action |
| 9:30 a.m. | 2021 Premium Resolutions | TAB 6 | Tanya Deuel, ERB Finance Manager Financial Services Division | Action |
| 9:50 a.m. | COVID-19 Follow up and Eligibility Policy Resolution | TAB 7 | Rob Parkman, Rules and Policy Coordinator, ERB Division | Information/ Discussion/ Possible Action |
| 10:15 a.m. | Diabetes Management Program (DMP) RFI Results | TAB 8 | Kat Cook, Benefit Strategy Analyst Benefits Strategy & Design Section ERB Division | Information/ Discussion |
| 10:30 a.m. | SEBB My Account Enhancements | TAB 9 | Jerry Britcher, Chief Information Officer ETS Division | Information/ Discussion |
| 10:45 a.m. | Public Comment | | | |
| 11:00 a.m. | Adjourn | | | |

***All Times Approximate**

The School Employees Benefits Board will meet Thursday, July 23, 2020. Due to COVID-19 and out of an abundance of caution, all Board Members will attend this meeting by telephone. All attendees will also attend by telephone.

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

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 July 20, 2020.

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 |
| Vacant | 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 |
| Katy Henry 230 E Montgomery AVE Spokane, WA 99207 V 509-324-2167 katy.henry@hca.wa.gov | Certificated Employees |

SEB Board Members

Name

Representing

Terri House
Marysville School District
4220 80th ST NE
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Employee Health Benefits Policy
and Administration

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3/27/20



STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue SE • P.O. Box 45502 • Olympia, Washington 98504-5502

SEBB MEETING SCHEDULE

2020 School Employees Benefits Board (SEBB) 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 27, 2020 - 9:00 a.m. – 3:30 p.m.

March 5, 2020 - 9:00 a.m. – 3:30 p.m.

April 2, 2020 - 9:00 p.m. – 3:30 – p.m.

May 7, 2020 - 9:00 a.m. – 3:30 p.m.

June 4, 2020 - 9:00 a.m. – 3:30 p.m.

June 24, 2020 - 9:00 a.m. – 3:30 p.m.

July 16, 2020 - 9:00 a.m. – 3:30 p.m.

July 23, 2020 - 9:00 a.m. – 3:30 p.m.

July 30, 2020 - 9:00 a.m. – 3:30 p.m.

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

7/2/19

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 09, 2019

TIME: 1:24 PM

WSR 19-15-021



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

DRAFT

School Employees Benefits Board
Meeting Minutes

January 27, 2020
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 4:00 p.m.

Members Present

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

SEB Board Counsel

Katy Hatfield

Call to Order

Lou McDermott, Chair, called the meeting to order at 9:00 a.m. Sufficient members were present to allow a quorum. Board self-introductions followed.

Chair McDermott noted that Sean Corry and Patty Estes are no longer on the SEB Board. Sean retired and is traveling the world! Patty stepped down after being a huge part of the Board and getting the SEBB Program off the ground.

Our newest Board Member, Dawna Hansen-Murray, is joining us today. Dawna has been working at Yelm Community Schools since 1992, starting as a para-educator in the fourth grade classroom at Southworth Elementary School. For the last 20 years, Dawna's worked as a library assistant at McKenna Elementary and Yelm's first middle school as a librarian's assistant. She is currently a librarian tech and is an active member in her union, serving as vice president of her local chapter. She and her husband have four grown children and seven grandchildren.

Dawna Hansen-Murray: One of the stories I wanted to share is I testified before the SEBB Program came into existence at a hearing explaining to the people in front of me that my daughter was not married to the father of her three children because of insurance costs. They got married on January 1 of this year at 12:01 a.m. [applause] I am paying \$49 a month to have a son-in-law now. [laughter]

Lou McDermott: That's awesome. I think Dave did share that story with us and it's very impactful.

Meeting Overview

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

SEBB's First Annual Open Enrollment – Preparation and Activities Summary

Scott Palafox, Deputy Director, ERB Division and **Renee Bourbeau**, Manager, Benefits Accounts Section.

Scott Palafox: Slide 2 – Since the Last SEB Board Meeting. This was absolutely a successful launch. It took a lot of hard work, dedication, and time. It was you as a Board, those in the room, on the phone, and out there still serving our school members and employees today, that had a part in this success. Although the launch was successful, it wasn't perfect.

HCA is now working on post-enrollment issues. I think the confidence given to HCA to administer this program was because of the great work we've done with our sister program, the Public Employees Benefits Board Program. We serve one member at a time. We're going to get it right and we won't be satisfied with the results until we get all issues resolved that came up during the launch.

Renee will talk about some of the new tools this year that employees took advantage of for this open enrollment. We learned a lot about our new members.

Renee Bourbeau: Slide 3 – Pre-Open Enrollment Engagement with Benefits Administrators. The SEBB Program started communicating with the SEBB Organizations a year in advance to prepare them for the transition. HCA conducted multiple webinars with the Benefits Administrators (BAs) to discuss SEBB My Account functionality and review critical project milestones. Other webinar topics included supplemental payroll set up, billing, COBRA continuation coverage, and responding to general questions.

Our Outreach and Training (O&T) Unit sent Benefits Administrators invitations in June for them to register for an in-person training event in August and September. The O&T team conducted 19 training events for more than 600 Benefits Administrators before open enrollment. The training was to provide them with the process of preparing their organizations for the SEBB Program's first annual open enrollment. Training topics included eligibility and benefits, SEBB My Account, the BA's website, the appeals process, and continuation coverage.

Slide 4 – In-Person Benefits Fairs. The O&T team conducted 20 Benefits Fairs for employees between September 30 and November 7, 2019. Evening and extended hours were available to accommodate SEBB Organization's employees unable to attend during the day. Benefit providers were onsite to answer questions regarding plans and benefits.

Over 10,000 employees attended the Benefits Fairs. We had to quickly deploy additional staff to assist the large number of attendees.

Dave Iseminger: Yakima and Mount Vernon especially had large numbers of attendees. I attended four Benefits Fairs myself and it was an enlightening experience. I had someone show me their pay stub to confirm they would not be paying the same amount for medical insurance in the future. I answered questions about deductibles and so many other topics.

Renee Bourbeau: Slide 5 – Open Enrollment Tools. HCA procured two new tools, a Virtual Benefits Fair and an online support tool called ALEX.

The Virtual Benefits Fair (VBF) launched October 1, 2019. The VBF is an interactive, online website, created with the same goal in mind as an in-person benefits fair, to make learning about the benefits and plans available to subscribers and their families easier and user friendly. The tool was available 24/7 and it had a direct link to ALEX and SEBB My Account. It had approximately 30,000 visits, with 21,500 being unique visitors.

On October 2, HCA also launched ALEX, an interactive, online decision support tool. The intent was to help school employees learn about their SEBB Program Benefits and make decisions about their health coverage. The tool was also accessible 24/7. We hoped to alleviate undue burden on the payroll and benefits office. ALEX had approximately 137,700 visits.

Slide 6 – Comments from SEBB Program Members Regarding ALEX. We had great feedback on ALEX. Those that used the tool found it helpful.

Slide 7 – SEBB My Account Assistance. HCA contracted with a contact center to provide technical support for things like new user registration, Secure Access Washington, SEBB My Account navigation, and help with uploading dependent verification documents. It was available to the Benefits Administrators beginning September 23, 2019 and to employees beginning October 1, 2019. The contact center had extended hours of operations during open enrollment, from 7:00 a.m. to 9:00 p.m., and on Saturday from 10:00 a.m. to 4:00 p.m. They received about 13,700 calls.

Dave Iseminger: As Scott mentioned, not everything about the launch was perfect! We published a call center number where we transposed one of the numbers. It turned out that incorrect number wasn't in use and HCA was able to buy it to make the wrong number the right number! It was much more economical to buy a second telephone number than it was to reprint all of the materials. So now we have two phone numbers for that assistance. I did not know you could even buy a telephone number!

Scott Palafox: Slide 8 – Other Assistance. As I mentioned at the beginning of this presentation, there were many hands involved in launching this program. There was the SEB Board who had 23 meetings and over one hundred hours of time spent making critical and tough decisions.

School districts, Benefits Administrators, and superintendents were excellent resources. We thank the Benefits Administrators for their patience as we temporarily take on some of the responsibilities of administering this program that we'll eventually give back to them. They were very anxious to help their employees. We appreciate the dedication they have to those employees and giving us a heads up on issues.

Washington Association of School Business Officials (WASBO) was tremendous with communication channels in assisting us and offering HCA significant time at conferences to provide training. They were crucial to us in giving us insight on our policies and rules.

Labor Unions were also essential resources for providing insight into policies and rules.

Slide 9 – Other Assistance (*cont.*). Educational School Districts provided space for Benefits Administrator trainings and supported HCA with communications and helping districts through this transition.

The Washington School Information Processing Cooperative (WSIPC) modified their data system so the districts were able to use their platform in sending HCA eligibility information.

Other state entities that provided invaluable assistance to the launch were: Office of Financial Management and the Governor's Office, Department of Enterprise Systems, Health Benefits Exchanges, Office of Superintendent of Public Instruction, Office of Insurance Commissioner, the Attorney General's Office, Washington Technology Solutions (WATECH), and the Legislature.

Dave Iseminger: Our relationship worked with WSIPC so well that they joined PEBB Benefits as an employer group. They couldn't join the SEBB Program so they joined the PEBB Program!

We were often calling the Department of Enterprise Services (DES) with rush printing projects! We needed 30,000 copies the next day! They were always very accommodating. They wouldn't make promises, but they always delivered. I can't thank them enough for so many different communications that ultimately made it into school employees' hands because DES was able to prioritize so well.

WATECH was instrumental, especially at the beginning of open enrollment. SAW was having a challenge because another part of state government was testing the servers to see how much it could take - coinciding on the second day of our open enrollment. HCA talked to WATECH and they temporarily suspended that agency's testing ability to make sure all of our things went through. There are lots of support and humorous stories. It was a team effort throughout a lot of different parts of state government.

Scott Palafox: Slide 10 – Other Assistance (*cont.*). Our carriers and vendors took a leap of faith with things that needed to be done and we appreciated their partnership in this endeavor, especially as we tried to negotiate contracts when there wasn't much information. They also assisted with training webinars, which was a tremendous help for Benefits Administrators in getting this started.

HCA staff put forth a huge agency effort. We elicited staff from all divisions within HCA. Within our own division, staff have taken on a new program, and many have duties for the PEBB Program as well. It's a tough balance between two huge programs.

Finally, all the school employees that took action to get us to this point. They forged ahead into something that is brand new to them, something they don't quite understand, but knowing they needed to do something in order for us to pull this off.

Slide 11 – HCA Additional Readiness Activities. Additional activities that took place in September. We provided SEBB Organizations with copies of the *School Employee Initial Enrollment Guide* in case employees came into the offices of the Benefits Administrators and weren't able to use SEBB My Account.

Our internal Enterprise Technology Services Division created a Command Center to help with technical components and questions regarding SEBB My Account.

There was a "hotline" box for school superintendents in case they needed to get program leadership for urgent issues. It had minimal use, which is a great testimony of how successful this program was.

HCA created external facing reports to let the organizations know where they were regarding eligibility data uploading. Lots of FAQs for Benefits Administrators and employees. We still go through those to review the questions.

HCA used data-driven decisions to help in taking necessary action. Towards the end of open enrollment, we could see who hadn't accessed SEBB My Account to claim their account, so we used that data to send the Benefits Administrators a message that could be forwarded to their employees letting them know they needed to take action.

Slide 12 – Targeted Communications. We did targeted communications. We currently have SEBB Program updates that goes out every Tuesday and Friday to the Benefits Administrators, talking about some of the changes or fixes made with SEBB My Account, any known issues we come across. At that time, they also got updates on the accounts claim and enrollment statistics.

HCA had reminder emails about uploading eligibility data back in September. We sent out templates of copies of mass mailing letters we sent to their employees so that they had a heads up when those employees come into the office with questions. We sent guidance on usage of marketing materials. Showed them how to run reports in SEBB My Account.

Slide 13 – Targeted Communications (*cont.*). We followed up with SEBB Organizations who did not provide us a list of their COBRA participants. We did targeted communication early in open enrollment for those that had less than 20% of their eligible employees claiming the accounts. Dave was featured in four Facebook Live events answering Q&A for employees. He had over 8,000 views.

Slides 14 & 15 – Dependent Verification (DV). Dependent verification has been one of our major issues. To ensure only eligible employees enrolled, we performed dependent verification on spouses, state-registered domestic partners, and children, including extended dependents and those with disabilities. SEBB Program rules are different than some school districts and we wanted to make sure we were all on the same page. HCA staff performed the majority of the verification review.

At the end of October, employees with pending and denied dependent verification status for approximately 25,000 dependents received a letter asking them to take additional action to confirm that dependents' eligibility prior to open enrollment ending. I believe this action helped reduce an estimated 20,000 dependents from having coverage denied.

Dave Iseminger: We were hesitant to send denial letters in October, instead sending the call to action letter. After open enrollment, we ultimately sent denial letters that covered about 4,500 lives. This is an example of date-driven decisions Scott spoke of earlier.

Scott Palafox: Slides 16 & 17 – Some Takeaways. HCA was set to have our system shut off at 12:00 a.m. midnight the night of November 15, 2019. Instead, at 12:00 a.m. on the night of November 14, it shut off and was down about six hours. When we arrived that morning and discovered the error, we sent out a targeted communication to the Benefits Administrators. We could see who tried to get into the system and reached out to those folks. We didn't see a need to extend open enrollment and there have been no issues since!

Dave Iseminger: When we arrived at 6:00 a.m. and looked at the number of people, there were between 900 and 1,000 people who had been in SEBB My Account between midnight and 6:00 a.m. It turned out that over 900 of them had already made their elections. It wasn't their first time in the system. But, we did a communication to everyone on our list. At the end of the day, under 20 people hadn't re-engaged in the platform later in the day who had never been in the system before November 15. If those twenty chose to appeal, we know who they were. We understand that midnight begins a day, it doesn't end a day, which now *everybody* in the Health Care Authority knows for sure.

Scott Palafox: There was some confusion between ALEX and SEBB My Account. Another lesson learned! Subscribers thought once they went through the Alex tool, they had signed up for their benefits. We sent the Benefits Administrators a forwardable message letting them know employees must use SEBB My Account to claim their account and make their benefit elections there. ALEX is a tool to help in selecting their benefit elections. We contacted the vendor for ALEX, Jelly Vision, to add alerts to their tool.

Early in open enrollment, we noticed a low enrollment in our supplemental long-term disability benefit. We made a few changes to SEBB My Account to make the enrollment opportunity more intuitive to subscribers and clarifying specific enrollment steps. With that change, we almost doubled the daily enrollment for the supplemental LTD. It's still not where we want to be, so we are looking to have a special enrollment for this benefit in May 2020.

The last future enhancement to discuss today is about having your dependent verification approved before selecting a plan. Subscribers believed that while they were waiting for their dependents to be verified, they didn't think they needed to (or could) make plan selections. We hope in the future they will make their plan selection in anticipation of the DV approval process being completed.

Dave Iseminger: The plan election for the dependents was on Screen A, the upload document process for verification was on Screen B. Our enhancement's will bring those together so you can't upload documents until you also affirm what your plan selections would be assuming the dependent's eligibility is approved. If we had linked those together as a requirement in the enrollment process, it definitely would have reduced the number of dependent verification appeals and the confusion school employees were experiencing. That is a planned enhancement in the next couple of months in order to have it in place by September 2020.

Scott Palafox: Slide 18 – Lessons Learned. We learned the value of Robocalls in getting the message out. It was an important communication tool. Districts established computer labs to help employees with claiming their SEBB My Account and working through the benefit elections.

Pete Cutler: Can you explain what a computer lab is? I don't have the context.

Scott Palafox: Many of the districts set up a room with computers to help their employees work through how to get into and navigate SEBB My Account. While we were at the Benefits Fairs, we had staff assisting employees with the mobile phone, too. We didn't have computers set up at the Benefits Fairs, but many of our employees went through that process with their mobile phones.

Dave Iseminger: Computer labs are also mobile. Some school districts had tablets and went to bus transportation centers as employees were moving from shift to shift or at a break to be able to help classified staff in those instances. They took the computer lab to them.

Terri House: I'd like to say thank you for letting me know that you could access the benefits enrollment on a tablet or cell phone. I took that information back north where I'm at and a lot of people don't have computers at home. They have tablets, they have their phones, and they were able to access information. Then they went to the computer labs and finished their enrollment. They really appreciated that a tablet and phone were part of the options for getting information and found it more user friendly.

Scott Palafox: It's important that employees make sure their addresses are up to date. We sent out lots of communication, lots of letters. We got many important letters back and had to resend those returned letters to the school districts to make sure they got to those employees. The system allows you to go in and update your address, or go to your Benefits Administrators to update.

We hope to enhance SEBB My Account to provide notifications to employees as they go through the enrollment process. You need to go through all the steps in order to be done. We need to establish and create methods to let employees know when they are done.

Dave Iseminger: HCA is looking at creating a button that you click when you are done with your enrollment confirming you are really done! The feedback has been that balloons, congratulations, or some bigger fanfare saying you were done would have been great! We will be thinking about how to do that. There was a confirmation screen, but it was not intuitive how to find it again later.

Scott Palafox: Adding additional staff to the in-person Benefits Fairs helped. They could navigate staff to the correct areas. Communications, both with the updates and the targeted communications, was very beneficial, as well as the webinars we did to help folks get through the process.

Slide 19 - Next Steps. HCA will continue to work and resolve the remaining open enrollment issues. We've learned a lot. We'll take those lessons learned and make improvements going forward. We never want to lose sight of our goal, offering affordable and quality healthcare benefits to our members.

Pete Cutler: I would feel very remiss if I didn't go on record saying how appreciative I am and really very, very impressed by the work the Health Care Authority did, and the Employees and Retirees Benefits (ERB) Division specifically, to implement the program. I had more than 36 years of dealing with employee health benefit budgeting, administration, and legal issues. And the K-12 context is so complex and involves so many parties. It was very impressive to see everybody get aligned when there had been a lot of conflict before and the resources.

The Legislature deserves a lot of credit for putting up the resources, giving Health Care Authority the ability to hire some folks. Health Care Authority deserves credit for building on those resources by adding in folks like Renee Bourbeau, who has a huge amount of background, great skillset, and other folks like Renee, who have worked with the PEBB Program before. It was being able to bring that kind of expertise to situations like the dependent verification, which would never have worked if you were just trying to do it purely with people who didn't have that history. A lot of people brought in contributions. It's across the board very impressive.

You can look to our Health Benefit Exchange and the federal one. It's really easy on these grand initiatives for something to crash, whether it's the IT side or some other major gap in terms of having people available who can answer questions. So really, the Health Care Authority deserves a lot of credit for having pulled this together so well. So thank you.

Scott Palafox: Thank you, Pete.

Lou McDermott: Dave has done an amazing job. Pete brings up a good issue. The Legislature did fund this well. We did get a lot of money for the administrative portion to be able to hire the vendors, the extra help, the consultants, the project managers. The work that was done by the individual leaders within the agency was above and beyond. We didn't hire another ERB Director. We didn't hire another ERB Deputy Director. We didn't hire new section managers or a new Chief Financial Officer. We didn't hire a new Communication's Director. For all of those individuals, this was above and beyond. It was a long two years, but who's counting, right?

Dave Iseminger: 135 weeks!

Lou McDermott: But who's counting! It was a long period of time, but the right people kicked in, and to Scott's point, all the other agencies. I think the feeling was no one wanted to be the weak link. No one wanted to be the reason why we couldn't get it done. Even areas that were traditionally a little bit harder to work with, or it took more

time, people just seemed incredibly nimble throughout the process. The answer usually was, “I don’t know how we’re going to do that, but we will try and do that.” Then we would work with them until we got to done. It was an amazing aspect of the project. So thank you.

Dave Iseminger: I don’t think the districts are getting the credit they deserve. As I’ve had conversations with different legislators, I try to drive home the point that so many districts stepped up in so many different ways. I talked to many of them most days. They’re my new best friends and we talk about a lot of different challenges. Whereas the Legislature funded and provided the ability for me to hire roughly fifty people in the last two years to help with the administration, there was not as much support at the local level for additional staffing. We took some things off their plate, COBRA administration being one of them. Every time we highlighted that, there were rounds of applause in every business administrator’s office around the state. But there were new things that they had to do. They were bobbing and weaving many of the times within their own existing resources. They performed admirably as you’re about to hear when we go through the numbers.

SEBB Open Enrollment Results

Dave Iseminger, Director, ERB Division and **John Bowden**, Manager, School Employees Benefits Section.

John Bowden: Scott and Renee went through what led up and what occurred during Open Enrollment, and now Dave and I will give you information about how it all went.

Slide 2 – SEBB Program Open Enrollment Key Results. About 146,000 eligible employees and 98% of these eligible employees, about 143,000, enrolled in medical, dental, vision, other benefits online. About 2% were automatically enrolled in benefits, which means about 3,000 employees didn’t make a selection and we enrolled them in UMP Achieve 1 and the dental and vision automatic enrollment plans.

About 183,000 eligible dependents enrolled, but this number is a little higher now. About 21%, or around 31,000 employees, selected supplemental life insurance. 18%, or about 26,000 employees, made selections for supplemental long-term disability insurance. And 13% of the employees waived coverage. That’s about 19,000 who decided they had medical coverage in other places, such as spouse’s or partner’s employer coverage, Medicare, Tricare, or something else so they didn’t need to sign up for SEBB Program medical.

Dave Iseminger: The 98% affirmatively making plan choices, or waiving, beat all expectations. As the numbers came in, we did not anticipate it being such a high active participation by school employees. To clarify, the vast majority of that was the individual going in and doing enrollment. We are aware that some districts had people turn in paper forms and then keyed them in themselves. That gets counted in the same bucket as directly utilizing SEBB My Account. But the vast majority of it was the employee themselves. The last 72 hours, we were at approximately 80% to 85% engagement, and that was starting to feel tolerable. We knew there was a big bough wave coming, but none of us expected 98%. That was incredible. So many school employees actively engaged at such a high level.

Pete Cutler: I would say that also is testimony to the incredible work put in by the districts, HCA, and everybody else, plus the communication tools and the willingness to bump up and adjust those communication tools when you saw issues. I'm curious about how these results and numbers compare to the assumptions that were built in either to the budgeting models, the models used to project rates, or to what assumptions the health plans had when they were building their rates. At some point, I'd like to hear a discussion of that.

Dave Iseminger: Tanya can talk about that during her presentation. But at a very high level, I could tell you some data points. Overall, there were more dependents than was projected, but fewer in medical. The employee waiver rate assumption in the modeling last March was around eight percent, which is what it is in the PEBB Program. So, the waiver rate in the SEBB Program population was higher than the original projections.

Pete Cutler: That's got to work out positively on the budgeting side.

Dave Iseminger: The directionality of that is on the positive side and the dependent information I think is a mixed bag. Lots of different moving parts. But for that specific lever, yes.

John Bowden: Slide 3 – School Employees with Medical Coverage. One of the things you often heard prior to going live was the difference between the number of dependents, people that would enroll from what they currently were enrolled, and particularly that three to one ratio where an employee would pay no more than three times as much for a full family as they pay for individual. We expected to see more dependents.

In the first column, Pre-SEBB Program Enrollment, are the numbers enrolled in year four of the Office of the Insurance Commissioner's data collection. From 2015 you can see the number of employees and the number of dependents that were enrolled in medical coverage. The middle column, SEBB Enrollment, you can see there was an increase of over 21,000, or about a 20% increase in the number of employees that signed up for SEBB medical benefits. For dependents, those are spouses, state-registered domestic partners, and children. The increase was about 39%, or almost 37,000 more dependents. The grand total is almost 58,000 more, so about a 29% increase in the number of members enrolled in the SEBB Program as it compared to 2015 prior to SEBB.

Dave Iseminger: We used calendar year 2015 data because it was the most comprehensive data set that existed. We wanted a comprehensive snapshot. Natural growth has occurred in school districts since then. For each of the intervening school years, the growth in staff was between 2½% to 3%. Although some part of that 57,800 is attributable to general growth within the system, still the vast majority is related to the change in eligibility and cost that came with the SEBB Program.

Alison Poulsen: Would the assumption be they were uninsured, underinsured, or this is a more economical way for them to insure their families?

John Bowden: It would really be all of those. There were some that had coverage other places and moved over, but there were a lot not enrolled anywhere. It did expand coverage.

Slide 4 – Medical Plan Enrollment by Member Type. We have more members, more employees, more dependents enrolled in dental and vision. But this slide shows the medical. Spouses includes state-registered domestic partners as well. Almost 37,000 have employees that enrolled with just their spouse. Employees who enrolled dependents, which is employee and child or children, about 93,000 enrolled. This includes both the employee and the dependents. For an employee also enrolling a spouse or state-registered partner and dependent children, almost 62,000 enrolled. Employee only had about 65,000 enrollees. That totals approximately 260,000.

Dave Iseminger: The other way to think about this is half of the circle is blue. That's the employee population and half of the employees' enrolled dependents and spouse. Half of all employees added twice as many dependents.

Pete Cutler: I think you're telling me that of those four tiers, the largest number is Employee Only. No, it's member enrollment. It includes dependents?

John Bowden: Yes. This is member. It includes the dependents.

Pete Cutler: So that doesn't necessarily mean the largest number of employees added dependents only, only the ones that did add dependents only, that tier had the most number of members of the four?

Dave Iseminger: Pete, to clarify for you, although there are four colors on this graph, they don't correlate to the four different tiers in our tier ratios directly. We were really trying to show that half of the population is dependents driven by half of the employees. The only one on this graph that truly correlates with one of the cost tiers that we've talked about for the last two years is the dark blue on the left, the single subscriber tier. The lower blue gets sliced up and added to purple and red get to the other various tiers.

Pete Cutler: Another way of putting it is the spouses and dependents part of the circle all are attributed down to that other part that says employee plus also enrolling. Thank you.

Dave Iseminger: Correct.

John Bowden: One quick point, again, this is medical. The total number of members in the SEBB Program includes both employees and all other dependents, which is almost 330,000. We have an additional number of dependents included in dental or vision, but not medical.

Slide 5 – Eligible Employees Submitted Per Day, shows the number of eligible employees submitted to the Health Care Authority for us to preload into SEBB My Account to be ready for open enrollment. The numbers are a one-week snapshot of the names of eligible employees submitted by the districts, the three ESDs with represented employees, and the charter schools. Approximately 70% of eligible employees were

uploaded in the last two days and 80% of all eligible employees were uploaded within one week's time.

Dave Iseminger: This was one of four areas in the entire launch that had my attention the most. If the eligibility data wasn't uploaded timely, we couldn't push it through SEBB My Account. HCA communicated early in the summer to the districts that the turnaround time was very short. SEBB My Account opened on September 3 and we asked for their data by September 10. HCA provided training in July and August. By the end of September, we had received about 98% or 99% of the data. September 10 was the deadline and 70% of the data was received in the last 48 hours. That was an indication to us that for open enrollment, the last couple of days for members themselves would be big days. We have to thank the districts retroactively at this point. We thanked them then, but so many pieces wouldn't have been successful in open enrollment if the data hadn't come in during that week in early September.

John Bowden: The Benefits Administrators had access to SEBB My Account for almost a full month prior to the start of open enrollment.

Slide 6 – SEBB My Accounts Claimed Per Day, shows the claiming of SEBB My Account by employees on a daily basis. Eligible employees were entered into SEBB My Account and then they needed to access and claim their account through WATECH and SecureAccess Washington®, the SAW account. There were multiple parts to claim their account, with 98% success. A little over 100 employees used paper forms sent to HCA to enroll, which is incredible, making online enrollment a huge success.

Dave Iseminger: The trend on Slide 6 is a similar pattern to the behavior in the PEBB Program open enrollment. There is a bubble at the beginning and a bubble at the end.

John referenced the approximately 110 paper forms we received. Some districts got paper forms and keyed them instead of sending them to the Health Care Authority. Towards the end of open enrollment, we strongly encouraged them, if they had the capacity, to key anything they could. HCA estimated we might receive 30,000 forms between October 15 through Thanksgiving. In actuality, for the PEBB Program we received 1,800 paper forms and only 100+ for the SEBB Program. It was a huge relief.

John Bowden: Slide 7 – Top Medical Carrier by County (All Members). This slide shows medical plan enrollment by carriers and county. It includes dependents.

Slide 8 – Top Medical Carrier by District (All Members) shows enrollment by school districts. The Uniform Medical Plan was available in every county and school district. And we had quite a bit of enrollment in the Uniform Medical Plans.

Dave Iseminger: When you compare the PEBB and SEBB Programs, the blue and brown colors on this slide shows the top plan in that district. Those plans don't exist in the PEBB Program portfolio, which is one of the reasons we went out for procurement to try and get as robust a portfolio as possible. School employees saw value in those extra plans that were procured rather than simply leveraging only the existing PEBB Program portfolio.

John Bowden: Slide 9 – Member Enrollment by Medical Plan. The Uniform Medical Plan (UMP) had the highest percentage of enrollment. About 36.4% of members are within one of the Uniform Medical plans. Premera had 25.3% of the total membership. Kaiser Washington had 21.3%, Kaiser WA Options had 13.4%, and Kaiser Northwest had about 3.6%. The three Kaisers combined had 38.3 %. Approximately 19,000 employees waived coverage.

Dave Iseminger: Pete asked earlier about comparisons to the modeling projections. The ultimate enrollment in UMP was higher than originally modeled. Original projections were a good 10% to 15% lower enrollment in the Uniform Medical Plan. That impacts some of the budgeting pieces because it impacts cash flow analysis of the self-insured plan. If you don't have claims at the beginning of the year because people are having to meet their deductible, it helps with those aspects. Ultimately, on the backend though, you have to account for the higher enrollment in the reserve buildup.

Pete Cutler: Will we get an update on the claims trend projections from Megan this afternoon? Did they change since the rates were set? By having more people in UMP, it could be a good thing or a bad thing short term budget wise, depending on whether your claim trend assumption was a little high or a little low. I'll be curious about that when we get to the rate setting discussion.

Dave Iseminger: Feel free to ask Tanya or Megan that as they come up later.

Pete Cutler: Okay, thank you.

John Bowden: Slide 10 – Member Dental Enrollment by Plan. Almost three quarters of the members are in the Uniform Dental Plan, which is also the plan they would automatically be enrolled in if they didn't make a selection. There was some confusion between DeltaCare and the Uniform Dental Plan. DeltaCare reported to us about possible employees who thought they were picking the Uniform Dental Plan, but enrolling in DeltaCare. We'll discuss actions taken in this instance when we discuss appeals.

Dave Iseminger: Just a reminder that employees cannot waive dental or vision, unlike medical.

John Bowden: Slide 11 – Member Vision Enrollment by Plan. MetLife Vision had the most enrollment. It is also the default plan if a member did not make a vision selection.

Slide 12 – ALEX Visits During Open Enrollment, the online benefit advisor tool. The total number of visits on ALEX were 137,648. It was a successful tool this open enrollment. As Renee mentioned, there were a lot of good comments about ALEX.

Slide 13 – SEBB Program Appeals. To date, we have approximately 5,200 appeals, about 37% of them were for dependent verification. Some employees had difficulties and were confused about how to verify dependents. Some employees uploaded the same birth certificate for all three of their children. There were issues when a spouse or a state-registered domestic partner needed to show a marriage certificate or state-registered domestic partnership certificate, AND a document showing they were

cohabitating, like a utility bill. In some cases, they only uploaded one document. We had a lot to work through a variety of issues that occurred with dependent verification.

The overall success of the Program is that more than 98% of employees did not have any problems. But that 2% is still a pretty large number if you are one of them. We do care about them and we're working through the appeals as quickly as we can.

About 42% of the appeals received are from employees who enrolled in DeltaCare thinking they were enrolling in the Uniform Dental Plan. If their appeal is to change plans, we will automatically make that change right now.

There were other plan enrollment corrections. Some subscribers thought they had completed their enrollment after going through ALEX. They are appealing. HCA staff is getting them in the right places. Some subscribers had screen shots of what they selected, but their confirmation of enrollment is different. Those issues are also getting corrected. That is a relatively small number, about 800, which we are also working through.

Dave Iseminger: If we had shut down open enrollment on Halloween, what would have happened to dependents? We had 25,000 dependents that looked like they were headed towards a permanent denial. On November 25, the Monday before Thanksgiving, we sent a letter to those ultimately impacted. We sent just under 3,700 denials related to dependents, covering about 4,500 lives. On that same day, we sent approval letters to 83,000 subscribers for about 185,000 dependents. The letter numbers highlight the results of the dependent verification process.

John highlighted some user challenges that might have existed with SEBB My Account. I do want to acknowledge one system limitation I think also contributed to some of the dependent verification challenges. Our file upload capacity was around six megabytes. The size of a file created some problems for folks. I didn't want to make it sound like there was nothing the Health Care Authority did wrong with regards to dependent verification. That contributed to those potential denials.

I'll also say that as we've gone through dependent verification, the estimated average is that about two-thirds of those appeals are being approved pretty quickly with regards to the documents submitted with the appeal. There's a sense from the appeals team that some of the remaining appeals could ultimately be approved based on the documentation received, and others unlikely to be approved based on not fitting the eligibility requirements. As they go further through the appeals process, there are additional opportunities to provide documentation. If it comes in, we would settle an appeal with adequate documentation by enrolling the dependent and ending the appeal process.

One appeal had people continually scanning the same document. When you scan certain documents of photos, it comes through as a black piece of paper. We kept getting the same black piece of paper. As we get to lower appeal numbers, staff will be able to call subscribers and discuss their options.

For the dental plans, it was helpful when Delta Dental told us information based on their historical data for K-12. What they had, plus the data we gave them, showed about

15,000 people, who for years had been in a PPO plan and for the SEBB dental had signed up for an HMO or a DMO. They were concerned about the number of appeals HCA would get. HCA was proactive and sent a letter to those 15,000 subscribers. When HCA received those appeals, at the same time as the other appeals, HCA summarily approved those dental appeals.

Another appeal type concerns plan enrollments that the subscriber believed the system got wrong. Actions in the system were needed after open enrollment. HCA had a judgment call to make. As we got to the end of open enrollment, about 5,500 dependents had no plan selection, but those dependents were verified in the system. HCA had two options. Do we deny coverage to all of those individuals and have the subset of that 5,500 who wanted coverage appeal to get into coverage, or do we put them all into coverage and have appeals taking a subset of them out of coverage. Because of those 5,500, some intended to have some coverage and some did not. HCA made the decision to create auto-enrollment logic for all of those instances putting them into coverage and sending default letters to the impacted employees.

Some of those enrollment corrections are related to the HCA-applied logic. So we are having to take some people out of coverage and refund premiums rather than risk that those individuals wanted coverage, went in for services at the beginning of January, and realized they did not have coverage. That seemed like the bigger challenge at the end of the day. You will hear people say the system had a flaw and it was wrong. Once we get through all the appeals, we can go back and evaluate each of those to determine if it was a true system issue. So far these appeals, in the initial stages, fit into the logic HCA applied deliberately to what was inconsistent or incomplete information in the system.

As of last week, a conservative estimate of completed appeals is 40%. We define done as when the member letter is sent. We believe we are further along and the target date for completion is February 3.

Pete Cutler: I'm very happy the agency decided that where there was some question of whether people had wanted to select into coverage versus out, that you did what you did. It's much easier to reverse the deduction of a premium rather than to deal with billing for services retroactively. That's another great decision by the agency.

Dave Iseminger: We have 5,200 SEBB Program appeals. All of PEBB last year had under 200 appeals. We went to the Legislature and asked for staffing models based off our experience. We've had to pull from a lot of different areas to find ways to supplement our standard appeals process staffing. We've either tripled or quadrupled, depending on what day it is, the staff handling different aspects of the appeals process.

John Bowden: Slide 14 – SmartHealth. We probably could have done better communicating this benefit, but we focused on the medical, dental, and vision aspect first. We had over 16,000 employees register for SmartHealth, the wellness program, and over 14,000 completing the well-being assessment during open enrollment. Those 14,000 will be eligible for a \$50 incentive, which is either a reduction in their deductible or added to a health savings account if they picked the high deductible plan. The points they get for having done the well-being assessment get added to those employees becoming eligible for \$125 incentive in 2021. If the employees registered for

SmartHealth complete the required number of points, they will receive that \$125. We can continue doing advertising for the SmartHealth Program. Employees can continue to sign up throughout the year and earn points to get the incentive for 2021.

Dave Iseminger: We will activate different communication streams related to SmartHealth going forward. HCA has at least one dedicated staff member the SEBB Program funds that relates to supporting districts regarding wellness. That individual goes to interested districts to help beef up their wellness portfolio. There is a SmartHealth table at all Benefits Fairs. We did push on SmartHealth during the initial open enrollment, but we were focusing primarily on medical, dental, and vision. We heard employees saying there was so much to read and so much information. We can promote SmartHealth year round.

Pete Cutler: We're saying that roughly 16,000 registered out of about 127,000 employees enrolled in the SEBB Program?

Dave Iseminger: If you go to the very beginning of the slide, the eligible employees was 146,000.

Pete Cutler: That would include the folks who waived?

John Bowden: 127,000 actively enrolled. 19,000 waived.

Pete Cutler: That would make the difference. Do we have any idea roughly how prevalent these type of wellness programs were with school districts? Is this a case where the SmartHealth-type wellness program new option was completely new to employees as part of looking at their health benefits, versus for many of them was a change in terms of this specific program from one vendor and one approach to another?

John Bowden: Going back to when the Insurance Commissioner was doing the data collection, I went around the state and talked with a lot of school districts. In the data reported to the OIC, every school district said they had a wellness program. I encountered only two that actually had a wellness program. For most districts, the carriers didn't see a benefit to offering a wellness program when some employees change to another plan, another carrier the next year. I also don't believe districts understood what a wellness program was exactly. I believe we will see more registration as we move forward.

Pete Cutler: That's very helpful information. It's also encouraging in a sense that there may be some fertile ground to be worked in terms of introducing the idea and showing how it's kind a win-win for everybody, as opposed to if you were dealing with groups who just had prior experience and were showing no openness. There are more opportunities ahead. Thank you.

Dave Iseminger: In November and December 2017, John did a presentation describing the prevalence of various products. While I don't remember the number, I remember the far right of the slide had very tiny bars compared to all the other benefits. Very little wellness had been recorded.

BREAK

2020 Supplemental Governor's Budget Update

Tanya Deuel, ERB Finance Manager, Financial Services Division. This presentation will be recurring throughout Board season as legislative proposals and budgets become final.

Slide 2 – SEBB Funding Rate. The funding rate is updated with every new budget. We establish two years of funding rate, but more than likely, the second year usually changes. The funding rate changes for the second year because throughout the year, HCA does quarterly updates. With the SEBB Program now live, once we get claims coming in, enrollment changes, we will do quarterly projections, update the model, update our final position, and the funding rate needed for the program. Don't be alarmed with this change. It is normal.

The first six months of the program has remained the same at \$994. The second part, \$1,056, remained unchanged for the last two months of the school year. What has changed in this version of the budget is shifting funding from a fiscal year to a school year funding rate. The \$1,029 would be the 2021 school year, reduced from \$1,056. This is still per employee per month and adequate to maintain the current level of benefits. This change is a result of open enrollment. At this point, when we did the model updates, we had preliminary open enrollment numbers, not final numbers.

Dave Iseminger: The final numbers, due to appeals, are still in flux.

Tanya Deuel: The percentage of waivers is one item that resulted in the reduced funding rate. The PEBB Program was used as the proxy for the initial SEBB Program modeling, which was 8%. In actuality, it was 13%. The additional waivers helped the funding rate position because the districts are still paying for those who waived medical, but still enrolled in other benefits. There was also more enrollment in the self-insured products. Originally, we projected around 20,000 subscribers in the self-insured Uniform Medical Plan, but in actuality, it was approximately 43,000. That also helped the overall position.

Wayne Leonard: Last year when the budget came out, there was a significant shortfall of the Legislature. We had quite a long discussion about it. At that time, I think the HCA felt like the program would operate at a deficit. Since that time, I guess with this data, it comes in better. But we're in the first month of claims and getting premiums here at the end of June, we're lowering -- is this based on estimates or we're lowering it based on what we think actual claims will be? Something is not connecting with me. We keep lowering the rates, but last year we were anticipating this program operating at a deficit. We were discussing the Health Care Authority asking for a supplemental budget request to help fund that. Help me work my way through that.

Tanya Deuel: These updates are not based on updated claims for the actual SEBB Program because we have not had any claims experience in the first 27 days in order to model. We're still using PEBB. What we do on the Uniform Medical Plan is apply the PEBB Program trend updates until we have separate SEBB Program trends, which probably won't be for about another year. We did have positive trend updates in the PEBB Program that we applied to the Uniform Medical Plan on the SEBB Program. This is primarily due to the positive enrollment in the self-insured plan, which does help our cash position because we are paying claims versus fully insured premiums. Claims

don't come in right away, whereas those fully insured premiums for the Kaiser and Premera plans we are paying right away. With the higher enrollment in the self-insured plan, it helps our cash flow position.

Lou McDermott: Tanya, I think what you're saying is that we had a bunch of assumptions going in that had to do with what plan you were selecting, how many people would waive, and how many dependents were coming in. Now that the real numbers are in, you are applying those to the models which affects the funding rates.

Tanya Deuel: Correct. I want to caveat, we still have a lot more data to come. We need this program to be mature. This funding rate, as we get through the House, the Senate, and the conference budget, could still change. We will give the Legislature and OFM one more update before the next versions of the budget come out. The \$1,029 could still change. But we won't have any more claims' data to rely on before the next update.

Another influence on the positive funding rate was the load for dependents to subscribers in dental. Originally, we anticipated about 2.5% on the member to subscriber ratio. I came in closer to 2.1%. That was a positive in the cash flow position.

Wayne Leonard: How long do you anticipate we would be getting mature data for the SEBB Program plan if it's different than the PEBB Program?

Tanya Deuel: This spring, when we start developing rates again, we're obviously not going to have any mature claims data. We are going to ask for one more year of school data use as a reference. Hopefully, we can apply that data, and the PEBB Program trends to the SEBB Program population. I think it's going to be at least one year of the Program, if not two, until the data stabilizes.

Pete Cutler: Tanya, my understanding is you're saying there was obviously PEBB Program trend relied on in coming up with the original \$1,056. Actually, if I remember correctly, what the Legislature did, against the advice of HCA, they based their rates on the assumption that the SEBB Program experience would closely model the PEBB Program claims' experience or something similar to that.

Tanya Deuel: Correct. For the Uniform Medical Plan.

Pete Cutler: Yes, and if I understand correctly, we have roughly at least three, maybe six more months of claims' experience in UMP than we did when the rates were established and that were used and built into the budget.

Tanya Deuel: Correct.

Pete Cutler: In terms of actual claims' experience, am I right, that the claims' experience in that period of time was more favorable than expected?

Tanya Deuel: I believe so, yes, but I can follow up with you on what the PEBB Program trend numbers were for medical that we applied. We update trends twice a year, in the spring and fall.

Pete Cutler: Even on a short session, the Legislature wants an update before --

Tanya Deuel: Correct, which is why this model that produced the \$1,029 is on an accelerated time frame that allows us to have our regular second quarter update during session.

Pete Cutler: I'm intimately familiar with the pressure put on people like you and the Health Care Authority. That makes perfect sense that in March, we'll have a little more polished open enrollment impact data; but more importantly, we'll have the most up-to-date trend data, which could go either way. I certainly would like the break out of what led to the change in the estimated cost, rates, and proposed rates, so we can get to the point Wayne is getting at. Is this a long-term adjustment that bodes well for the school districts in terms of not having a dip and then spike? Or is it a more limited thing. I think March makes perfect sense in terms of timing.

Tanya Deuel: I will bring that back. I agree with you. The second year open enrollment, too, is a big question. Will these enrollment patterns stick in the second year as well? We'll be able to rely on those for modeling the second year of the Program.

Pete Cutler: It seems like we're hopefully going to have more detail about what's going into the rate assumptions for the next school year when we meet in March. Thank you.

Dave Iseminger: Now that we're starting to get into a steady state, you will often hear Tanya say the phrase "adequate to maintain the current level of benefits" because there are three or four finance questions asked all the time. One this time of year is, "What is the magic number needed in the funding rate?" The answer is, there is no magic number, because based on all the different projections, the question should be, "Is there any direction to the agency or Board to change benefit levels to fit the number being said?" There are all sorts of variables in the funding rate. HCA always tries to present it in a way that doesn't have to go into all the variables in the calculation, but instead we summarize and say, "There's no direction you are required as a Board to take action to change the benefits package in either direction."

Tanya Deuel: Correct. Slide 3 – Funded Decision Packages. There are two decision package requests submitted that were funded in whole, or in part, in the Governor's budget. The first one is audit capabilities for staffing to support audit functionality. We received four FTEs total, two in the PEBB Program and two in the SEBB Program, totaling \$234,000.

Dave Iseminger: Now that we have 305 new employer friends in the SEBB Program, and we already have about 500 friends in the PEBB Program, the historical audit process has been through the appeals process. This decision package is about setting up proactive audit functions on eligibility and a cadence for random audits of employers to make sure they are applying criteria correctly. We requested four staff to start. We have suggestions as to how frequent the cadence will be. As that matures, there may be a time where we ask for additional staff. This will get us started with proactive eligibility audits.

Pete Cutler: Am I right that this is parallel to what the Department of Retirement Systems does with auditing for the adherence to the State Retirement Statutes and administration?

Dave Iseminger: I believe the answer is yes.

Pete Cutler: Do you know if there's going to be coordination between the two?

Dave Iseminger: I'm not aware of that at this point, but that's something we can talk about during development.

Pete Cutler: They found it very helpful in the 1990s to expand the auditing capacity. As much as some employers, at first, were not welcoming it, it greatly reduced the number of situations where they were after the fact, a slap on the wrist for things they were doing wrong. There was a greater focus on making sure they understood and doing it right. I hope this will have a similar focus on let's assume everyone's acting in good faith but proactively making sure people are understanding what is supposed to be used as a standard for eligibility and adhere to it. I'm glad to hear this has support.

Tanya Deuel: The next decision package is the K-12 Non-Medicare Risk Pool. If you remember, last year we had a report due to the Legislature on risk pool arrangements between the PEBB Program, the SEBB Program, and retirees. This was funding and FTEs to implement the change of the Non-Medicare school employees staying in the active risk pool in the SEBB Program instead of moving pre-Medicare age over to the PEBB Program and then back, and then moving into the Medicare risk pool once they're Medicare age. HCA received 1.3 FTEs and only \$15,000. Those don't go together but the good news is the signal is to keep moving forward. We did provide feedback on this one. We will see what comes forward in the next versions of the budget.

Pete Cutler: Can we be sent the copy of the decision package so we can see the details?

Tanya Deuel: They are on OFM's website. We can send you the link.

Pete Cutler: I have to admit, historically, I've had a hard time tracking down decision package information on the web, so that would be great.

Dave Iseminger: The way these often work is HCA makes a recommendation in a report and notes resources. If it's funded, that signals implement the recommendation that was put forward. That's the cadence for how these work. If we never put forward the decision package, we might never implement the recommendation. It tees it up to say, "Yes, proceed with what you wrote in that report."

Tanya Deuel: Slide 4 – Other Items of Interest. Items not in a formal decision package but included in our modeling or a need. These were included in the budget. The first one is a diabetes management Request for Information (RFI). We currently have a virtual Diabetes Prevention Program but not a diabetes management program. This is a request for one-time funding to do an RFI and get information on the programs available in the marketplace. We received \$75,000 for each program to complete an RFI.

The second request was regarding our Third Party Administrator (TPA) fees that HCA pays Regence, MODA, and the Uniform Dental Plan. As we got the higher self-insured enrollment, we needed higher spending authority to pay those administrative fees. This is a technical spending authority because the money is baked into the funding rate.

Dave Iseminger: I feel the need to mention one piece. We'll be talking about it more as we go further into Board season, and even at lunch. Typically we don't talk about decision packages that are put forward and not picked up in a budget proposal. But there's one you are well aware was submitted. It is not in Tanya's list and there is nothing in the proposed budget related to the long-term disability (LTD) benefit. We have been working on different ideas to bring to both Boards about ways to work on the LTD benefit. I wanted to acknowledge that. Marcia can attest that I told her back in the fall, assume it won't be picked up so in January we've already got a head start. There has been a team working on an alternative parallel plan all along. We'll be talking more about options as we go forward.

Pete Cutler: Six months ago, and 12 months ago before that, school districts, and specifically Wayne on this Board, expressed a concern about the unknown impact of changing eligibility standards for the SEBB Program and the whole funding structure. How would that impact school districts in terms of having employees they're not going to get money for from the state. Are we, at some point, going to get a briefing on how districts are being impacted, how things are shaking out with the interplay of the new SEBB Program coverage for employees, plus other changes with K-12 funding?

Lou McDermott: I don't know how we would know that, Pete, to be honest with you. Besides having a detailed work group with the districts to understand that, I don't know if we have that level of detail.

Dave Iseminger: We might be able to put some pieces together. We know the funding rate. We know the benefit allocation factor. We're not experts on the K-12 prototypical model, but we know people who are. We know what we're billing, so there might be something we can do. I'll consider that request made and will talk with the finance team to see what can be put together to address that type of question.

Lou McDermott: Pete, you're looking for the delta?

Pete Cutler: Quite frankly, like with WASBO, do they feel like this has turned out to be a huge issue? Now that things are shaking out, and after February's levy votes, maybe they'll know more. Is the sense that there are problems still but they're manageable in terms of a small number of districts? Or is it we have a major systemic structural funding problem that's going to eventually cause huge headaches for school districts? It's important in terms of long-term success of the Program to figure out the answer to that general question. It's primarily a school funding issue, probably more than a SEBB Program funding issue. It seems like a very important public policy issue.

Dave Iseminger: Pete, Cade's going to talk about different legislation in the Legislature now. There's at least one of them in its current iteration that does at least have a specific OSPI-HCA joint study, at least on substitutes that starts to get at this general topic, even if it's not for the entire program.

Pete Cutler: Great, thank you.

Legislative Update - Bills

Cade Walker, Executive Special Assistant to the Employees and Retirees Benefits (ERB) Division Director. I am the ERB Division legislative liaison and work with analysts to provide an analysis to our Legislative Affairs Division, and provide feedback to the Legislature on bills that impact our Division. Other subject matter experts look at bills and let us know if the bill could be an issue we need to address. I also coordinate with our vendors to ensure there is an understanding from them impacts proposed legislation may have.

We are in short session this year, which started January 13. We are on day 15. The last day of session is March 12. We have been running full speed from day one. There were a few pre-filed bills from last session that we had already addressed, which gave us a head start.

Slide 2 – Number of 2020 Bills Analyzed by ERB Division. As of January 21, we did 119 bill analyses in our ERB Division. We primarily focus on high impact bills that impact our Division and the PEBB an SEBB Programs. There are currently 27 high impact bills and we are lead on 14.

Dave Iseminger: When we say something's high impact, there's usually two criteria. Either it requires rule making or possibly benefit design changes, or it has an impact anticipated to be over \$50,000. Given the size of our programs, any change to benefits is going to have an impact greater than \$50,000.

Cade Walker: Slide 3 – Legislative Update – ERB High Lead Bills. This slide shows bill progress within the legislative process. The bills cascade down with a total at the top so when we see the origin of chamber, the policy, that will be the total number of ERB high impact bills we are leading. I will cascade that number down so you can see what bills are moving through the process and how many have reached the Governor's desk.

Pete Cutler: Do I understand correctly that basically this cascading slide shows that there are 14 ERB high lead bills in total as of this date. Four of those have passed out of the Policy Committee into the Fiscal Committee?

Cade Walker: That's correct.

Pete Cutler: Either of those four, or it's possible you could have something that would pass directly from the Policy Committee directly to Rules, or it could go through Fiscal to Rules. Those two bills shown under Rules or Floor, are they two of the four above?

Cade Walker: It's one and one. You're correct that they don't necessarily have to pass through the Fiscal Committee if there's no fiscal impact. One of those did go through the Fiscal Committee and the other did not. It went straight to the Rules Committee.

Pete Cutler: Do you have those numbers off the top of your head?

Cade Walker: I don't.

Pete Cutler: I'll look it up later. Thank you.

Dave Iseminger: Remember that sometimes the Fiscal Committee is also the Policy Committee. It's not necessarily that all four of those bills passed Policy into Fiscal. But when it comes to compensation and benefits packages, those bills often start directly in the Fiscal Committee because they are considered policy bills of fiscal state policy. There are different ways a bill can move through the process. Slide 3 is a general funnel.

Cade Walker: Slide 4 – SEBB Program Impact Bills. House Bill 2208 and its companion Senate Bill 6144 is about implementation credits and performance standards in insurance contracts. This had a hearing last week and we testified in support. This legislation HCA worked on with OIC before session. OIC introduced the legislation in response to an issue with one of the vendors and the implementation credits that we have pretty standard in our contracts with our vendors. HCA testified in support of the legislation and we're working closely with OIC in making sure we help this legislation move along, as we feel it is very beneficial for our contracting purposes. Not only to have the implementation credits for when we change vendors, but more importantly to have the performance guarantees in those contracts. As I mentioned to the Legislature, performance guarantees help us hold the feet to the fire of our vendors and ensures we're providing the best quality of benefits and services to our members.

Dave Iseminger: This bill is basically to write and change the words in statute to match what everybody has been doing because of some concerns raised in the past couple of years. It's not actually changing how we're doing work, it's so the statute reflects how the work is currently being done. This came up because there were concerns that in the insurance code, granting or holding a performance guarantee penalty was actually a retroactive revision to the rates filed with the Insurance Commissioner's Office and might run afoul of rate filing requirements. This cleans up those concerns. It wasn't a concern with what we were doing, but how it should be reflected in state law and the practices OIC follows with the filings.

Pete Cutler: Thanks for that clarification. I was curious of what specifically this would hone in on. Are the carriers the Health Care Authority works with supporting this legislation?

Cade Walker: I'll get back to you on that. I am not confident one way or the other.

Pete Cutler: Okay, thank you.

Cade Walker: House Bill 2458/Senate Bill 6479 were introduced this session and address optional benefits offered by school districts. This is amending language from SB 6241, which precluded school districts from offering benefits that were in conflict with the offering authority of this Board. The proposed legislation clarifies the types of benefits school districts can offer, including fixed payment benefits - cancer insurance, hospital indemnification insurance, emergency transportation. These fixed payment benefits would be allowed under this legislation, as well as other particular types and categories of benefits.

Dave Iseminger: When Cade comes up later to talk about our optional benefits survey, it's intimately related to the existing authority that would be changed by this bill.

Cade Walker: Slide 5 – SEBB Program Impact Bills – Eligibility. These three bills directly impact the eligibility of SEBB Program members. Senate Bill 6189 already has Substitute Bill. The original bill entitled Eligibility for School Employee Benefit Board Coverage would have removed eligibility from substitutes and from employees who work in the languages, an indeterminate schedule, or anyone without a contract at the beginning of the school year indicating they would be working 630 hours. They would no longer be eligible for benefits. Additionally, the bill would remove dual PEBB/SEBB Program enrollment by retirees and PEBB/SEBB Program dual enrollment by employees.

Since the hearing on Friday, a proposed substitute bill was heard that does not have the eligibility requirements that were in the original SB 6189 regarding substitutes and those employees who work indeterminate schedules. It's asking OSPI, with assistance from HCA, to conduct a study on the number of substitute teachers and those who work indeterminate schedules. Currently, the study would not be due for quite a while. It's not necessarily providing relief the districts seek on the financial side. It's unclear if the depth of this study would get to the full extent of what is needed in order to answer the larger question. It may be an opportunity to determine the overall impact based on population, which is largely those unfunded, which is our understanding of the master model for K-12 funding. Many substitutes are not funded through that mechanism.

Senate Bill 6290 - Contribution to, and eligibility for, school employee benefit plans. This bill has two adjustments to RCW 41.05. First, it attempts to modify what happens when an employee waives their coverage. The actual language does not necessarily achieve what we believe the bill intended, which was school districts don't have to remit payment for waiver. The mechanisms to do that would need some adjustment HCA proposed language if that's what they wanted to do. Additionally, it removes eligibility for substitutes and coaches. SB 6189 was addressing substitutes and those who worked an indeterminate schedule. SB 6290 removes eligibility for substitutes and coaches, as well as modifying language on what happens when an employee waives.

Senate Bill 6296, Health care benefits for public school employees, would remove eligibility for employees in a job sharing arrangement. As we learn the definition of job shares, we appreciate it's a defined term when there is a single position split between two or more employees to allow flexibility for achieving the work needs of that particular FTE.

With regard to these bills with eligibility, we don't have great numbers on how many job shares there are, how many substitutes there are, how many employees work an indeterminate schedule, or how many coaches there are. We sent a survey to all SEBB Organizations on Friday, last week, to inquire and start getting data of how many substitutes are in your district. How many of those employees currently have SEBB Program benefits? We asked about job shares and other types of employees. That will help us get an idea of what the fiscal impact would be. I can appreciate the data we get will be rough. It's evident there is a lot of variation between the districts and standardizing how we collect data that is a work in progress for us to continue appreciating how to get data that is as accurate as possible.

Dawna Hansen-Murray: The prototypical school model will pay for one lab teacher or five lab teachers and then a district might hire ten para-educators instead. That is not considered job sharing. Am I correct?

Cade Walker: I wouldn't know how to answer that entirely. We're still learning how districts classify job sharing. It was an issue we raised to make sure the term "job share" was very clear in what they were intending to do, that it wasn't just parsing out headcounts. There needed to be something more definitive about what was intended by job sharing.

Dave Iseminger: I think it was Senator Hasegawa during the bill hearing who said he might appreciate a definition of job sharing because he understood with almost 300 districts, there might not be uniformity in understanding of such a key term in the bill. It's an area we're watching. We think it is unlikely we all have complete clarity. I'm sure if we asked everybody in this room, there would be at least a dozen different definitions or examples.

Wayne Leonard: I know a lot of these bills were based on the concern Pete brought up about the cost of providing these benefits to substitutes. I think that's why these bills are coming up. I got the email last week about the survey. I haven't had a chance to go look at it. I know in our area, many school districts have changed the criteria for substitutes in terms of what they're allowing substitutes to work, in order to avoid people getting 630 hours. I don't think that was the intent of this bill. In terms of how they're trying to manage their costs and budgets, that's what they've done. I don't know if that's a question in the survey, if that's some data you will be collecting. I think the further we get into the school year, a lot of districts are realizing that's going to be problematic if you can't get a substitute when you need one in your classrooms. I know it's occurring in our local area.

Cade Walker: I appreciate that input. It wasn't something we particularly asked for on this survey. We were trying to keep it high level to start, answering general questions. As we have opportunities to understand these issues more, and are requested to dive further into understanding what's going on and how things are adjusting, that's a prime question we will ask in future follow-up.

Dave Iseminger: Most of the time, these eligibility bills, they have future effective dates. They'll either reference the 2020-21 school year, or sometimes the 2021-22 school year. Most of the time, they're doing prospective applications.

Another important piece to highlight, with SB 6290, I did testify on that bill to provide context about why a waiver assumption is included in the funding rate and how *not* paying for waivers actually would drive the funding rate up. The way I described it to the Legislature, to try to level set here, is you have a complex funding rate formula with many variables. $X + Y + Z = \$2 \text{ billion}$. We need roughly \$2 billion to run the program year over year. If you eliminate, or put downward pressure on one variable, you need opposite and equal reactions on the other variables because you still have a fixed constant to solve, which is \$2 billion. That is how we tried to describe the goal of this bill might not achieve the desired end results because the money still has to come in to fund the projected Program. The only way to change that \$2 billion fixed cost at the end is to change the assumption when there were actual waivers in the system, and change

some of those variables that produced that \$2 billion. When you get to the funding rate calculation, you can't just pull out not paying for waivers because then you're shorting the overall program fund.

Another concept I've heard about, and there isn't actual language yet, but an amendment is possibly coming. It potentially adds into the eligibility framework, the ability to terminate eligibility after 60 days of nonpayment of premiums. You may have heard from school districts some concern that come up in the substitute area, where they reach 630 hours but don't pick up hours for the rest of the year. The concern is how to collect the premium. They have eligibility until the end of the school year. I've heard there is some language being drafted and may be an amendment to the eligibility framework.

Tanya Deuel: One important comment on SB 6290 is when an employee waives, they're waiving medical. They are not waiving dental, life, vision, LTD, and the various other things the funding rate covers. Those costs still have to come from somewhere.

Dawna Hansen-Murray: In talking to some finance people from different districts up north, food service workers' funding is different. School districts are finding they're paying more out-of-pocket per employee for food service workers. I think there's some concern there as well.

Wayne Leonard: They are funded differently, but I don't know about the second part, why they would be paying more out-of-pocket if they're all on the SEB Board plans.

Dawna Hansen-Murray: I think most food service workers work in the three and a half to four hour range. I think districts have to pay a higher amount out-of-pocket for those food service workers. They're not reimbursed under the federal programs as FTEs.

Wayne Leonard: I think that was the intent of adjusting the benefit allocation factor formula in the negotiated agreement. I don't know. The federal subsidy for a school lunch isn't going to cover the benefit. But food service workers are covered under district employment contracts. They have to come up with funds someplace else. Many of the food service programs don't cover their costs because the reimbursement rates, or the fees they're charging for a lunch and the amount they can actually collect for that, is not sufficient. That's just the way it works.

Dawna Hansen-Murray: I think that, and compounded with substitutes, districts are paying more out-of-pocket.

Wayne Leonard: They're paying more out of their M&O levy?

Dawna Hansen-Murray: Yes. I believe there are fixes we need to make first, with covering all employees before substitutes. I think that's an important piece.

Cade Walker: Slide 6 – Topical Areas of Introduced Legislation. Without getting into specifics, this slide addresses trends we're seeing in other legislation being introduced this year. We see these come up every year in different ways, shapes, and forms!

There are a few bills regarding provider health carrier credentialing. Some bills tighten up requirements for credentialing. Some loosen the requirements for credentialing, depending on the provider type across the spectrum of health providers and carriers.

We also see pharmacy bills. HCA is tracking bills that would impact the SEBB and PEBB Programs. There are a couple bills on expanded durable medical equipment (DME) coverage, including expanded coverage for hearing aids, prosthetics, and orthotics.

Pete Cutler: If I send you an email, can you give me a couple bill numbers on the credentialing area and prescription tourism. Those are two categories I'm curious to see.

Cade Walker: I'd be happy to send to.

Pete Cutler: Fine, I'll take it from there. Thank you.

Annual Benefits Planning Cycle

Marcia Peterson, Manager, Benefits Strategy and Design Section. Congratulations on successfully launching 2020 benefits for the SEBB Program. Today we'll talk about the process to improve those benefits, add new benefits, or change those benefits going forward.

Slide 2 – SEBB Benefits Cycle. This slide explains the cycle we use to improve, create, or change benefits. Starting today, benefit changes discussed now would become effective January 1, 2022. Ideas for new benefits can come from Board Members, subscribers, and sometimes from public comments at our meetings. We hear them through our customer service and correspondence, too. We encourage new ideas from all areas.

HCA meets with the plans themselves to talk about trends in their books of business with their other plans and what sort of changes they recommend. We get recommendations from the plans themselves in terms of new benefits or changes that could be made. In addition, we try to stay on top of what is going on with other employer-based plans, other plans throughout the country. We pay attention and do an environmental scan and bring things forward.

The Legislature can come to us with mandated benefits at any time, regardless of our cycle.

HCA is open to hearing ideas. Staff will research, evaluate and vet the ideas. We apply criteria to identify how many members are impacted. It could be a small number of impacted members, but with a huge impact for them. We look to see if it's evidence based. Is there clinical evidence for it? We turn to our colleagues in the Clinical Quality and Care Team (CQCT) to advise us on evidence-based medicine, whether the benefits would improve the health of the population. Is there evidence around that?

We look at costs and savings. Would it result in savings? Would it impact rates overall if we go forward or is it a small increase that wouldn't impact the rates overall, or possibly there could be savings. Staff vet them and the agency proposes, if

appropriate, in the October-December timeframe. We propose new benefits in the Governor's budget.

Then a year has gone by and we are back in January going into 2021. Items that theoretically went through the Governor's budget may or may not appear and be funded through the Legislature in the January to April timeframe. If funded, we can take them forward. Now we are to July for the 2021 Board vote. That's when you vote on them. Implementation takes place and new benefits go live January 2022.

What doesn't make it through one year may make it through the next. An example is the Diabetes Management Program. It hasn't been funded, but we continue to take it forward.

Slide 3 – Discussion. Are there new benefits you would like to see included in our portfolio?

Katy Henry: One thing that has come forward from people that I've heard from is the ability to expand payroll deduction, specifically for those optional buy-ups. Many of the employees have been used to having the payroll deduction through their districts. Most of them can't do that now.

Dave Iseminger: Depending on how the bills work through the Legislature, that legislative action might supersede many of those conversations. But noted.

Dawna Hansen-Murray: To add to what Katy said, a lot of those deductions were also pre-tax and we've lost that ability for pre-tax.

Pete Cutler: One thing that strikes me as, I guess surprising or quizzical on this cycle, is that it shows -- I guess I would start with, and I'm being parochial, I admit, the statute that creates this Board says this Board will design proposed benefits and review for school employees. Yet this cycle does not mention a SEB Board role involved with the research and evaluation of new benefit ideas, or any kind of review until a Board vote. That's after this cycle showing the Health Care Authority would be proposing new benefits in the budget and the Legislature making decisions on funding those.

It seems that's really inconsistent with statutory intent. It may be just an oversight, which would be fine. But if the idea is really that the Board only gets to influence benefit policy and design decisions after you've gone through the Health Care Authority proposing new benefits in the budget, the Governor supporting it, the Legislature supporting it. Then a month or so before, or two months before you're supposed to lock in contracts, the Board is stuck with it. The Board is asked to basically do an up or down on this and everybody's expectations have been raised. You're going to approve it. It seems incongruous with the way the statute talks about this Board's role on authority involving benefits. I'm hoping it's just kind of an oversight on putting together the cycle circle and not an intentional indication that the Board's influence is limited to the last minute.

Lou McDermott: I think the Board has influence throughout the entire year. One of the things we grapple with as the agency is that you have multiple players at the table. You have Collective Bargaining, the Legislature, the Governor's Office, internal staff, and the

Board. While yes, Pete, you're correct, the statute does say the Board has that ability to control that, it's control is within that environment. There are many things that occur during the Board season that are taken into consideration as those things are developed, as the budget packages are developed, as the model is being updated. Those run through the Governor's budget. I think there is a little bit of a rub that occurs throughout the cycle as to which partner is going to do what. The SEB Board can say, and the PEB Board for that matter can say, we're going to do X. If those funds aren't funded by the Legislature, it creates this dynamic. Trying to get all the parties to walk along that circle is Dave's challenge and his mission in life. But yes, it's acknowledged. There are issues with the cycle.

Dave Iseminger: We used to describe it as every 12 months we have an 18-month cycle. But really, it's every 12 months we have a 24-month cycle because in that environment Lou was describing, everybody needs to be first. The time has crept so everybody wants to have a step before everyone else. Ultimately Lou is right that if the Legislature doesn't fund it, or they're upset with an action taken by the Board, they have ways to reverse those actions or curtail authority. An important piece, Pete, is that we have these conversations in the next six-month period about what the Board is interested in being evaluated and put forward. Ultimately, what is picked up by the other parts of the authorizing environment and funded does influence what is left at the end of the day for Board action. We've deliberately expanded the 18-month cycle to a two-year cycle so there can be Board conversations in advance as part of the research and development process.

Pete Cutler: So that would support my guess that the issue is the Board's not listed explicitly as part of that research and evaluation of new benefit ideas. In my mind, that's where the Board should be involved at the front. I agree with Lou. Obviously, other players need to buy off, but unfortunately, without the Board listed, it implies the Board is the last one that gets to have influence. That every other player gets their influence and gets to veto or approve something and the Board is at the very end of the influence cycle. I think there should be something on record indicating research and evaluation of new benefit ideas includes the Board. It would be nice to have it clear on the record.

Marcia Peterson: Thanks, Pete. I think you've seen a lot of examples of the way we do this over the last two years. It's very similar. Even though this was a new program, it's similar to what we do with the PEB Board. For instance, the Centers of Excellence Program was more than two years to rollout. It was HCA talking about the Bree criteria with the Board and how it might be applied. It was talking about total joint replacement and how it tends to be a procedure with a lot of unnecessary surgeries. We talked about that with the Board and it was a couple of years before we even came forward with how we were thinking of implementing the benefit. What do you think? If you were to look at that cycle, it's really the January to July in the first year and then it's January to July in the second year. We've got a couple of stabs at it with monthly meetings with the Board. It's a good point you make. It's something we've struggled with because as Lou says, there's a lot of people at the table. We do feel strongly that we want forward involvement. We want the Board to direct this. It is part of their authority so we'll be bringing things forward. Hopefully, you feel like you can bring things to us and we will evaluate them and bring you back our findings.

Pete Cutler: Again, and Marcia, I do want to stress, I think with this Board, the approach that was taking in terms of bringing us up to speed on the Centers of Excellence type options and the pharmacy, I want to call it tiering.

Marcia Peterson: The formulary?

Pete Cutler: Formulary policy decisions that involved that kind of education and taking feedback well before something was locked in as a proposal. I'm not criticizing, in fact, I appreciate what the Health Care Authority has done in terms of briefing. I just thought this particular cycle, it leapt out at me that the first reference of the SEB Board is way late in the process and I don't think that was really the intent. Thank you.

Marcia Peterson: Thank you.

Wayne Leonard: To add on to Pete's comments, too, is Dave and I had a conversation in September about a similar thing when the optional benefits memo came out about the supplemental medical plans. At that time I was confused too about the process. I got a lot of phone calls and emails because it was communicated that the SEB Board had made this decision. I got a lot of calls and emails and told them the SEB Board had never talked about it. I appreciate Pete's comment about when does the SEB Board make the decision or when does our involvement occur. When is it an agency determination? Having said that, the only other benefit we talked a lot about last year, Dave already mentioned, was long-term disability, improving that benefit. It seems like that would be an area where we should do more work.

Lou McDermott: For the edification of the Board, the question as to who gets the say, whether it's the agency or the Board, that debate rages on issue by issue. If the world were to change in a certain way, either a new law, a new federal regulation, some dynamic in the market, those discussions are made with internal staff who have historical perspective on what we've done in the past with our attorneys. We try to figure out where that balance is, because it's not cut and dry. Some issues are fairly cut and dry. Unfortunately, the majority of them seem to be that we all need to get into a room and figure out is this an issue for the Board? Does the Board need to take action? What does it look like? I don't think you're ever going to get the clean, we just send you a one-pager that says, "This is what the Board does. This is what the agency does." It's never that clean, unfortunately.

Dave Iseminger: I'll just add, because of all people in the room, Connie will appreciate this. When we communicate things out and we try to say SEBB Program versus SEB Board versus SEBB Benefits, those nuances are captured by many people in this room, Connie and me most of all. But the recipients of our language lump it all together as the Board. There's always that challenge, as well. As carefully as we try to tailor who did what, where, when, it's always read as the Board did blank, even if it wasn't the Board and even if our communications don't say the Board did it, that's how it's received. There's always that communication challenge.

Marcia Peterson: I also want to also point out, in case it isn't obvious, and Lou will attest to this, we didn't always have this sort of orderly approach. It drove us crazy, where the carriers would come forward and say, "We have this great idea. If you would just change this one little benefit, you'd save gillions of dollars." And we'd say "Okay.

Well, we'll consider it." Then the next week there would be another thing they'd come up with. Halfway through the year, somebody would come up with something. We had to determine if we could implement in time. Is this idea you're giving me today going to be superseded by something later on that's even better? What do we do? We had to put some hard stops around it. They're not completely hard, of course. The Legislature can always come forward and mandate things. But we did want to make it manageable, so it fits with the realities of including open enrollment and communicating new benefits. We try to put some discipline around it, which is not to say things do come up and we will consider things along the way.

Lou McDermott: That was one of Marcia's first tasks when she was hired - to square that away because it was chaotic. People thinking that at any time during the year we can initiate ideas. You've got the funding rate. You have the modeling. You have the Board season. You have the legislative season. It felt disjointed. This cycle at least brought some order as to when things usually happen.

Dental Options for 2022

Ellen Wolfhagen, Senior Account Manager, ERB Division. HCA is looking ahead to potential benefit designs. Slides 2 & 3 – Recap. Originally there was a dental procurement resolution which called for looking at whether we should do a new procurement. Among the things considered were could our current contracts with Delta Dental of Washington and Willamette be renewed every year. A new procurement is not recommended at this point. 90% of providers are already under contracts and there are costs involved in doing a procurement. Instead, we'd like the Board to look at potential alternative benefit designs.

Slide 4 & 5 – Potential Benefit Options. Options might include things like increasing the orthodontia benefit level for children, adults, or both. Providing an incentive that rewards the use of preventive services, for example, cleanings and x-rays. The current orthodontia benefit level is \$1,500. All current plans cover both children and adults.

Another option is to increase the benefit level for posterior composite fillings, which is the most common kind of filling. This is the white material on your back teeth instead of the metal amalgam. Most plans charge a difference between the amalgam and composites. We can look at a targeted education effort to help spread the message that oral exams can improve general health and identify medical issues early. If we develop good habits with children, especially not being afraid of going to the dentist, there will be a big payoff later in continued good health for the entire population.

Slide 6 – Benefit Design Consideration. Some of these options may be budget neutral by balancing the benefits. The focus is mostly on the Uniform Dental Plan (UDP), a preferred provider organization, in part because this is the largest covered population and the most opportunity to change the structure of how benefits are delivered. The fully insured dental options are managed care plans and already have some built-in benefit incentives.

Slide 7 – Incentive Benefits – UDP Only. An incentive plan could be similar, but not identical to, what Delta Dental offered previously under the WEA Trusts, in Seattle Public Schools, and others. You can change the percentage the member would pay if you use preventive services. For example, if your responsibility was 40% for fillings, if

you used preventive services in the first year, in the second year, your cost would be 30%. You could keep bringing it down for every year preventive services were used. Or alternatively, you could raise the plan maximum, which is currently \$1,750, not including the ortho benefit. Or you could have a combination so the co-insurance could eventually get to zero, keep decreasing the amount the member has to pay until you get to zero.

I'd like to confirm the Board wants HCA to explore benefit options.

Dave Iseminger: This is one of the top three areas of discussion at Benefits Fairs. Changing from an incentive-based plan to others. We heard different conversations in the prior two Board seasons about interest in looking at dental at some point. It may seem counter-intuitive because I think every word on all of these pages was increase, but then we said there might be ways to do this in a budget neutral fashion, the devil is in the details. We would bring all of that to you as we're looking at different options. We really do want to confirm the things we heard from both members and an underlying theme from many of you in prior years, that you do want us to explore these types of things and be bring back ideas for your consideration.

Pete Cutler: Ellen, welcome to the world of the School Employees Benefits Board Program. I was going to say I hope this first meeting has not discouraged you from your new career choice. On providing an incentive that rewards use of preventive services, I'm curious. Is the underlying motivation for this to promote good or better dental health or is the underlying motivation to reduce costs, to save money?

Ellen Wolfhagen: The primary motivation would be to improve dental health. We only have information on PEBB members right now, but we have found there is a high percentage, more than 25%, of members who never take advantage of preventive services. Those preventive services are covered at no cost.

Pete Cutler: I know my family, maybe it's because I have a budget background, a fiscal background, I couldn't imagine leaving those dollars on the table. It was free.

Dave Iseminger: It's not free, Pete.

Pete Cutler: Well, you're right. It was no additional cost to me. [laughter] I think that's a great motive to have but with the \$1,750 total dollar amount for the maximum the plan would pay in a year, it did not seem like it was likely going to reduce claims costs that much. But, thank you for that information.

Dave Iseminger: I'm curious from the Board. We've highlighted there were two ways to balance this. You can either have a migrating percentage-base coinsurance that changes based on your preventive services, or a flat change in the annual plan maximum. Is there any insight, especially from those who use these benefits and had them before, your sense from your colleagues as to if there might be a tendency towards more of one than the other as we prioritize things to analyze?

Dawna Hansen-Murray: Coming from a district that had an incentive plan, 70%, 80%, 90%, 100%, a lot of us - I go to the dentist twice a year. I was at 100% for quite a few years. Then the question is, if we ever go back to that, do I have to start all over again?

That's also going to come up if we do that. It was a very good plan and I try to tell people we were on an extremely good dental plan. We had WA Dental and it was amazing. It covered crowns at 100% if you did your preventative maintenance. There's got to be some give and take somewhere. That's what I'm thinking about.

Pete Cutler: It occurred to me, we were asked a question. Not sure if it's entirely rhetorical but just for the record, yes, I, as one Board Member, would like to have the Board investigate and do some research, pull together information on these options.

Dave Iseminger: For the record, there were head nods to that comment from other Board Members.

WORKING LUNCH

Special Long-Term Disability (LTD) Open Enrollment

Kimberly Gazard, Contract Manager, ERB Division. I'm here to discuss long-term disability and the upcoming enrollment opportunity.

Pete Cutler: Am I correct that this is your first SEB Board meeting? Have we been introduced in the past?

Kimberly Gazard: I presented at least once last year.

Pete Cutler: I was going to ask you to provide a little background on you and your role in the agency, but maybe I've just forgotten it from a prior Board Meeting.

Kimberly Gazard: I joined the Health Care Authority about a year and a half ago. I relocated from Florida.

Slide 2 – Supplemental LTD Results. Out of 145,139 eligible subscribers, 26,856 subscribers enrolled in supplemental LTD. That is about 18.5% participation. We believe the low enrollment may be due to subscribers focusing on medical, dental, and vision plan choices. There were also employees coming from a previously richer, employer-paid plan. Subscribers may also be under the impression they have a rich employer-paid plan, not realizing it's \$400.

Dave Iseminger: The Standard came to us in October and said the daily enrollment isn't trending high on this benefit, so we made a change mid-open enrollment. At the beginning of October, subscribers elected optional benefits in SEBB My Account by clicking on a separate tab. Mid-open enrollment we moved it to the main tab where you elected your medical, dental, and vision. The day we made the change, enrollment in supplemental LTD doubled every day thereafter. We were able to get to the robust 18.5%. It would have been much lower but for that change. Another example of a carrier bringing us an issue and by changing product placement, it resulted in a higher uptake. There's still a lot of work to be done here.

Kimberly Gazard: Slide 3 – Supplemental LTD for 2020 Plan Year. HCA negotiated and worked with The Standard on a 2020 plan provision regarding evidence of insurability. Evidence of insurability is not required for the 2020 plan year, as long as a subscriber hasn't previously enrolled, disenrolled, and attempted to enroll again. That is

when the subscriber would be subject to evidence of insurability. If it's a new enrollment during the 2020 plan year, evidence of insurability is not required. That will change January 1, 2021, when it will be required, with the exception of newly eligible, who have their 31-day period where they can enroll with no evidence of insurability. That would be the exception.

Slide 4 – 2020 Supplemental LTD Enrollment Opportunity. As Dave mentioned, we've been working with The Standard the last couple of months who are very supportive of having an enrollment opportunity for the 2020 plan year. After discussions with The Standard, we discussed having an enrollment opportunity for this year. We try to learn from past experiences. The PEBB Program had a very successful enrollment opportunity last March. So with the SEBB Program, we wanted to rinse and reuse that strategy and work plan. March of last year, the PEBB Program had an open enrollment opportunity, which showed a 19% increase in participation. So we went from 40,000 subscribers to 47,690. These enrollment opportunities proved to be very successful. HCA is looking forward to having this opportunity for the SEBB Program. The advantage here is the SEBB My Account platform to enroll online. That's a very advantageous opportunity for SEBB Program subscribers.

Dave Iseminger: To clarify, we will be using SEBB My Account as the planned online enrollment and move away from paper. The PEBB Program was a paper-based LTD enrollment only with payroll offices in each of the state agencies and higher education keying in forms. We might have even greater uptake when all you have to do is click a button.

Kimberly Gazard: Slide 5 – 2020 Supplemental LTD Enrollment Opportunity Details. May 2020, eligible school employees will have the opportunity to enroll in supplemental long-term disability. For this enrollment opportunity only, LTD coverage members had prior to January 1, 2020 will be credited toward any pre-existing condition exclusion. This is a great opportunity for everyone to take advantage of this enrollment opportunity that's only going to be offered until May 31, with an effective date of June 1, 2020.

Pete Cutler: When it says long-term disability coverage -- this opportunity in May 2020, LTD coverage for members with coverage prior to January 1, will be credited towards the pre-existing condition exclusion. I assume that's based on if they were covered under a different company's plan or something offered by the school district? Otherwise, if you think of it in the SEBB context, if you already enrolled, maybe this gives you a chance to change what you're enrolled for, but you only get credit towards a pre-existing condition exclusion if you already signed up with The Standard. I'm trying to confirm it doesn't matter what company you had your LTD coverage with.

Kimberly Gazard: It's more like time served that you don't have a lapse in supplemental long-term disability coverage. If someone enrolled in May and had six months in 2019 that ended December 31, 2019, The Standard would consider there being no gap in coverage from January until they enrolled in May. The Standard works with the prior policy and compares the prior policies in making sure it doesn't exceed the SEBB policy.

Pete Cutler: They will want to know who you had coverage with because presumably, if it were a much skimpier coverage or something with a very long waiting period,

there'd be some adverse election, risk that would not be there if the policy was somewhat similar to what the person is signing up for in The Standard.

Kimberly Gazard: Right. They'll review and compare the policies.

Slide 6 – Planned Communications for 2020 Supplemental LTD Opportunity. The Standard has agreed to hosting on-site presentations at the larger SEBB Organizations throughout Washington. The ERB Outreach and Training Unit will provide training to the SEBB Program Benefits Administrators, providing forwardable email messages to communicate to employees. We'll have ongoing information that will be provided through our SEBB Update e-newsletter and GovDelivery emails. We will also have a targeted letter mailed to SEBB Program subscribers not currently enrolled in supplemental LTD insurance. This letter will be emailed to PEBB Program subscribers who subscribed to the GovDelivery service. We will also be working on an FAQ and fact sheet regarding the enrollment opportunity. This information will be updated on HCA webpages.

Lou McDermott: For the PEBB Program, working with the unions was important as well, getting that message out through their channels.

Kimberly Gazard: We have that on our work plan, as well.

Dave Iseminger: Another piece slightly different between PEBB and SEBB, in PEBB we were able to leverage the cabinet agency directors to do a concerted push from the leadership all the way down telling staff, "This is the first time in 40 years this has happened, and the benefit hasn't changed in 40 years. You should really think about it now because, although enrolling in optional employee-paid isn't the long-term fix to the level of employer-paid benefit, it's short term, there's an opportunity for you to have coverage." We leveraged cabinet agencies to push a message. We will look for a comparable option with the SEBB Program. We'll go through the Benefits Administrators as we did in the PEBB Program.

We saw some big jumps in agencies where their leadership embraced that role and pushed out messaging. I myself was one of the 7,000 people newly enrolling because I was young and invincible when I started with the state and didn't think I needed this coverage.

SEBB Medical Plan Update

Lauren Johnston, SEBB Senior Account Manager, ERB Division. Slide 2 – Objective. Today we'll walk through a medical plan update. We'll discuss potential changes to the medical plans for 2021, review medical plan enrollment data, as well as, and Children's Health Insurance Program (CHIP) updates.

Slide 3 – 2020 Medical Plan Service Area Criteria. School employees may select medical plans based on the county where live, and some employees may have other plans available to them if the employee works in a district that straddles county lines, or is in a county that borders Idaho and Oregon.

Slide 4 – Service Areas. HCA heard concerns from school employees throughout open enrollment comparing plan options with other school employees based on where they

live or work. In addition to no longer having access to their current or previous medical carrier based on the live and work criteria, specifically members who were enrolled in Kaiser may now not have that option based on where they live or where they work.

In addition, members who previously had Premera and wanted to remain with Premera, under the SEBB Program, may not have that option. For example, Wenatchee School District is wholly within Chelan County. However, a number of employees working for Wenatchee School District live in Douglas County. The two counties have different plan options. Employees working in Wenatchee School District, but live in Douglas County, only had three UMP options, whereas employees working for Wenatchee School District and living in Chelan County had the addition of two Premera plans. There are similar scenarios like Wenatchee throughout the state.

Katy Henry: I heard from members, especially in the Northeast in Stevens and Pend Oreille Counties, that many of their clinics are run by Providence. While Premera showed up as an option, they really couldn't use them because Providence doesn't accept Premera. They were very frustrated by what they considered not real options because the clinics and hospitals in their area did not take Premera.

Lauren Johnston: Yes, that's something we are very aware of.

Dave Iseminger: Thanks, Katy, for sharing that. I know Premera had a lot of feedback during open enrollment. They have multiple different networks, some of which include Providence and some of which don't. The network included in SEBB did not include Providence. They heard quite a lot of feedback and we will definitely be talking with them to see if there are opportunities to work on their network for 2021.

Pete Cutler: Am I right the UMP plan options were available in those counties?

Lauren Johnston: Yes.

Pete Cutler: Do they include Providence?

Lauren Johnston: They do.

Pete Cutler: It was an issue of wanting to stay with both Premera with access to Providence?

Katy Henry: The clinics is what I think are the frustration. These are very rural communities who had established relationships with their providers. Sometimes to travel even from Colville to Spokane is an hour and a half. They were really frustrated. They did have UMP. Sometimes it wasn't the same coverage and/or their provider wasn't working with them. It wasn't as simple as just that. Yes, they did have other options, but it limited them within their community.

Lou McDermott: I want to be clear on that. We're saying there were providers that used to work with Premera that under these Premera plans were not available because they were Providence? UMP did not have contracts with these providers?

Katy Henry: This is based on feedback I got from employees. They were rather frustrated. I didn't check each one of them. I don't know.

Lou McDermott: Okay, it's my understanding, and start correcting me if I'm wrong here, all Premera providers covered are also covered by Regence, and back and forth. If Premera has products available they contract with, then Regence has access to those providers. It's sort of the Blue's agreement. It shouldn't be not covered unless Premera no longer works with that particular provider. And that is possible. Am what I'm saying right?

Lauren Johnston: I'm sure there are cases where someone is not contracted with Premera, so they're not contracted with UMP, as well. The difference is the Premera network that was offered to us under SEBB is a subnetwork, whereas the larger network may actually include those Providence providers in those communities; and therefore, UMP would also have access to those contracts as well through Premera.

Lou McDermott: If you get specific examples of providers, we'd be more than willing to check into that for folks to see what's going on.

Dave Iseminger: Send them to me.

Katy Henry: I can do that.

Dave Iseminger: But you said, and I wrote it down, you did say it right, Chair McDermott, about the relationship with the Blues and that was my follow-up. There shouldn't be differences between the two. But specifically you were talking about Pend Oreille and Stevens Counties.

Lou McDermott: There were also issues with the doctor's office not understanding what coverage the member had. We had members calling the doctor asking them if they were still going to be covered. The doctor indicated, yes, they took Premera, not understanding they actually don't take Premera in this subnetwork. The unions were the ones sending out communications to members telling them to verify their coverage. It got a little messy.

Terri House: That's the case in Snohomish County. There are doctors that are exclusively Premera that do not take Regence and vice versa.

Dave Iseminger: East side and west side reciprocation rules and Blues rules are different. That is possible under the west side, less reciprocation rules, whereas there's supposed to be total reciprocation on the east side.

Terri House: Well, very frustrating in Snohomish County because the Premera option offered in Snohomish County was a lesser plan, more out-of-pocket for the member. Trying to navigate finding a doctor, which the online tool was very helpful for several people. I can't imagine how many times I passed that link on to people. It was an eye-opening experience for a lot of people on the west side.

Lou McDermott: When Board Members hear of these specific examples where something doesn't sound like we've described it, definitely forward them to us so we can determine if there are mistakes or other issues. That would be helpful.

Terri House: It was very evident on your link that you provided, Find the Doctor and Pharmacy, where we could go through and look up each individual doctor, because what we found when we communicated this with union members was to look specifically at your doctors, not their practice. The practice does one thing, but under that umbrella, each individual doctor might have his own things he accepts or doesn't accept. I think maybe it's the practices or the insurance companies that represent them. That area needs to be cleaned up because your link provided the most accurate information.

Lauren Johnston: We are looking to address these concerns and the potential for carriers to expand into other counties, starting in 2021, as well as expanding the number of district-based plan offering exceptions.

Dave Iseminger: Some of these requests could have cost impacts and we'll be talking about those and possible trade-offs, some of which could be under Executive Session based on where we are in the procurement process. But these would be some of the issues we'll ask for in the RFR process as we go forward this spring.

Lauren Johnston: Medical Plan Options. Questions we heard from school employees during Benefits Fairs included, "What do all these deductible levels mean? How does the deductible level relate to the premium? How do I choose between plans? Does a higher deductible level mean more services are covered?" We will address their questions by increasing consumer health education. Another option would be for the Board to reduce the number of medical plan offerings. Something to keep in mind for next Board session.

Dawna Hansen-Murray: What I saw in my building and district were people not looking at the mobility of the plan and selecting plans in a tighter network not knowing their kids who were in college may not be covered. So maybe a little more clarity on that.

Lauren Johnston: Slide 6 – Member Medical Enrollment by Plan is the same slide from Marcia's presentation.

Slide 7 – Employee Medical Plan Selection by Deductible Level. This slide shows the medical plan selection by deductible level at the different Tier levels, employee only, employee and spouse, employee and child or children, and then the full family. The yellow color is the higher deductible levels, either the \$1,250 or \$1,400. Green is the mid deductible level, and blue is the lower deductible level, which is \$125 or \$250, depending on the plan selected.

Slide 8 – Employee Medical Plan Selection Based on Lowest Deductible Level (\$125 or \$250). Keeping the blue columns in mind, this slide breaks down data further. It shows the employee medical plan selection based on the lowest deductible levels. Most employees enrolled in Kaiser WA SoundChoice, Kaiser WA Options Plan 3, or the UMP Achieve 2.

Pete Cutler: Do we have this data for Premera plans?

Lauren Johnston: Premera does not have a \$125 or \$250 deductible. Their lowest deductible level is \$750.

Slide 9 – SEBB Program and Apple Health/CHIP. HCA received a number of questions regarding the SEBB Program and the Apple Health Children’s Health Insurance Program (CHIP). Under federal law, if a child is enrolled or eligible for a state organized employee health plan in which the state pays a portion of the premium, the child is not eligible for CHIP.

Slide 10 - SEBB Program and Apple Health/CHIP (cont.). The Governor’s 2020 budget includes funding to pursue maintaining access to CHIP for children of public and school employees as well as increasing access to CHIP. The HCA program and finance staff are working together to compile a list of options and correlated impacts to continue coverage of services in the future. We are waiting for further legislative direction before finalizing any long-term plans.

Dave Iseminger: There are wraparounds that allow these provisions, which we are looking at pursuing. There are viable pathways to achieve these goals of allowing this dual coverage and a variety of states have federally approved policies. It’s an option and there have been preliminary discussions with CMS to determine if it’s possible.

Lauren Johnston: Slide 11 – High Deductible Health Plan Changes. Something to keep on your radar for 2021 is that UMP’s high deductible plan deductible level will likely need to increase in 2021 in order to maintain qualified plan status for the health savings contributions. There will likely be changes to the maximum allowed HSA annual contributions, which are typically made after open enrollment materials are finalized. Changes may have a lag of one plan year. Any changes to the deductible and HSA contributions will be made through the annual request for renewal process.

Dave Iseminger: To be in a plan and be eligible to put money into an HSA, there is a floor for how low the deductible could be. In the PEBB Program, and then initiating in the SEBB Program, from the member perspective, it’s the highest deductible plan in the portfolio but it’s actually among the lowest allowed under IRS rules. We’ve never changed the deductible level since the introduction of the plans in the PEBB Program since 2012. It’s now at the point where inflation or other consumer pricing indexing changes have happened at the federal level making our deductible in this HSA qualified plan be almost the bare minimum. We will look at moving that along and raising the deductible incrementally to maintain the HSA aspects that are the reason many people are electing those particular plans.

Lauren Johnston: Slide 12 – Anecdotal Stories. During open enrollment, we heard countless stories that were very encouraging. A number of people said that no matter what plan they chose, they would save hundreds of dollars a month on insurance premiums alone. One gentleman I sat with after the benefits fair had closed told me he pays \$800 a month now under his previous non-SEBB plan coverage. He needs a knee replacement in 2020 and asked about cost and where. I was able to tell him about the UMP Centers of Excellence Program. Based on plan selection, if he selects UMP Achieve 1 or 2, he would have no out-of-pocket costs and all the perks of the plan. He

got teary-eyed. He was so happy and relieved to know you put this program in place for him. It was a special moment for me.

Alison Poulsen: I'm hesitant to say this after that, but one of the things interesting in the school district my kids go to is how teachers have felt where both teachers were employed by a school district and no longer had dual coverage, with the opposite impact that you're describing. I continue to be super supportive of more people having health insurance, which makes the whole system work better, I do think it is important to be aware of the loss of benefit some of our families are feeling.

Dave Iseminger: I went to four Benefits Fairs and I'd say over half of my time was spent discussing non-state registered domestic partners and why that wasn't part of the eligibility requirements. That was another prominent area. I walked several people through the rationale behind it, going back to the beginning of state policies in 2004. We discussed the reasons behind why that type of policy might exist. This was definitely very frustrating for new SEBB Program members.

School District Optional Benefits Reporting

Cade Walker, Special Assistant, ERB Division. Slide 3 – Additional Optional Benefits – Authority. RCW 28A.400.280(2) articulates that school districts must report to the Health Care Authority optional benefits they offer to their employees. The SEB Board has the responsibility to determine if those offered benefits conflict with the SEB Board's offering authority. If not, we are to evaluate whether or not those benefits are something the SEB Board should consider offering as part of the SEBB Program portfolio of benefits.

Slide 4 – Interim Guidance. Last year HCA offered interim guidance to the districts on cancer insurance. HCA told the districts cancer insurance was an allowable benefit. Our guidance on that changed after taking a closer look and realizing this may be in conflict with SEB Board's offering authority. HCA issued revised guidance on this benefit. We appreciated some bargaining units had already gone ahead and included cancer insurance in their Collective Bargaining Agreement. We issued guidance stating that if you had relied on our prior guidance pertaining to cancer insurance and included that in a Collective Bargaining Agreement, we would allow that for the year and readdress cancer insurance in 2020.

Dave Iseminger: As an agency, we needed to provide guidance because part of this was about protecting the purchasing power of the Program. HCA started getting a variety of questions. The Board has offered and authorized term life insurance. So what about whole life insurance? There were dozens of different permutations of those questions. We took the step of providing guidance to say, "Under this, our interpretation of the statute that we are to provide guidance on, we believe these are the things that are clearly allowable, these are the things that aren't allowable."

In the context of cancer insurance, as we learned more, it moved from one list to the other. We provided guidance because, at the time, all questions coming in on allowable benefits needed some sort of clarification. It became apparent there would be legislative discussions. There are people who disagree with HCA's interpretation and that's being brought up as part of the legislative debate on changing this very statute.

We had to put a stake in the ground and describe what we thought the rules of the road were and now everybody responds.

Pete Cutler: Are you saying the Health Care Authority directed school districts that they may not offer insurance like cancer insurance? I hate to sound like a broken record, I wasn't sure what the statutory language said, but right here we have it. It says very explicitly, the School Employees Benefits Board, not the Health Care Authority, very explicitly, the Board shall review the optional benefits offered by districts, and they determine, the Board shall determine, if the optional benefits conflict with the School Employees Benefits Board's plan offering authority.

In terms of the next step, I do not see how you get to having the Health Care Authority -- there are many benefits where I would agree that the statute is at least unclear or sometimes explicitly leaves it to the Health Care Authority, that's an administrative decision. That's not part of what the SEB Board is supposed to have authority over. But with this explicit designation to the Board, I just don't see how the Health Care Authority could have provided that guidance, except perhaps on some purely advisory level. As it may be, it's water under the bridge. We're almost six months past then.

I'm not sure what that means for going forward. But, once again, it troubles me that the Board's authority and role seems to have been set aside and ignored when it was not convenient. That is a pattern I find frustrating. I just wanted to get that on the record. And if there's anything in terms of what the Health Care Authority plans to do going forward that involves the Board, I'd be very interested in hearing about it.

Dave Iseminger: Pete, I think there's a couple of different pieces here. Some pieces of the questions we received were unquestionably in conflict with what was offered by the SEBB Program. For example, the questions around term versus whole life insurance. There was no reasonable argument that whole life could be offered because the Board offered term life insurance. The statute says it must be outside the Board's authority. The Board's authority clearly has life insurance. The districts were really churning and asking for answers and directions about what this could mean. While reasonable minds clearly disagree as to what counts, because we're in a legislative bill situation of talking about it, we needed to provide guidance in real time about those pieces because the questions were coming en masse. There was something that needed to be answered and there were pieces that unquestionably would be benefits that conflicted with this Board's authority and could potentially erode its purchasing power long term. Many of the districts simply complied with the guidance.

Cade's going to describe areas that look like there are differences. We have the full picture after the first data report to say here's what it looks like. We gave guidance leading up to the January 1, 2020 implementation.

Another prominent question from districts during the fall was, "Is this in affect for January 1, or is this based on the eligibility date in September?" There was a lot of work done this fall where these products were continuing to be offered until December 31 as part of the standard start of the new school year. I won't speak for the districts, but it may have been seen as an opportunity to talk about this with employees until December 31. We will ask for clarification during the legislative session. By the time we get to the next school year, all the rules will be clear from everybody's perspective.

We are here now to bring you the results of that optional survey, talk about what the lay of the land is, and see what the Board's perspectives are on what's being offered within the districts as of December 31. In theory, no one had authority until December 31 because the statute says these benefits don't exist. Here we are at our first meeting talking about what those requirements are. HCA needed to give guidance in the interim leading up to the implementation.

Pete Cutler: Thanks, David. I guess my question in terms of the water that's already under the bridge is, I guess it's not a question, just an observation. The Board could've been included in communications. The Board could've been called to a meeting if it were that important. But be that as it may, the question going forward, the statute talks about the Board making a determination about whether different optional benefits conflict with SEBB plans offering authority.

Dave Iseminger: That's why we're here today, Pete, to talk about what we see and then talk about what you want to do.

Pete Cutler: Okay, so this is that determination and discussion. I guess that's what I was asking. Thank you.

Cade Walker: Slide 5 – SEBB Benefits. This slide lists the Board's explicit authority under statute and the benefits the Board is authorized to offer. The Board offers: medical, dental, vision, prescription drug, life insurance (whole and term), AD&D, liability (including home and auto), disability, Flexible Spending Arrangement (FSA), and Dependent Care Assistance Program.

Dave Iseminger: It's actually even more nuanced than that because the Board doesn't have authority over FSA and DCAP. That's in RCW 41.05 under the agency's authority. And even though FSA/DCAP aren't mentioned in RCW 28A, the exclusive authority is with the agency. That was another area with lots of questions. "Can we do limited purpose of FSAs?" With the attorneys that called us about the questions related to optional benefits in FSA, we went through every aspect of the SEB Board versus HCA's authority. It was clear that under RCW 41.05, HCA has the exclusive authority of FSA/DCAP. We try to lump it all under the program even though they bifurcated authority based on benefit.

Pete Cutler: I do acknowledge in that area there is an explicit statutory language you can point to. It would still, I think, have been appropriate to include the Board in the conversation. Be that as it may, we can go forward.

Cade Walker: Slide 6 – Data Collection. Our data collection efforts were as robust as possible under the circumstances of trying to conduct open enrollment. Staff sent an online survey to all SEBB Organizations and extending the deadline to December 20 once they got through open enrollment. Although the statute has a particular deadline for the districts to report the information to the SEBB Program, we felt it was important to extend the deadline. The vast majority of the SEBB Organizations did respond to the survey, providing information on their benefits.

Slide 7 – Data Reporting. 267 SEBB Organizations responded. HCA has reached out to those Organizations who did not respond.

Of the 267 reporting districts, there were 717 optional benefits reported. We bucketed those into 23 different benefit categories. There was an “other” category, too, which often times was used when they were describing an annuity or VEBA. Those reported benefits included approximately 85 different carriers, insurers, and vendors.

This high level data is the starting point for that data collection. As the Board may direct, we can go back and ask for more nuanced information on specific benefit types should the Board want to see more information.

Slide 8 – General Categories of Benefits Offered by School Districts. In general, the categories were put into five primary categories: Retirement/Financial, Employee Assistance Programs, General Liability, General Indemnity, Supplemental Health Indemnity.

Alison Poulsen: I was curious if you saw any rural school districts offering a particular type of benefit that might be unique to living in a rural community.

Cade Walker: I hadn’t quite gotten to that level of grouping them and seeing if it’s large districts versus small districts. At this point, we’d be happy to start digging in further. We wanted to present the general trends observed and allow the Board to direct us further where they’d like us to focus on providing deeper analysis on those benefits.

Slide 9 – Conflicting Benefits. This slide lists the types of benefits HCA felt was in conflict with the Board’s authority. I categorized eight different types of benefits, with the most frequently reported being disability, life insurance, accidental death and dismemberment, cancer/intensive care, accident, critical illness, hospital indemnity, and emergency transportation.

There were 32 SEBB Organizations with at least one of these types of potentially conflicting benefits reported and several others with multiple types.

What was not clear, while we had tried to indicate the information requested was for benefits being offered as of January 1, 2020, some districts reported benefits that were ending December 31. There may have been a communication issue.

Slide 10 – Top 5 Offerings. The topmost reported benefit offerings from the districts are: Annuities (194), VEBA (182), Deferred Compensation (95), Employee Assistance Program (59), Legal Services (24), and Gym Membership (19).

It’s worth noting that districts had multiple varieties of either annuities or VEBA broken down by the type of bargaining unit. They may have different VEBA contribution levels depending on the bargaining unit, same with annuities. They may be facilitating different types of annuity programs within a single district.

Dave Iseminger: It was interesting to me to see deferred compensation brought up so often because our instructions specifically said not to include things like deferred compensation.

Cade Walker: Slide 11 – Other Key Observations. There was minor variance in benefits offered to different bargaining units (VEBA or annuities). It appears the vast

majority of districts complied with the guidance we provided and the benefits they were offering. What we don't know is how many districts had been offering the benefits and then pulled back in accordance with our guidance. We have been working with vendors like AFLAC and American Fidelity to get information about the extent of coverages and products they were offering.

There are several different insurance products the SEB Board could consider requesting legislative authority to offer.

Slide 12 – Next Steps. I have been notifying the SEBB Organizations, based on the Board's direction, of their conflicting benefits. There is very little enforcement ability in statute to address those districts that don't comply. The language in the statute merely says to inform them their benefit offering is in conflict with this Board's offering authority.

As it pertains to the non-conflicting benefits, we will provide notice to those districts as well that they are not in conflict with the Board's authority. The Board may wish to consider requesting more information on those benefits and to seek legislative authority to offer those benefits to the SEBB population.

Wayne Leonard: One of the comments I've heard mostly from districts in the Puget Sound area in particular, because I think in the Spokane area, most everyone offers similar benefits packages, but in some areas they viewed these optional benefits as a way to compete for employees, as a way to recruit. In these areas it's difficult to get candidates in certain job categories, like bus drivers, for example. Going to a statewide plan with fences around what you can do is totally new to K-12.

We've operated like the wild, wild, west in the sense that you could do whatever. We've kind of taken a laissez faire attitude. If these are optional benefits and people are paying for them themselves, what do we care, kind of thing. Why wouldn't we let them do it? Culturally, that's what you're coming up against in some respects with these benefits, or with the ability for school districts to offer it. We have 295 school districts with their own tax and authority, their own School Boards, their own bargaining groups, their own set of employees. The more clarity we could offer, the better it would be.

Dave Iseminger: This came up as part of 2018 legislation. It wasn't the original 2017 legislation. What we're seeing play out is people having different understandings of what that component of the bill did in 2018. It became pretty clear early in Fall 2019 there would be a discussion during the 2020 legislative session that would provide clarity one way or the other. But previewing the agency's interpretation of our role of defending parts of the purchasing power of the program was important. That at least set the stage for the clarity people are seeking. They could say, "Well, this is what a state agency believes the statute means." Unless somebody changes that, at least everybody knows what the state agency believes is the interpretation of that statute. That's often how different parts of state law are crafted.

Another area I was going to highlight is auto/home. It became a very prominent part of September discussions. Many people were surprised and asked why the Health Care Authority was focused on auto/home. The challenge there was the statute for the Board's authority includes the phrase "liability insurance" in RCW 41.05.740. That same phrase exists in the PEB Board's authority, RCW 41.05.065. Liability insurance

has historically been interpreted and implemented as auto and home. It felt like it caught people off guard so we made sure they knew that's what liability has historically meant at the state level. HCA told the districts, "Because this is coming at the end and it feels almost like Lucy pulling the football out at the end of the game," we said, "that's what our interpretation is, because that's what the state has historically meant. We'll wait and see if any clarity comes from the legislative session. So feel free to keep doing auto and home for this school year. But know that could be coming down the road as a potential piece next year."

That was another example of the kind of questions we had with so many different moving parts, trying to preview what the historical interpretation has been on different parts of statute, and then answering those questions before us. But I think you're right. The description you've given is very accurate. There are a lot of districts, and the pieces you've highlighted are part of the legislative debate that's going on now about potentially changing RCW 28A.

The other part of the conversation has been some districts were using these as ways to entice different employees. On the other hand, I've heard it introduces variability back into the very system that was just consolidated to reduce variability. And then you keep flipping back and forth between the coin of, well, it's employee paid so can't people do what they want with the money that they've earned? There's two sides to that equation.

Wayne Leonard: I would agree with you but it's weird because what we're doing with trying to consolidate all health care and benefits, we've done the opposite with salaries. We had a different kind of a statewide salary schedule and now we've gone to everything's wide open kind of thing. Depending on what we're talking about, it seems like the Legislature's taking different viewpoints on things.

Pete Cutler: I guess I remain concerned about how this has been handled. I want to start by acknowledging that looking at Slide 5 about what the Health Care Authority thinks are the benefits that are authorized to be offered through the SEBB Program. Scanning it quickly without benefit of really a lot of background information, I tend to agree with the list. So it's substantive and I don't think I have a big disagreement with. However, as you might have noticed, I have a very strong concern about the fact that the Board was left out of this and the process by which this information was provided, and the very presumption that it was presented as, "This is for the Health Care Authority to determine." The agency has very explicit language about it being something the Board will determine.

I look at it now as somebody who briefed policy makers and budget folks for a long time. My reaction is I personally would not be comfortable voting on a list of how these are described - which optional benefits conflict with the SEB Board offering authority without more information. I think the rationale that underlies the conclusions listed on Slide 5 of the handout, I don't have any of that in writing. I think we should, as Board members, understand the rationale that led to the Board determining for each of those bullet items what language they're relying on in the statute or in rule to come to that conclusion.

On the data, again, all we have is an extremely high-level summary. I think it's incumbent on the agency to provide the Board with information policy makers should have to make an informed decision, which I think should be a lot more specifics than we

have here about what these different benefit options are, the information that we've gathered. It's not different than what's been collected, but I don't think it's appropriate, and certainly legislators don't generally vote on proposed statutory changes based only on very high-level kind of summaries of what a proposed statute would be. There's a requirement for more detailed analysis. Something more detailed is called for here.

I think as part of the background, we should have a reference to what the statutory or administrative rule provisions are that deal with the Health Care Authority's authority to enforce program requirements. My recollection is a statutory change was made precisely, because for a long time Health Care Authority assumed it could not legally require or force agencies -- or this was PEBB agencies or employers -- to follow PEBB interpretation of PEBB rules that were adopted by the HCA. Some kind of statutory change was made to make it possible for the Health Care Authority to enforce, or to provide greater leverage for the Health Care Authority to require, PEBB employers - and I think it was amended to include SEBB employers - to require them to adhere to HCA's interpretation application of rules. I at least would like to understand what that authority, that framework is before we lock in a decision.

It seems to me at some point there should be a proposed motion brought to the Board suggesting this is how we think, the Board, and we would recommend the Board adopt what optional benefits conflict. It may not be much different than Slide 5. I think we should, but I, as a Board member, do not want to vote on such a motion until I have the kind of background information I just discussed. That is what I would hope to have the agency address.

Lou McDermott: Pete, I just want to understand, how much specificity do you want? What happens in the middle of the year if we become aware during an audit or something that a particular organization is offering a particular benefit. Are you suggesting this get adjudicated by the Board case-by-case, or again, setting the high-level policy, which the agency will implement? Is it coming down to case-by-case?

Pete Cutler: That's a legal question in terms of what kinds of limits can the agency enforce right now. I guess I'm going to not give an off the cuff kind of legal guess. That's the kind of thing the agency should look at the statutory language. If they think there's a case for saying, "School district, you can't do this," I guess I would start with presumptions that the agency can't say, "You can't do this," until they can point to statutory language that gives it the authority to set a limit, and language that somehow can be reconciled with this language that's on Slide 3.

My guess is the Legislature did not actually say, "Okay, these are the kind of optional benefits that are permissible and these are not," because it was so wide open in terms of what's going on. Nobody really knew. The thought was we should find out. Once we collect information, we should set some limits. But I would leave it to the Health Care Authority, the Attorney General's Office, to determine, looking at the whole statutory framework for the Health Care Authority and SEBB Program to determine what it thinks it can do up until the point the SEB Board takes the action mentioned on Slide 3.

Katy Henry: I support what Pete is saying. Also, going back to something Alison said. So two things: 1) I don't feel comfortable making a decision without more detailed information related to what Alison shared. What are the districts? How big are the

districts that are offering these benefits? Who are they? Just a little more information that would help us understand how they arrived at what they did. 2) To what Pete said, the authority to make the determination. I don't feel comfortable that we've gotten a full explanation of where the Board is and where the agency is. More information around that would make me feel more comfortable.

Dave Iseminger: Good news, we weren't asking you to take action today. [laughter] That's been my catchphrase the last six months. This was the first in a series of conversations. It's helpful to have context of additional things Board Members are looking for. I'm interested in any other Board Members' opinions as well.

I will highlight one other layer of the onion to the various questions that come up. This is codified in RCW 28A, not RCW 41.05, which is not typically where Board or agency items are codified. That in itself has its own fun questions for Katy Hatfield and her colleagues.

Dawna Hansen-Murray: Wayne, you were talking about the differences across the board and how our funding is based on an allocation because every community has different needs. That gives our districts their local control. I'd like us to not take that much away so our districts can have that local control to entice people, or to have transportation to get somewhere because it's so much further for them to go that they need reimbursement. Whether we offer that to them through us and they choose based on their needs, or if we free it up more so they can do that on their own level.

Dave Iseminger: That's an interesting perspective, Dawna. I've heard that before, maybe the Board or HCA could create a marketplace for these other benefits. It's still centralized purchasing, but not mandatory participation. I think that's what you were describing. I want to make sure I understood right.

Alison Poulsen: Can you comment on the implications of cost and how the funding presentation we got this morning, if you were considering additional benefits, is that insinuating you'd be asking for more dollars from the Legislature, or trading off of some of the current benefits, or that would to be determined?

Dave Iseminger: With regards to optional benefits, all of these have been employee-paid pieces, which wouldn't have implications other than if we were to do something like a marketplace where the agency has to do a procurement, and then manage a contract. That would have administrative aspects because we don't have staff that currently do that. But in general, because they're employee-paid, it shouldn't be something that has significant impacts on the funding rate. I can't say for sure.

I hope this doesn't conflict with what I just said, I'm not asking you to take action. If you turn to Slide 9, I'm curious for the Board's perspective on the top three bullets, the things that squarely are within this Board's authority. If we see, as an agency, a report that school district A is doing a life insurance policy, a disability product, or an accidental death and dismemberment, where those words literally exist in RCW 41.05.740, is there concern from the Board? What's your perspective? Is there anything you believe HCA should or shouldn't be doing? HCA's perspective would be, it's squarely the agency that can take the protective action on behalf of the Program to say these are in conflict. They squarely fit the terms on the page and in statute.

Terri House: I think Pete alluded to that because he said, “What are you going to do about it? What’s the Health Care Authority going to do about it?” And he said, “I thought you guys, based on how the law is written, have that authority to do something and what would that be?” Am I correct, Pete? Is that what you alluded to?

Pete Cutler: I’m not sure I’m free to those items in the bullet list, whether they’re going to be comfortable with their Assistant Attorney General saying, “Yep, that language and statute there means we can set this limit.” This is a classic case. I’m not comfortable giving any kind of advice about saying you can set limits without more briefing on here’s the context and here’s the statutory line. As I said earlier, personally, from having reviewed many of these different kind of benefits over my career, and especially at the Insurance Commissioner’s Office, my guess is I will end up supporting this as being in scope of the SEBB’s authority, and it’s appropriate to say, yes, what’s in the scope of this Board’s authority to provide these benefits cannot be offered by a school district.

I’m very personally uncomfortable saying, “Well, yeah, you can go tell employers that I as a Board Member said that there is this limit,” when I don’t have enough information to really land there yet. I guess to answer your question, David, if you want to say yes, do you have Board Members who would raise questions or might be concerned? I guess I would definitely get to that level of agreement. But in terms of saying, well, the Board said that’s a limit, that’s appropriate for us at the Health Care Authority to establish and enforce, I’m not comfortable with going that far at this point, based on what I know so far.

Wayne Leonard: Of those top three you mentioned, the life insurance typically to all employees has just been a general group life. I am aware that historically, some school districts have offered key employees, typically the superintendent, some kind of cash value. Life insurance is part of their salary and benefit package they’ve negotiated directly with the School Board. I think that’s happening less and less, but I know there have been contracts like that in the past.

Dave Iseminger: Sounds like we’ll be having more presentations about this in the near future. The backdrop of all this is potential legislative change that Cade will provide an update in his first presentation at our March 5 meeting. I think we’ll have a more insight as to what the Legislature’s thinking around this provision as bills work their way through the process. Clarity is a good thing for everybody.

Eligibility and Enrollment Policy Development

Barb Scott, Manager, Policy, Rules, and Compliance Section, ERB Division. I have two policy resolutions for your consideration today. Slide 2 – Annual Policy and Rule Development Timeline. This Board did a lot of work over the past two years. We brought resolutions and policies to you almost every meeting. Through that, the foundational work for the SEBB Program was put in place.

Now that we are live, I want to talk about the timeline going forward. Currently, the work done each year is to get policy changes in place prior to the beginning of each new plan year. In order to get information out to employees and to SEBB Organizations on time, we build our timeline backwards.

Year round we capture feedback from stakeholders and internal staff as they discover things, or as they come across issues that need to be resolved. Staff spend a good amount of time in December and January each year going through those issues to determine which fall within the SEB Board's authority to make a policy decision on. Staff research those issues in order to prepare policy recommendations to bring before the Board for discussion.

We will start bringing the Board proposals at the April Board Meeting, although we have two today. The two today are issues that came up during implementation. We would like to get those issues resolved today, if possible. But there are others being teed up for you for April.

Once we introduce proposals to you, we then will bring a follow-up recommendation with an actual policy resolution to the Board for action at the May Board Meeting. As you can see on the timeline, there's an overlap with rule activity or the actual rule drafting and the Board's policy development. We are targeting the June Board Meeting to have final action on policy recommendations in order to be able to file our rule making notice, which puts the draft rules out for public comment. I'm filing that on June 15, 2020.

The June 15 filing date will allow us to have a public hearing on draft amendments in late July with final adoption of the rules soon after in order to support the implementation needs that our communications require to be ready for open enrollment. Policy resolutions adopted during that time typically have an effective date of January 1. We line those up with the plan year.

Dave Iseminger: As we get into standard rule making, if you happen to sign up for our other agency list serves or Barb's rule making list serves, you'll see the administrative procedures act process that goes through rule making starts really early on. We have to file documents that say, "Here's what we think we might be doing in rule making." It starts off very broad and we cast a very wide net. And just because something is in those original rule making steps does not mean we're usurping your authority as a Board by saying the Board might act on this. We have to cast the wide net to foreshadow what might be happening.

Barb Scott: There are a number of required documents that have to be filed. The CR101 is filed early in the year around March or April in order to ensure we file timely. We have to work within a legal framework to make sure we get the work done. The CR101 is a generalized document with little detail. The CR102 document will be filed around June 15.

Pete Cutler: Barb, I think you explained it very well, but just to be clear. If the Board takes action by its June meeting, are you comfortable that you have time to file the CR102? There's a certain length of time, once you file a CR102, the Administrative Procedures Act requires that the process not drag on. I guess that choice of words reflects my legislative bias against the frustrations of the Administrative Procedures Act. In order to have officially adopted rules, and start printing, or updating the website for open enrollment, you need to have all this stuff locked in. It really has to be ready more like October than the end of December, which some of us in Legislature used to think, you had until January 1. Can't you do this in December?

Barb Scott: You can't.

Pete Cutler: You can't, right. I wouldn't want to postpone until first week of June Board action then find out that it's somehow not going to work to get this information locked in for open enrollment.

Barb Scott: Our hope really is that we will have done enough work. Staff have been working on this already. They're doing this in addition to legislative bill analyses and a number of other rule items going on within the Division. It's my hope you will take action in May. The target date of June is going to be tight with the filing on June 15.

Dave Iseminger: The Administrative Procedures Act is not the only thing that guides decisions. Decisions that you make also could impact rates. Rate setting is also occurring at the same time of these briefings. We will always bring things to you and be as clear as we can about the need for action at certain times and the impacts it could have on the rate development process that is simultaneously occurring. June may be fine for Barb's rules but not fine for Tanya's rate setting. We'll always be clear about which things have to be done by when.

Barb Scott: Slide 3 – RCW 41.05.740(6)(c) & (d) shows the Board's authority.

Slide 4 – Interim Guidance Regarding Inclusion of Paid Hours. During implementation, HCA had a number of questions related to leave and how the use of leave might impact the eligibility determination being made by a SEBB Organization. We felt it was problematic enough as they were making eligibility determinations that the agency did something which is not typical of us to do. September 2019 we issued interim guidance on at least one of those policy resolutions. That guidance is in your packet today.

The eligibility issue brought to us specifically related to the exclusion of paid leave hours in determining eligibility. The guidance issued is in the Appendix, and is slightly different than what I'll show you today. We did stakeholder the interim guidance prior to issuing it, with the legislative budget committees and Office of Financial Management. It was our belief that neither the Legislature nor the Board intended an employee's use of a day of sick leave or a personal day off would impact their eligibility. The guidance we issued was based on that stakeholdering. We did more stakeholdering after having issued the guidance.

Dave Iseminger: It is unusual for us to issue this type of guidance in September. But we did do stakeholdering with various other parts of the authorizing environment as to what was really intended by "anticipated to work hours." In Barb's example, let's say you have an individual anticipated to work exactly 630 hours who calls in sick for one day, one shift. Districts were thinking they were not going to kick the employee off benefits even if they were told to. So looking at guidance to lean forward and give, we ended up giving guidance that is good for at least this school year. If the world changes, nobody's going to pull the rug out from you in the middle of this school year. If the rules are going to be different in the future, it'll be different for the entire next school year. I talked to 17 different parts of state government to ask, "Is this okay?" This is one of the only times that everybody had unanimous insight and said, "Of course that's what everybody meant." It felt somewhat safe in this particular instance to issue guidance we felt would be good for at least one year, and bring something to the Board

at their first meeting to see if there's a way we can codify it in rule. Everybody, from districts, to OFM, to the Legislature, all angles of the 17 people were in unanimous agreement this was not intended to kick someone off benefits mid-year if they used one day of sick leave and fell below 630 hours.

Barb Scott: Slide 5 - Proposed Policy Resolution SEBB 2020-01 – Inclusion of Paid Hours, is the first one of the year. It would require SEBB Organizations to include paid leave and holiday hours when determining a school employee's eligibility. There is a difference between the interim guidance and this resolution. The most notable difference is the inclusion of paid holiday hours.

The exclusion of the holiday hours was really a vestige of the idea that when we initially laid out eligibility, there was the requirement the employee be anticipated to actually work at least 630 hours. If we were going to include paid leave hours, we couldn't find a justifiable reason to exclude holiday hours. That's why you don't see it in this version compared to the Fall 2019 guidance issued from the agency.

HCA is recommending, on this policy, implementing with an effective date of January 1, 2020. It's also not normal for us to recommend a retroactive effective date. But we know some eligibility terminations were based on what districts had done and felt was right, which was to include paid leave hours in their view. We know others were following our rules to the tee and excluding those hours. We would recommend that you go retroactive and we've heard from stakeholders that they would like you to go retroactive on this particular policy proposal, too.

Slide 6 – Inclusion of Paid Hours – Example #1. In this example, a school employee who's, at the start of the school year, is expected to work exactly 630 hours. The school employee ends up taking one day of sick leave, which would reduce their number of hours so they would have worked under 630. If this resolution is approved, the hours compensated for the sick leave would be included in the eligibility determination. The employee would still be eligible for benefits in this case.

Pete Cutler: I guess it's clear, but I want to double check. This deals only where the person is compensated. So the employer expects they employee is going to work exactly 630 hours in a school year. For whatever reason, that employee takes a day of leave without pay, no compensation, then they would have that draconian impact of no longer being eligible. But we otherwise try to treat all different types of pay, for whatever reason you're on leave, even including the holidays, as long as you're paid for that period of time, it'll be treated as an hour of work for the purpose of interpreting the eligibility statute.

Barb Scott: That's correct. It's specific to the inclusion of paid leave only, not unpaid leave hours.

Dave Iseminger: Barb, correct me if I'm wrong. The real question for the employer in that instance would be do they have enough information such that they're going to revisit their anticipation to work? Because that employer may say, "Oh, I see you're going to be a day under but here's another day that you can pick up or here's another task you could pick up," to maintain 630 hours. They wouldn't automatically be deemed

ineligible. The question for the employer would then be do I have reason to change my original anticipation? Is that right?

Barb Scott: That's correct.

Pete Cutler: And I'd advise any school district, do not set somebody at exactly 630 hours. Get it up there, 640 or something. Give yourself some wiggle room.

Barb Scott: It is our understanding that many of them do just give 630 hours and there's additional hours that show up that they could accept that would put them in position to meet eligibility.

We did do some additional stakeholdering beyond the initial stakeholdering that Dave talked about related to the interim guidance. Once the interim guidance went out and we began to formulate policy proposal for the Board, we sent that out more broadly to get additional feedback. The stakeholder feedback we received was in support of the policy that's in front of you today. We didn't receive any negative feedback on this particular policy proposal.

Pete Cutler: Did you discuss this at all with retirement systems?

Barb Scott: We did not discuss this with retirement systems that I'm aware of.

Pete Cutler: It's been a long time since I worked with eligibility there, but my recollection is that their standard is -- say, 70 hours of service and they have to find it as compensated service. So, if for a long time they have worked with treating any hours for sick leave or annual leave as hours that count towards qualifying you for eligibility for a month, a quarter, or month of service credit. I think that's still the case. And in my mind, that also argues in favor of adopting this resolution because having a consistency so your school districts are not having to figure out this is PEBB eligibility and not SEBB eligibility, and not SERS, or TERS, or whatever. Keeping things simple would be a worthy goal.

Barb Scott: We may have looked at their rules around that, the eligibility, but I don't know for certain if we've reached out to them.

Pete Cutler: You might want to just kind of double check. Regardless of how they answer, I support the motion.

Barb Scott: Slide 8 – Proposed Policy Resolution SEBB 2020-02 – Benefits Eligibility After Returning to Work. Again, this is leave related. This policy would require SEBB Organizations to consider whether the work schedule for an employee returning from an approved leave of absence, approved leave without pay, had it been in effect at the start of the school year, would have resulted in the employee being anticipated to have worked the minimum hours needed to meet SEBB Program eligibility. If the schedule would have resulted in eligibility, the employee will be eligible for the employer contribution towards SEBB Benefits the first day of the month following the date they return to work.

This addresses many of the questions we received around employees who were maybe out on maternity leave or other types of leave. They were returning and districts were trying to deal with how it affected eligibility. In their view, historically, many of them had provided benefits upon return to these employees and so they were asking that we bring forward a policy resolution that would address this and take care of them being able to explain to these employees how this would affect their eligibility going forward.

We didn't stakeholder this as broadly as we did the prior policy, but we did send it out to many of the key stakeholders we have worked with through implementation. We stakeholdered this with a couple stakeholder groups we meet with on a regular basis and received positive feedback on this as well. They were in support of the policy resolution. One district had some concern that it would create a conflict with contract negotiations they currently do in advance of people going out on an approved leave. They had a concern that it might conflict with what they've been doing in determining ahead of time for staff whether or not eligibility would be in place when they came back versus not being in place. That is the only concern noted. That stakeholder feedback is in your booklet.

Dave Iseminger: It was included in your email. It's not in your physical booklet in front of you.

Barb Scott: We did get support from stakeholders on this policy resolution as well. They're hopeful it can be resolved retroactively with an effective date of January 1, 2020.

Dave Iseminger: I have heard, although we don't have a comprehensive data set on this, there are some districts who believe this is what they were supposed to do and are doing it already. Although it's not specific to this resolution, I've heard a variety of districts say it seems like the Board only does eligibility expansions. If you go back to your Board's authority, you can be no less restrictive than the statute. I've had a variety of conversations like, "I don't have a problem with this and I don't have a problem with that, but the sum total of it is suddenly increasing the cost of the program." I would be remiss if I didn't convey that on behalf of all of those conversations. It's not this policy that's concerning, but the overall -- there's only status quo or expansion with the Board, and the only way for any contraction is through a legislative process. So again, not specific to 2020-02, but a general piece around the eligibility framework.

Barb Scott: Slide 9 – Benefits Eligibility After Returning to Work – Example #1. In this example, a bus driver who went out on unpaid maternity leave on September 1 returns to work in November prior to the end of her FMLA leave. She is not expected to work 630 hours in the remaining months of the school year, but would have worked more than 630 hours but for the unpaid maternity leave. In this situation, the question is, "Can the SEBB Organization terminate SEBB benefits upon return from FMLA leave? If the Board were to adopt this policy, the answer to the question is no. Her benefits are maintained uninterrupted. While you're on FMLA leave, you're eligible for the employer contribution. Upon her return, if she was anticipated to work the 630 hours, her benefits would remain uninterrupted as long as this policy is put in place, even if that were less than the 630. I may have just messed that one up. I'm going to bring Rob up to help me through this one.

Rob Parkman: Depending on the time she's coming back to work, she's on protected leave. She never really comes back off protected leave. Prior to her FMLA ending, she comes back, and with this resolution passing, and depending on the actual details if we had them, she might be anticipated for that year. But based on this resolution passing, she is going to come back. As she comes back, if it would've been in effect for the whole year, she would've been eligible. So as soon as she comes back, and her pattern would have got her there, then she is still eligible in this particular case. She never loses benefits.

Pete Cutler: I'm curious whether the fact that she's on FMLA leave is relevant. Would FMLA require this result regardless of what the state statute says?

Barb Scott: During the FMLA leave, her eligibility for the employer contribution would remain in place. As long as she's on FMLA, if you're benefits eligible when you go out, the employer has to keep your benefits in place during the FMLA leave. The reason we brought this particular example is because upon return from the leave, if she wasn't going to meet the 630 hours for the year, her employer could look at that and say, "You're not eligible because you're not anticipated to work 630 hours in the current school year." This example is here because this was one of the questions brought to us during implementation. They were struggling with the fact that when the person returned and they did the calculation, it's going to be less than what's necessary for SEBB eligibility. We specifically used FMLA because of that question.

We also learned a lot about FMLA, of which, depending on where it plays out in the year, it works slightly different for school employees because when they're off on their summer break, you don't consider that in the 12 weeks when you're determining how much time someone is approved for FMLA leave. We tried to lay something out in an example that wasn't too complicated. But as you found with me stumbling through it, it is complicated.

Pete Cutler: But the bottom line is FMLA doesn't automatically protect the person from losing future prospective coverage. It only guarantees the coverage while they're under FMLA, the 12 weeks or whatever. That's useful to know. Thank you.

Katy Hatfield: Pete, there is a letter ruling from the Federal Department of Labor that talks about a very similar situation to this where someone requested guidance on a plan where the amount of hours worked in the previous calendar year would impact whether you got benefits for the next policy year. In that situation, the person had gone out on FMLA and so their number of hours worked in year X was lower than the threshold amount because of the FMLA. The Department of Labor said you could discontinue them for benefits the next year because they didn't work the hours so the benefits would get cut off the next year. So out of an abundance of caution, we put this in.

Pete Cutler: Thank you very much, Katy, because that does seem to be directly on point and as inconsistent as it sounds, like it is with underlying FMLA policy, if that's what they've said then yes, this would seem to be needed. Thank you.

Dawna Hansen-Murray: Because I'm in the classified world, we have employees that would never qualify for FMLA based on the number of hours they work. Had this been a bus driver who only worked 630 hours the previous year, she would not be out on

FMLA. She would just be out on unpaid leave. How would that affect her? She would still come back with her benefits intact?

Barb Scott: The prior policy we had in front of the Board today, SEBB 2020-01, only had you include the paid leave hours. This one would have you consider the unpaid leave hours based on the schedule when they returned. If the schedule they're returning to is three and a half hours a day, it would include three and a half days a week during the unpaid leave period.

Dawna Hansen-Murray: So the FMLA thing has nothing to do with it for that person?

Barb Scott: FMLA has nothing to do with it. You just take the schedule upon return and use that during the period of unpaid leave. When you come out with a calculation, if they're 630, you would give them benefits upon return, first month following.

Barb Scott: Slide 10 – Benefits Eligibility After Returning to Work – Example #2. This example is a full-time teacher who went on unpaid maternity leave on August 1, 2020. She communicated to her district that she will not return from maternity leave until March 2021. Given this information, she is not anticipated to work 630 hours in the current school year. She loses the employer contribution when her protected leave runs out. She returns to her regular work schedule on March 3, 2021. When is she eligible for the employer contribution towards SEBB Benefits? It would be March 3, 2021, upon her return. Her coverage would begin the first day of the following month, April 1, 2021.

Dave Iseminger: Barb, the effective date of April 1, 2021 is in line with the prior Board's policy decisions about coverage. Eligibility that exists in the middle of the month becomes effective the first of next month. I think that was Resolution 12.

Barb Scott: Coverage always begins first of the month following the date you gain eligibility, yes. Except for September, which is a special month.

Dave Iseminger: The other piece that was brought up related to these two resolutions is the Board previously passed eligibility resolutions, the number escapes me but about people who are hired late in the year. You might remember we showed you calendars and counted back eight weeks. And if you had enough hours in six of those eight weeks and were planning to come back to a similar position the next year, then you get benefits the first of the month in the current school year. That was juxtaposed against this idea. If a full-time teacher comes back from unpaid maternity leave, she doesn't get benefits, but the new hire that was hired the same month does get benefits. Barb didn't highlight that specifically, but it is another piece of this conversation that was brought to our attention - the potential inconsistency between a late year hire and somebody who's a long-term employee returning from unpaid leave.

Barb Scott: Districts were struggling with whether or not they could apply that mid-year hire rule early on. It really was meant for late hires. A decision on this will be helpful for them to be able to determine eligibility for the others who are returning from different types of leaves.

Pete Cutler: Barb, I think the answer is obvious. If the Board were to decide to adopt this resolution, am I correct that if we found it was impacting costs, impacting districts in

a negative way that was not anticipated, the Board could pass another resolution in the future to have it implemented prospectively? Can we change our minds? That is not unlike retirement systems where sometimes you get locked into things. Once you've said yes you can never take it back. The Board can amend eligibility standards?

Barb Scott: Eligibility standards can be amended by the Board. We typically try to watch for issues raised throughout the year. It's atypical for us to bring it to you like this, same as it was for us to issue interim guidance. But at the same time, we do collect them throughout the year and try to identify problem areas to bring to the Board. It wouldn't be unusual to adjust eligibility going forward if that were necessary. The PEB Board, your sister Board, has done that in a number of different cases where it's been reasonable that the eligibility needed to be modified. I think it's unusual in what I've seen, but not something that doesn't happen.

Pete Cutler: Now that you mention it, you're right. They have dealt with that. Am I correct that there have been individuals identified who would be impacted by this rule change?

Barb Scott: Yes. Districts have been asking us for the answer to this one as quickly as the last one. If you have feedback on the drafting of these resolutions, if you have modifications you'd like to see, we can do that. Otherwise, we're recommending that the Board take action on Proposed Policy Resolution SEBB 2020-01 today. We're asking for Board direction on how to proceed with SEBB 2020-02, which we are recommending you take action today if you're comfortable with that.

Lou McDermott: Policy Resolution SEBB 2020-01 – Inclusion of Paid Hours

Resolved that, effective January 1, 2020, all hours for which a school employee receives compensation from a SEBB Organization during an approved leave (e.g., sick leave, personal leave, bereavement leave) or a paid holiday must be included when determining how many hours a school employee is anticipated to work, or did work, in the school year.

Terri House moved and Pete Cutler seconded a motion to adopt.

Julie Salvi, Washington Education Association. Good afternoon. I wanted to thank the Health Care Authority for the work they did in stakeholdering this fall as these issues were identified. This clearly addresses some fairness issues and brings some consistency and ease of operations for everyone. So thank you for considering it today.

Wayne Leonard: I have a quick question. Earlier in the year, Dave did call, we discussed this, and I don't have any problem with it. But I guess I haven't heard why we have to adopt it right away, why we couldn't follow our normal process and adopt it at the next meeting.

Barb Scott: This one is unusual. Because we had so many questions raised during implementation, the agency stepped out on a limb and issued guidance. This really falls within your authority to decide. We have the opportunity to bring it before you. We would like a decision from the Board since it falls within your authority for resolution rather than ours.

Dave Iseminger: We did the full stakeholdering process on 2020-01 before this introductory meeting -- as if the resolution had already been introduced to the Board. I think that's different than the other resolutions last year. Also, even though this wouldn't yet be codified in rule until the next rule making cycle, we would be able to point to this as a Board policy that can be relied upon, effective beyond our interim guidance. It could provide further reassurances to districts that what they're learning and applying will be the world going forward.

Wayne Leonard: Just to be clear, there's no emergency legal reasons that we need to do it. I mean, your guidance has been out there for five months and so another five weeks of comment --

Lou McDermott: My understanding is there are employees in the SEBB Program who are being impacted by this now.

Dave Iseminger: To clarify, our understanding is that districts are relying on our interim guidance now. The emergent need question you're raising, Wayne, there is not necessarily an emergent need. I would go back to we've already done all the stakeholdering we would do in the next five weeks on SEBB 2020-01 and we wouldn't anticipate any other information coming forward. The guidance has been out for five months. I'd be curious what your concern is or if there's something you'd be wanting stakeholdered further because there has not been a single piece of concerning feedback from any angle. That's highly unusual when it comes to anything like this. There has not been a single dissenting voice anywhere. I'm curious if there's something you're concerned about that we can address.

Wayne Leonard: I don't have a concern about this. Like I told you in September, we wouldn't cut someone off from that in my district. I guess I don't want to have things appear that we're rushing things through and not following normal process and be criticized as a Board for that.

Dave Iseminger: So it's not a substantive piece.

Wayne Leonard: No.

Dave Iseminger: I think that's a fair point for your colleagues to consider.

Pete Cutler: I have to admit, I was under the misimpression that maybe there were people who were covered now and based on the agency representation, advice, or whatever who were at risk of having their coverage terminated retroactively, or at least afraid of that. For me, that was my major reason for supporting this, to make absolutely certain we have nobody feel any risk that their SEBB Program coverage might be terminated retroactively.

Barb Scott: To answer your question, Pete, the interim guidance slightly differed from the policy that's in front of the Board today. It specifically excluded holiday hours. If this policy is adopted as it is in front of you today, especially if it's a retroactive effective date, there would be some eligibility determinations that would need to be reviewed by districts based on that difference between the interim guidance and the policy today.

Voting to Approve: 8

Voting No: 0

Lou McDermott: Policy Resolution SEBB 2020-01 passes.

Policy Resolution SEBB 2020-02 – Benefits Eligibility After Returning to Work

Resolved that, effective January 1, 2020, school employees who return from approved leave without pay will maintain or establish eligibility for the employer contribution if their work schedule, had it been in effect at the start of the school year, would have resulted in the employee being anticipated to work the minimum hours to meet SEBB eligibility in the school year. A school employee who regains eligibility under this policy establishes eligibility for the employer contribution towards SEBB benefits as of the date they returned from approved leave, and coverage will become effective the first day of the month following the employee's return to employment.

Alison Poulsen moved and Katy Henry seconded a motion to adopt.

Julie Salvi: Good afternoon again. Thank you for bringing this and considering this today. This is the policy where I do expect there are some employees that may be affected this very school year. It is not uncommon for someone with a very young family to have been on leave without pay for the first semester and come back second semester part time and second semester will be starting for many districts now, end of January, early February.

As I have done my own stakeholdering on this idea, my sense is a lot of districts have found ways to determine eligibility. But it is not consistent across the state and there are examples out there. This policy change, or clarification, would provide consistency among districts. It would also provide fairness as Dave noted between those who are hired mid-year versus a long time employee returning. Also, it would bring fairness for those who happen to be on leave without pay at different times of the year. Because someone who is off the first semester comes back and their district tells them they're not eligible because the hours won't have any employer support the entire year. Whereas another employee who was working part time the first semester and then had to go on leave without pay would have had that employer support. So we strongly recommend that you adopt this today and just to help the fairness across the system. Thank you.

Pete Cutler: I just want to confirm that my understanding is under the current rules or resolutions, if we do not pass this one then that person who's been on approved leave comes back would not be expected to work the 630 hours for the remainder of the school year. Right now the Health Care Authority direction would be that person is not eligible for SEBB coverage. Is that a correct understanding?

Barb Scott: The Board passed a policy that says a SEBB Organization can change their anticipation if there's a change in the work pattern, something along that line. Some districts would apply that and say if a person were to come back later in the school year after being on approved paid leave, that person, based on the remaining number of hours, they're not going to be eligible because they are not going to make the

630. Some districts are trying to apply the late hire rule to it and say they would be eligible because of the late hire rule.

If the employee starts off the school year and is anticipated to work the 630 hours, we have some districts who are saying the employee's going out on maternity leave, for example, then we don't anticipate that they're going to meet the 630 anymore. Because of that, we changed our anticipation and they're not going to be eligible then. We would take away benefits once they go out. Other districts are saying, no, we've never done that. We always kept benefits in place. We're going to do it a different way. There is no consistency across the districts.

This policy would help districts know they have to look at the schedule when an employee returns and decide with that schedule, had it been in place while they were out on paid leave, would have met the minimum requirement for SEBB eligibility, and then make a decision on that unpaid leave. There's truth that the districts have a lot of questions about it and they're trying to figure out how to apply eligibility based on the situations in front of them.

Pete Cutler: Presumably, there are some employees within some school districts, coming back from unpaid leave who under current rules, their employer would just say, sorry, you're not going to get in 630 hours this school year so you're not going to get health coverage even though if you hadn't gone on leave you would have. Wayne raises a good point. Normally I'd strongly agree. I like having the stakeholdering done to get the input, bring the issue to the Board, have a month to think about it, vote later. I guess I'd like clarification on this specific resolution, if the Health Care Authority thinks that it will, if we vote this meeting versus March, make a difference to those people who are in those districts where the employer is saying no now. Are you saying that if we pass this, somehow it will make those employees eligible this year and affect them in a positive way right away or would this only have impact in 2021 anyway?

Barb Scott: This one has a retroactive effective date as well so it would affect employees this year. We do know districts are struggling with making different decisions around saying no, or yes, because we previously anticipated you would work 630 hours, so we're going to keep benefits versus now, we know you're asking for leave for three months to deal with a health issue. We're going to issue you a letter that says you will only get benefits upon return if you happen to return to this number of hours per day. Otherwise, you wouldn't have benefits when you return. Districts are struggling with it and employees are relying on what they're being told at the district level.

Pete Cutler: Okay, I like the policy change and clarification. I hesitate only because of the concern about liking to maintain the structure of the process in terms of good stakeholdering. It does sound like it's not a hypothetical question for some people. It's actually going to affect their situation in the next couple of months. Okay, thank you.

Dave Iseminger: I'll just add in your email when the Briefing Book was sent out, there were a variety of letters from school employees. I believe if you look at those closely, there was at least one or two examples that were talking real time about the impacts. If you were to decide to table the motion and take action in March then they would continue for the next five weeks to be in the same position they are today with that particular employer saying under the current rules, you're not eligible. Whereas, if you

passed it today, the agency would be able to provide immediate training and guidance that the individual is, in fact, eligible effective immediately.

While the agency wasn't able to do the *full* stakeholdering like we've done every resolution for the past two years, we did do *some* stakeholdering. We didn't send it on the GovDelivery list serve to 1,400 people who get our emails and can respond. But we did go to our key organizations that we have been stakeholdering policy resolutions through with this draft. But the level of stakeholder review was less than our typical process and less than resolution 2020-01 discussed earlier in the meeting.

Katy Hatfield: It's not a concern at all. I was looking at the very last word and I was thinking the word "work" might be more appropriate than "employment" because the person is already employed. They're not returning to employment. They're returning to work. If somebody wanted to make an amendment to change that word to "work" you could do that.

Terri House moved and Pete Cutler seconded a motion to amend the word "employment" to "work."

Voting to Approve: 8
Voting No: 0

Lou McDermott: The amendment to Resolution SEBB 2020-02 passes.

Voting to Approve Amended Resolution: 8
Voting No: 0

Lou McDermott: Amended Policy Resolution SEBB 2020-02 passes.

BREAK

Annual Rate Process

Megan Atkinson, Chief Financial Officer, Financial Services Division. Slide 2 – SEB Board Authority. This slide indicates the Board has the final authority on authorizing employee premium contributions. Until the Board takes action, the rate development and premium setting process is not actually complete. It won't be unusual in future years to have several rounds of communication with the carriers even after you have seen the final rates. It's not unusual to present those to the Board and then for the Board to instruct the agency to go back to the carriers, especially in years where you might be considering different benefit additions or subtractions. In real life, the rates are not final until the Board takes action. The Board can also clarify what information it will consider in setting the premiums.

Slide 3 – SEBB 2019 Rate Development Process Recap. This slide recaps the process we went through last year. HCA publicly published the last round of rates that we had from the carriers. A couple of days after that information for all the carriers and the self-insured plans was publicly available, a carrier, unsolicited from HCA, submitted revised rates. We then presented the revised premiums at a subsequent Board Meeting. Ultimately the Board accepted the revised rates.

There was an extensive amount of conversation around this process. It highlighted for the agency the confusion the Board had around when the rates are final, what is the process, and how clear was it to everyone. To provide additional clarification and to lock down the timeline, we are proposing a resolution for action at a future meeting.

Slide 4 - Proposed Resolution SEBB 2020-03 – Rate Development Procedure. Beginning with the rate development process in 2020 (to set employee premium contributions for plan year 2021) and annual rate development processes thereafter, the SEB Board will not review or consider unsolicited revised rates after proposed employee premium contributions are published publicly by the Health Care Authority on its website.

I want to underscore that we have included the word “unsolicited” because there could be instances where the Board could direct us to go back to the carriers to solicit additional revisions to the rates. The resolution says you will not consider anything that is presented unsolicited. A similar proposed resolution will be introduced to the PEB Board, too, to help standardize Board processes.

Slide 5 – Next Steps. We are interested in your feedback. Is there anything you want us to consider? It will be sent out for stakeholdering and we will bring a recommended resolution to you at the March 5, 2020 Board Meeting.

Slide 6 – SEBB Plan Year 2021 RFR Process. For 2021, HCA will do a Request for Renewal (RFR). We will be renewing with the existing plans but we won't be opening up a procurement to additional new carriers. We will update the RFR language on the process and timelines for final premiums if the Board approves Proposed Resolution 2020-03. We will also be standardizing the bid rate process between the PEBB and SEBB Programs to provide for better comparison across the programs.

In terms of setting expectations, even with this resolution, if the Board were to go forward and adopt this resolution, or something similar to it, we would not necessarily anticipate in the RFR that we would delineate specific day dates, specific days in the process. We would still have a bid process lined out that would give expectations to the vendor community of the general timeline. As you can imagine, in a rate development process for something the size and complexity of the SEBB Program, there may be times when a run of the data model takes a few days longer than we anticipated, or something like that. We could easily end up falling off a procurement timeline for a few days. Again, to set expectations, we will clarify the steps in the process and the general timing of those steps, but you won't see us issue an RFR that delineates specific days for the vendor community.

Lou McDermott: Megan, I'm assuming if this resolution is passed, it will be clearly communicated with the carriers about what that means?

Megan Atkinson: Yes.

Pete Cutler: Just to reiterate a point that Lou just clarified, but under this proposal, what you're saying is it won't be like a procurement where you say, okay, on June 4, this step will be taken or decision made. And on June 30 this decision or whatever. The key factor in terms of this resolution will be at what point does the, in effect, impact

of the rates bid by the carriers become visible to the broad public because it shows up in terms of the premium rates that are proposed premium rates that are published publicly by the HCA. At that point, you say whatever date that is calendared on June or July, when that action takes place, that's when you lock it in.

I think that makes perfect sense because that goes to the key issue of transparency as opposed to just a calendar date. I think it's a great thing to take steps once you've figured out an area where you don't have clarity or transparency to try and do it. The only question I have is whether the carriers that we work with, is the idea that we would have feedback from them about what they think of this policy before we actually vote on it?

Megan Atkinson: We do anticipate doing stakeholdering with the proposed resolution. We can reach out to the carriers, absolutely.

Pete Cutler: Based on input, at least by the one carrier last year, we can imagine one carrier in theory will support this because it's consistent with what they said they thought they were working with. But as a Board member, I know there are certain advantages to that approach. If there are disadvantages, if some carrier can come forward and say for public policy reasons, for getting the best bang for your buck, here's what we propose as a different resolution, I'd like them to at least have the chance to suggest that. I just want to confirm they'd have a chance to comment before we actually vote.

Megan Atkinson: Ok.

Dawna Hansen-Murray: Obviously I wasn't on the Board when this happened.

Lou McDermott: You missed it. It was very exciting.

Dawna Hansen-Murray: No, I didn't. I watched it all unfold online. [laughter] It was the day they were posted that I showed all the rates to my daughter who wasn't married at the time because of insurance costs. So I will never forget that day.

Educational Service District (ESD) Report Discussion

Cade Walker, Special Assistant, ERB Division. Slide 2 – ESHB 2140: HCA ESD Report Legislative Charge. I've been asked to helm our report obligation. HCA must conduct a report on the ESDs and their employees. In consultation with OSPI, ESDs and OFM, HCA was instructed to conduct a study about the employee benefits in educational service districts and the impacts of the participation by the ESDs that are currently in either the SEBB or PEBB Program on their employees.

Our analysis is to include health benefit plans and their costs, health benefit comparisons between ESDs and the SEBB Program, estimated costs of ESD participation in the SEBB Program, and discussion on ESD funding mechanisms. ESDs were granted a reprieve for their non-represented employees to join the SEBB Program. Out of about 3,300 employees in the nine ESDs, approximately 300 of them are represented employees, that because of bargaining, were kept in the SEBB Program. The rest of the ESD employees are not mandated to participate in the SEBB Program until 2024, even though some of those employees are voluntarily in the PEBB Program as an employer group in PEBB. There are some ESD employees in the SEBB

Program, some in the PEBB Program, and some in neither. We will conduct a study to address those four points. The report is due to the Legislature December 31, 2020.

Slide 3 – HCA ESD Report Data Sets. We have been working with the ESDs through the Association of Educational Service Districts (AESD) on data sets. We've been in touch with them quite regularly and are working with them to refine the list of data we are collecting from them. We anticipate collecting demographic information on their employees, their current eligibility criteria, benefit plan information, and financial information. Those are the general buckets that we feel will be necessary for us to answer the question that the Legislature has posed for us to report on. We anticipate those data sources primarily coming from ESDs, who are working with WSIPC where appropriate.

We also have some of that information contained in house within the PEBB Program. We may go to OSPI for additional information, if necessary. As it is now, we are not currently working with OSPI for any data. We feel confident that between the other three stated sources, we will have the data necessary to answer the questions.

Slide 4 – ESD Report Working Timeline. We are in the second phase of our timeline, collecting data from the Educational Service Districts. We are currently on schedule!

Slide 5 – HCA ESD Report Next Steps. HCA has sent data specifications to the Association of Educational Service Districts (AESD). We're fielding questions and having a dialogue with them, making sure we are refining and honing in on those questions and responses, and answering their questions and concerns.

Data is due from the ESDs by the end of February. We feel that will give us adequate time for our finance team to do their analysis, provide the answers and the data the Legislature is looking for.

Lou McDermott: Is there a consideration that the next Legislature will have that report and they may modify that timeframe because they could only modify it to 2023? They are supposed to be in by 2024, correct?

Cade Walker: Yes. They currently said the entire population of ESDs are slated to come into the SEBB Program January 1, 2024.

Lou McDermott: Could the Legislature do something for 2022, depending on what they see in the data.

Cade Walker: Yes.

Pete Cutler: Am I right there's nine ESDs?

Cade Walker: That's correct.

Pete Cutler: Given that HCA has already tackled collecting data from 296 school districts, you should have this down.

Cade Walker: Yes and no. What we collected from the school districts wasn't the same level of demographic information. It wasn't the eligibility information. We were getting some experiential data for rate setting. I don't think we were getting the same level of detail we're asking from the ESDs.

Pete Cutler: I acknowledge it is a more detailed, and actually should be interesting for that reason in that the comparison should include enough different factors to be a little more informative. It's hard with school districts having so much variation to come up with a generalization that was both helpful, but not so overly broad, that you can't work with it. Have there been proposals in the current legislative session to exempt other current populations within the School Employees Benefits Board Program to exempt them out?

Cade Walker: I have not seen any proposal to exempt out any other organizations. If we consider the organization types that are currently in the SEBB Program, we really have three, school districts, Educational Service Districts, and charter schools. I haven't seen any legislation this year that would exempt out any one of those, or parts of those, entities. We have seen the eligibility where we're seeing some proposals on changing eligibility, removing eligibility for substitutes and the like, but nothing on an organization basis.

Pete Cutler: But in terms of which employers are SEBB Organizations and subsets, this has not so far turned into a, "Oh, if they can get out then maybe we can," at least in terms of proposed bills.

Cade Walker: I have not seen anything.

Dave Iseminger: No, Pete. I would just add illustrative is Oregon's experience. When they created the Oregon Employees Benefits Board (OEBB) Program, they had some school districts exempted. That was before the program implementation launched. So even in the OEBB Program, whenever there were school districts in Oregon that were allowed to continue under their own authority (unless they later went into the OEBB Program, in which they had to stay in the OEBB Program forever) that was all done before the program launched. Here it's launched, everybody's in, and I haven't heard any conversations.

Pete Cutler: Yeah, given the previous four years, that's great. Okay, thank you.

Dave Iseminger: Previous 34 years. [laughter]

Pete Cutler: 30 years ago, it was such a pipe dream, nobody bothered trying to get out of it.

Public Comment

Julie Salvi, Washington Education Association. I wanted to share some of the feedback we have been receiving since the last time we met, whether it's input on implementation areas or benefit levels. So lessons that we heard or learned from the implementation, educators want more opportunities to ask questions one on one, whether that is more Benefits Fairs, a phone line. There was high demand whenever anything like that was up. We would encourage the Board and HCA to continue to look

for more opportunities to do that, whether that's partnering with school districts or creating more HCA offered events.

We expect there's going to be a continued need for training out in school districts. Benefit Managers are still learning the system and they've learned a lot in the last six months. But we will also naturally have turnover out there. So I just think in the next few years we're going to have continued need for training.

With appeals, I realize this year's a unique year, but there is a great need for more feedback in the process. When someone sends an appeal in, even to get a recognition that it has been received, or some way for them to check status along the way, because we are hearing from a lot of educators right now who have a lot of angst because it's felt like it has gone into a void. And so as you can find ways to provide more feedback, that is helpful.

In terms of some of the benefits in the plans, coverage areas, we heard a lot early on when things first came out in the fall of educators in Clark County, Douglas County, Island, and other counties, where they felt like they didn't have as many benefit options as other areas. So the more we can look at finding more ways to get either more providers in those counties or more exemptions as has been discussed of more ways for someone to choose based on where they work and where they live, those will all be beneficial.

As was mentioned before, some of the networks were more narrow, so both better publication of the networks and negotiations to expand those networks would all be appreciated.

Working towards payroll deduction for all benefits. A lot of educators were surprised, even this January, when not everything they signed up for was going to be payroll deduction. Some of these are direct pay. I recognize you had a lot to do to get this up and running and these are things we can improve on over time, but those are the things we are hearing.

In terms of benefit levels, dental, as you talked about today, is clearly an area where we're getting a lot of concern of it feels to educators that benefit level is not where it had been before. Same with vision and prescription drugs are key areas where we are hearing questions and concerns.

As you know, long-term disability feels too low and we would like an increase in that. Also, the take up rate wasn't very large and you talked about that today. I honestly don't know what is possible in the world of long-term disability. But some of it was sticker shock of what it would take for a person to buy into long-term disability. So if there are ways to find that they could either buy a lower percentage level, or not have as much of their salary counted, or some way to tier that, again, I don't know what is possible but there may be more take up rates if it could be sized differently.

And I have to say that many of our members are still wanting the dual enrollment options they had before, as Alison had mentioned, you are hearing that, we are hearing that. For those members, it is feeling like a takeaway, especially in dental and vision.

And then finally, I just need to say in terms of some of these optional benefits that were discussed today, I appreciate the discussion that happened at the Board. And educators just do not understand why a financial tool that they are choosing to buy with their own money for protection for themselves, whether they've had cancer in their families or seen a friend go in a hospital, they want access to buy that. It is not something the districts are supporting with their money but something that educators want to spend their money on and they don't see the link terms of the basic medical that you get here and a financial protection tool they may want for themselves. So we appreciate that the Board is continuing to look at that and asking for more questions and more detail. Thank you.

Fred Yancey, School Administrators and School Retirees. First of all, again, thank you for all your hard work and certainly thank the agency for being unique among state agencies in terms of launching a very successful computer driven program. It's probably set a state record in my brief history with the state. Anyway, congratulations to all the hard work and you should be justly proud of that.

On a retiree issue, I'll just point this out, that retirees are a little confused and need a little clearer guidance. I've gotten some recently, which I'm sharing with retirees about what happens when a retiree hits the 630 hours. Do they stay in Medicare? Do they opt out? Do they move into the SEBB? And then the process that they have to do to maintain eligibility in whichever route they go. They just need clear guidance and thanks to Ms. Scott who gave me some. I'm sharing that.

I would like to see, and I'm glad that more information is coming, Julie alluded to it in terms of a district cost. You know, we've seen enrollment numbers, how many are in the program. But we've not seen the cost to school districts for implementing this program. The Ways and Means Committee had a hearing the other day on these bills that Mr. Walker walked you through. It was the first time those committee members actually heard cost figures from school districts as to how much out-of-pocket this is actually costing them. You just need to know the data. That's all.

I would love to see Health Care Authority do a study just like they're doing for ESD, developing specifications, requesting information from districts, in this case ESDs and then sharing it with the Board. I'm pleased to see that at least there's going to be more follow-up on that issue.

The last item I'll speak to is as school administrators and school business officials, this optional benefit issue really needs to be discussed in much more detail. I have looked and when the handout Slide 5 says the SEBB Program is authorized to offer the following benefits: health care coverage including all forms. I don't see the word "all forms" in the RCW at all. It's one thing, you know, to offer the following benefits: medical, dental, vision, and prescription. But the term "all forms" certainly opens up much broader -- I looked at the RCW and didn't see the word "all forms" in there. That's an interpretation in my opinion of the Health Care Authority. And I'm pleased to see that we're going to study that more because it really is an issue.

The bill before the Legislature, which is 2548 or 6479, basically says districts should be allowed to offer any benefits that Health Care Authority's not currently offering. It's probably too simple to understand but it's certainly the right approach because again,

these are employee-paid benefits for their own protection. Julie mentioned the cancer one. You can see the benefit of that. Why would you take that away from somebody? Because you want to hoard your power to be the sole offerer when you don't have it. That's not right. It just isn't. So I'm pleased to see you study that more. That's all I have to say and I thank you very much for your time.

Preview of March 5, 2020 SEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the March 5, 2020 Board Meeting.

Next Meeting

March 5, 2020

9:00 a.m. – 12:15 p.m.

Meeting adjourned at 3:06 p.m.

School Employees Benefits Board
Meeting Minutes

March 5, 2020
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 12:30 p.m.

Members Present

Pete Cutler
Dawna Hansen-Murray
Terri House
Dan Gossett
Wayne Leonard
Kari Karch, Chair Pro Tem

Member via Phone

Alison Poulsen

Member Absent

Katy Henry

SEB Board Counsel

Katy Hatfield

Call to Order

Kari Karch, Chair Pro-Tem, and HCA Director for Planning and Performance, called the meeting to order at 9:02 a.m. Sufficient members were present to allow a quorum. Board self-introductions followed.

Meeting Overview

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda and an update on COVID-19.

HCA is working with many other agencies and at the direction and coordination with the Governor's Office regarding COVID-19. We have regular communications throughout the day. For the SEBB Program, I want to highlight a few actions already in place or in the works.

First, our carriers have been sending communications to members and posting information on their member-facing websites with the general public health information the Department of Health has been encouraging all state agencies and their vendors to promote.

Second, regarding prescriptions, Premera, Regence, and Moda for UMP have already lifted their refill too soon limits on prescription drugs. Members will be able to get their next medication refills for many of their prescriptions even if they are a little further out than the typical 14-day stop that currently exists. Kaiser Northwest and Kaiser Washington are in the process of implementing a one-time refill that would override the same refill too soon limit. Many of their enrollees are currently accessing 90-day prescriptions as part of their standard benefit through a mail-order process. All of these refill limit exceptions exclude controlled substances like opioids. It's for general medications.

Third, we are working on adding public health information about the COVID-19 virus within SmartHealth activity tiles so people are encouraged and can get points for learning about how to wash their hands and many other important things that are public health messages.

Last, we have been consulting with the Legislature about impacts with PEBB and SEBB Program eligibility. In the PEBB Program, there is an eight-hour maintenance rule to maintain the employer contribution for benefits, but there is no comparable type of setting in the SEBB Program. There is a question about potential long-term school closures and would that result in an anticipated to work schedule requirement change. What would happen with benefits for impacted employees?

Depending on those discussions, if there is something we feel is within your purview that isn't acted on by the Legislature, you may be hearing from me to talk about any needs for this Board to act sooner than April 5, 2020, your next meeting.

We continue our agency coordination with the Governor's Office during this evolving situation. We have provided you with key websites that are a good source of truth documentation. The Department of Health for the state is a very good place to go for high-quality information about the current status of affairs within our state.

Approval of August 29, 2019 Meeting Minutes

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

Follow Up from January 27, 2020 Meeting

Dave Iseminger, Director, ERB Division. When Marcia Peterson had her annual benefits planning cycle discussion, a variety of ideas came up that could be considered in the next upcoming annual procurement with the medical carriers. We have not released that procurement document yet. In the document, we address or make requests related to service area expansions and network issues. Those topics are included within the draft procurement documents. Other follow-up areas will be addressed in today's presentations.

Legislative Update: 2020 Supplemental Budget

Tanya Deuel, ERB Finance Manager, Financial Services Division. Today I have updates from both the Senate and the House. I hope to have final numbers to share at the next Board Meeting.

To follow-up on an item for Pete, you asked about the underlying Uniform Medical Plan (UMP) trend assumptions. I confirmed verbally last Board Meeting that the trends for SEBB Program UMP are based on the PEBB Program trend updates. I want to confirm that yes, there was a positive impact on trends, around 1%, from Fall 2018 to Fall 2019.

Slide 2 – Proposed Funding Rates. I want to emphasize the bottom two boxes – adequate to maintain current level benefits and no significant concerns with funding rates and underlying assumptions. The funding rate is per employee per month.

Slide 3 – SEBB Funding Rate. The Governor's Proposal are the numbers shared with you in January. For the Governor's, Senate's, and House's proposals all have \$994 as the funding rate for the first six months of the program for fiscal year one. I mentioned in January they're looking at switching to a school year funding basis in the future versus a state fiscal year. For the next two months (July and August 2020), the funding rate is \$1,056 for all three proposals.

For School Year 2020 – 2021, the Governor's proposed budget has a \$1,029 funding rate. The change from \$1,056 to \$1,029 is partly due to a huge change in the waiver assumption from the original model. Originally, the calculation was around 8%, based on the PEBB Program. After open enrollment, the waiver calculation was a little over 13%. Also, there was increased enrollment in the self-insured plans from the original projections. That led to the \$1,029 funding rate decrease in the Governor's proposal.

The Senate proposed budget reduced the funding rate to \$1,014 for School Year 2020 – 2021, and the House proposed budget reduced the funding rate is \$1,000. Underlying changes can be made at the Legislature's discretion on how much risk to put on the program, how aggressive they want to be in their underlying trend assumptions, or how they fund certain items, reserve balances being one of them. Those were the main differences between the Senate and the House proposals.

There were no reductions in benefits. It's the underlying assumptions the Legislature takes that were different from how the Governor's budget made those assumptions.

Dave Iseminger: Another important piece from the state budget perspective at the Legislature is they have to do a four-year outlook. They often have to book very similar numbers for the outlook years similar to what occurs at the end of the biennium. If, for example, they want to be more aggressive or less aggressive on the reserve build up, if they build up all the reserves with the funding rate in the first year, that same funding rate may end up having to be used throughout the four-year outlook. They might choose to be more aggressive at different points in the biennium based on what they need to do for four-year outlook purposes. For more context, a school district may say if \$1,029 and \$1,000 are the same, I prefer the \$1,000. But it does come with different levels of risk the Legislature is willing to take on.

Pete Cutler: Are there other elements that come to mind in terms other than differences in building the reserves?

Tanya Deuel: The differences between the Senate and the House, as opposed to the Governor's budget, was how they funded the Premium Stabilization Reserve (PSR). The PSR Account we keep for our self-insured plans. For medical, the target is 7% of

projected claims and for dental the target is 4%. Both of those versions were phased in. It's building it up slowly versus funding it all in the first year of the program. The House did reduce the trend assumptions in the self-insured plan. Those were the two things outside of the surplus level. A couple smaller things change the funding rate because for every decision package they fund, or additional dollars they give us, that also impacts the funding rate. I will give you an example on the next slide.

Pete Cutler: One more question. Can you remind us why we had a bump for the months of July and August of 2020 in the rate? Just logically, it seems a little confusing to go from \$994, bump up to \$1,056, and then drop back down. I'm sure there's a reason for it but it just seems a little strange.

Dave Iseminger: The \$1,056 was part of the original March 2019 modeling that was provided. In the original budget passed last year, it was \$994 and \$1,056. They parsed out \$1,056 for the two months of July 2020, August 2020, and then foreshadowed that they were going to move to a school year. Since the state is on a fiscal year, benefits are on a calendar year, and they're moving the funding on a school year. One of the things as you look at the overall fiscal year funding, it helps smooth out by giving more in the two months of July and August and smoothing out with the transition to the school fiscal year.

Pete Cutler: So a primary motive of was to smooth out the funding rate going forward?

Dave Iseminger: That is part of it.

Megan Atkinson, Chief Financial Officer. Once the Legislature authorizes a funding rate that goes into a school year, they typically don't make changes because the school districts have already made contracting decisions based on that funding rate. To Dave's point, as we balance now across three years (calendar years, state fiscal years, state school year) you're going to have hangover months, July and August months.

Pete Cutler: Thank you.

Tanya Deuel: I'm sorry. I misunderstood your question. I thought you were asking why it jumped from \$994 to \$1,056. I can tell you those periods were blended when they were given to the school districts, the \$994 and the \$1,056.

Wayne Leonard: We as a Board aren't familiar with the modeling you do and this is a new program. All we've seen is what these monthly rates are going to be. At some point in the future as our plan matures, are we going to get a financial report on how our plan is doing? What are our reserves? I'm used to seeing more of a financial report, revenues, claims, expenditures, those kind of things.

Tanya Deuel: Traditionally, we haven't done that level of detail with the PEB Board so I think we'd want to take that back and figure out the best way to provide that information. That's something we can look at.

Wayne Leonard: Okay.

Tanya Deuel: Slide 4 – Proposed Budget Similarities. These are three similar items within the Governor’s, House’s, and Senate’s proposed budgets. I spoke about the audit capabilities in January. As a reminder, this is FTEs for one year to audit the PEBB and SEBB Programs. All three budgets included \$234,000.

The next item is the K-12 Non-Medicare risk pool, also described in January. These are one-time funds to implement the changes of the Non-Medicare retirees currently in the PEBB Program. HCA will work to keep them in the SEBB Program. The \$15,000 shown is not enough to implement that change, but I think it signals we can go ahead with those changes as long as HCA can absorb it within our current budget.

The third item is the Third Party Administrator (TPA) fees. These are the fees we pay Regence and Moda to administer our self-insured plans. There was higher enrollment in our self-insured plans than originally projected and this is the spending authority to align with that increased expenditure.

Pete Cutler: Are the \$234,000 and \$15,000 increasing your appropriated funds?

Tanya Deuel: The \$234,000 is increasing the appropriated administrative account. The \$15,000 is one-time funding. The TPA fees are in a non-appropriated allotted account.

Pete Cutler: That’s the same structure they’ve had for a while?

Tanya Deuel: Yes.

Slide 5 – Proposed Budget Difference. The differences between the three versions of budgets are reflected on this slide. The first one is the diabetes Request for Information (RFI). HCA requested funding to complete an RFI to look at the market and decide if there’s a diabetes management vendor available. There is currently a Diabetes Prevention Program, but not a Diabetes Management Program. This is half of the funding received. The other half is in the PEBB Program. We actually received \$150,000 in the Governor’s and the House’s budget. The Senate did not fund this decision package.

ESSB 6189 is funding to implement prohibiting dual enrollment between the PEBB and the SEBB Programs. This is IT funding to allow our system to manage this effort.

Dave Iseminger: Tanya, there’s a mistake on Slide 5. The funding was in the Senate’s budget, not the House’s budget. It was a Senate bill that passed.

Tanya Deuel: This is what happens when the budget comes out on Monday and your slides are due Monday. I’ll get that fixed.

Dave Iseminger: For the record, the \$1.7 million listed on the House budget is actually in the Senate budget. Usually when a bill is passed in either chamber, often it will be funded in that chamber’s budget as the debate about that bill goes forward. Just draw an arrow up. The money was in the Senate budget.

Pete Cutler: Can I confirm that most of that \$1.7 million is for information technology work?

Tanya Deuel: Correct.

Legislative Update: Bills

Cade Walker, Executive Special Assistant, ERB Division. Slide 2 – Number of 2020 Bills Analyzed by ERB Division, shows the amount of work done to date. Analysts in the ERB Division have completed 252 analyses as of last week. It's actually in the mid-280s as of this week. As things come to a close, we continue to work diligently at legislation that's been proposed to determine if there are potential impacts to the Division, the agency, or the PEBB and SEBB Program members we serve.

Slide 3 – Legislative Update – ERB High Lead Bill. This slide shows the progress of where these bills are in the process. As a reminder the high impact bills are those with a fiscal impact of more than \$50,000, would cause a change in rules, or is something to keep an eye on due to the impact it has to either the PEBB or SEBB populations, or to the programs. There is a cutoff tomorrow. As of yesterday, the two bills listed under the opposite chamber fiscal have moved to rules.

If bills haven't passed the March 6, 2020 cutoff by tomorrow, unless they are necessary to implement the budget, would likely be dead for this session and not moving forward.

Slide 4 – SEBB Program Impact Bills. On the next two slides, you will see some bills with a strike through and some that are not. The strike through is when a bill dies in committee or hasn't progressed far enough. House Bill 2208/Senate Bill 6144, the implementation credit bill, has not moved out of the last committee by the necessary cutoff date.

House Bill 2458/Senate Bill 6479, regarding optional benefits offered by school districts, made it to the opposite house rules committee. We expect to see action on that before the end of session. It has changed substantially since the last time we spoke in January. I presented on the work the program had done regarding the school districts coming in and providing information on their optional benefits. You will hear more about this bill at a future meeting. It is still evolving. As the bill stands now, the current version of the legislation confirms that the optional benefits offered by school districts are not to compete with the SEB Board offering benefits, or any other benefit offered by the Health Care Authority under our salary reduction plan. If this bill passes, the Board has the authority to study and consider offering new benefits, including emergency transportation, identity protection, legal aid, long-term care insurance, non-commercial personal automobile insurance, personal homeowners or renters insurance, pet insurance, specified disease or illness triggered fixed payment insurance, travel insurance, and VEBA accounts. The Board can request information to consider offering those as supplemental benefits in the SEBB Program portfolio.

Dave Iseminger: People have asked if this bill means HCA and the SEB Board have a project. No. This bill, if passed in its current form, would reserve the right to look at these benefits at a future date. There are still a lot of things to stabilize with the program launch. Unless you specifically had an interest in doing a specific benefit immediately, we would be talking about a long-term plan for evaluating new benefits.

School districts would be able to offer, in the interim, anything on the enumerated list until a point at which the Board offers that benefit.

Cade Walker: The bill has a directive to the districts to work with Health Care Authority if a competing benefit is identified as being offered by a district. The carrier of that benefit and the district are to work with the Health Care Authority to resolve the conflict, by either revising what's being offered, or removing it from the district's offering. We will see if it moves into the Rules Committee before the cutoff.

Slide 5 – SEBB Program Impact Bills – Eligibility. Senate Bills 6290 and 6296 and House Bill 2771 have died in Committee. As Tanya eluded to earlier, Engrossed Substitute Senate Bill 6189 is still alive requesting two studies be done. The first study is by the Joint Legislative Audit and Report Committee (JLARC), in conjunction with, and with assistance by, the Office of the Superintendent of Public Instruction and the Health Care Authority. The study has three primary parts: to study the number of employees who worked full-time, or less than full-time, during the 2018-2019 and 2019-2020 school years, identifying hours worked, how many of those employees were eligible for the employer contribution, and the amount of the employer contribution provided to those employees, breaking it down by major job category.

Other legislation we saw looked at particular types of categories, whether it was substitutes, coaches, job shares. This version of the report wants a breakdown of all the employee types, part-time versus full-time, and what the contributions look like. In addition, they are to report on the split between certificated and classified employees, the number of employees who waived by school district, as well as what the funding for the certificated and classified employees are from the state to the districts. It's a more comprehensive study being requested by the Legislature. The report is due September 2021.

A second study in ESSB 6189 is an HCA study our finance team will prepare, which is due September 2021. The study will consider the effect of waiving, putting forth options that would include a variable rate for employees who waive medical coverage, and consider the effects of allowing members to waive all benefits, not just medical benefits. Currently, employees who have other eligible coverage are allowed to waive their medical coverage, but they must take dental, vision, basic life, and basic LTD benefits. What is the financial impact? Are there other options?

The last part of the bill is the prohibition on dual enrollment between the PEBB and SEBB Programs. This Board and the PEB Board have adopted resolutions saying you cannot enroll in SEBB-SEBB Program dual coverage or PEBB-PEBB Program dual coverage, meaning if you and a spouse are both eligible to receive an employer contribution under the SEBB Program or the PEBB Program, you are not allowed to cross over and have dual enrollment in the same benefits.

Pete Cutler: On that last point, first you had two studies being done on ESSB 6189. The third issue in terms of prohibiting dual enrollment between SEBB and PEBB Programs, it sounds like you're saying the bill would actually put into statute basically a prohibition of that dual enrollment.

Dave Iseminger: That's correct. The implementation timeline of the bill for the prohibition is January 2022. It would codify in statute that dual enrollment is prohibited. We talk about it as PEBB-SEBB Program dual enrollment because that's the piece that currently is allowed. It would also put sacrosanct in statute that SEBB-SEBB and PEBB-PEBB dual enrollment prohibition because it says enrollment is limited to one of medical/dental/vision in either program. This Board has already done SEBB-SEBB Program dual enrollment. The PEB Board has already done PEBB-PEBB. The last piece to do, as a result of this, would be PEBB-SEBB. There wouldn't be the ability for this Board to repeal SEBB-SEBB dual enrollment because the statute will have codified that type of dual enrollment prohibition as well.

We anticipate as we go forward there may be policy changes that either one or both Boards need to make. For example, your policy on waiving benefits only includes medical. As we evaluate how to create a world in which dental is waivable, there would at least need to be some action to refresh that resolution to say dental and vision are waivable. There may be actions along the way that are needed in order to implement. It's more complicated every time we look at it. There was a general understanding it couldn't be done until 2022.

Pete Cutler: Thank you. In theory, within a week, we'll know whether this bill passed and in what form. At our April meeting we should have specifics. Is the fiscal note for this new version of the bill lower than the original one that involved all the IT work?

Dave Iseminger: No. The fiscal note for the substitute striker is \$300,000 more than the original bill. The first two parts transferred from implementing changes to eligibility on substitutes and changing the waiver rate. We have to package data to give to JLARC, or do our own study, so actuarial dollars were added to the fiscal note. I believe the original fiscal note was \$3.7 million and now it's \$4.0 million.

One other thing about the waiver provision study. Another piece of that is a good educational opportunity for anybody who picks up legislative reports on the website. As we've tried to describe, we know that the funding mechanism in the SEBB Program is very different than what was used before the SEBB Program. There's been a lot of frustration or questions from school districts asking why they pay for somebody who doesn't want benefits. It's not that simple. The funding rate represents the *average* individual within the population, not the *actual* individual the funding rate is being paid for. It's not that the funding rate amount attributable to medical for the person who waives medical isn't being used. It's funding mechanism used to fund the entire population. If an employer didn't pay for waivers, they would be shorting the overall program fund and creating a bigger deficit position year over year.

In the PEBB Program years ago, there was concern from the Legislature that there might be incentives or barriers to electing or encouraging waiving of coverage. That is partly why the model was set up the way it was in the PEBB Program - to prevent incentives or disincentives for individuals being encouraged or discouraged from taking on coverage. I told the Legislature in the Senate Ways and Means Committee to think of the funding rate as a big formula. $X+Y=\$2 \text{ billion}$. The variables can change. If you put upward pressure on X then you have to put equal and opposite pressure on Y because the end is a fixed number you're working towards. The money comes from somewhere and this report would be about different ways of creating a funding rate to

solve the same ultimate math problem to fund the projected needs of the program. It's a great opportunity to also dig into one of the most complicated topics in a report within the PEBB and SEBB Programs.

Cade Walker: Slide 6 – Topical Areas of Introduced Legislation. Topical areas that still have pieces of legislation moving through the process include provider and health care credentialing, a slew of bills related to pharmacy specific to diabetes medication, insulin, pharmacy tourism, pharmacy importation, several bills on substance use disorder, as well as bills on expanded durable medical equipment coverage, specifically related to hearing aids, prosthetics, and orthotics. We'll continue to track those and provide a conclusion at our April meeting.

Dave Iseminger: There was one more question I wanted to answer from last month. Pete, you asked in the implementation credit bill, House Bill 2208, if the carriers supported it. I confirmed that none of the carriers testified during the hearing so I can't say whether they support it or not. None of them testified and the House didn't have a hearing on the bill. No one is on record from the carrier community related to that bill.

Robert's Rules of Order - Parliamentary Procedure

Michael Tunick, Assistant Attorney General. Michael provided an overview of parliamentary procedures. He reviewed meeting basics, motions, debate, amendments, voting, and types of motions.

Slide 3 – Parliamentary Procedure. The general principles are one subject at a time, every subject is fully debated, rights are equal for every other Board Member, majority rule, and respect.

Slide 4 – Authorities Governing the Board. Other authorities may take precedence over Robert's Rules. Those authorities include laws like the Open Public Meetings Act, Ethics in Public Service Act, and laws specific to the Board. Board by-laws set forth various procedures, then Robert's Rules of Order apply, and finally, customs or practices of the Board.

Slide 5 – Informal Procedures in Small Boards. With small boards, like the PEB Board and SEB Board, more informal procedures may be followed.

Slide 6 – Meeting Basics addresses the presiding officer, quorum, agenda, minutes, and presentations.

Slide 7 – Motions, Debate, and Voting. There are six steps to motion practice. They are motion is made, seconded, Chair states the question, debate, Chair puts the question, and Chair announces the result.

Dave Iseminger: I just want to add there are no requirements related to minutes. They can be as robust or as minimal to convey the significant actions. But as this Board knows, we take a very expanded view of the significant actions taken, including most comments said by virtually anybody who says anything on a microphone. That's a custom and practice, not a written rule required either by the OPMA, Robert's Rules, or anything else. You may notice we have a relaxed aspect with the agenda. Sometimes

we run ahead. We're always very cognizant about where we told the public things were going to be discussed and try not to get too far astray from timing aspects.

Michael Tunick: Slide 8 - Motion Practice. The Board's business is conducted by motion. There are six steps to motion practice.

Slides 9 – 13 – Motion to Amend. These slides walk us through how to amend a motion.

Slide 14 – Other Secondary Motions. There are four other types of secondary motions. Lay on table, take from table, point of order, and parliamentary inquiry.

Pete Cutler: Michael, thank you very much. I do agree that a 15-page summary is more helpful than the 700-page version of the rules. On page 14, if you raise a point of order, is that something the Chair makes a decision on? Who decides?

Michael Tunick: The Chair decides.

Pete Cutler: And on the parliamentary inquiry? Does the Chair provide the answer or information, or does that go to the Assistant Attorney?

Michael Tunick: It goes to the Chair though the Chair often will consult with his or her parliamentarian. It may be that ultimately Katy provides insight to the Chair, but it will come from the Chair.

Wayne Leonard: I have a quick question on voting. I think we've typically done our resolutions by roll call vote. Is there any requirement that other votes would be by roll call, or are they by consensus, or is that up to the parliamentarian, the Chair also?

Michael Tunick: Yes. There are various acceptable ways. One of which is the voice vote I see here. There's no requirement otherwise. As far as the number of votes required for passage, that may change. Most of your votes are done by majority, whereas if you were trying to amend the by-laws, for example, that requires a 2/3 majority vote.

Dave Iseminger: Wayne, any time there is a consensus vote like we do for minutes, there's not a requirement to do it either way. If somebody wants a consensus vote, they can ask for one. I think it's called asking for "division." Or you can ask for a roll call vote in lieu of a consensus vote. You'll see that happen on various amendments.

Wayne Leonard: But it's not a requirement for our resolutions for a roll call vote.

Dave Iseminger: Correct.

Michael Tunick: I will add there is no secret voting. That's in the Open Public Meetings Act.

BREAK

HCA Legislative Report on Consolidating PEBB and SEBB Programs

Marcia Peterson, Manager, Benefit Strategy and Design Section, ERB Division. The Health Care Authority was assigned in 2019 to produce a report for the Legislature. There is no action required by the Board, but we would like your input.

Slides 2 - 4 – Legislative Charge. HCA must study the potential cost savings and improved efficiencies in providing insurance benefits to employers and employees participating in the PEB Board and SEB Board systems that could be gained by consolidating the systems.

The consolidation options studied must maintain separate risk pools for Medicare eligible and Non-Medicare eligible employees and retirees. They must assume a consolidation date of January 1, 2022 and incorporate the experiences gained by the Health Care Authority during the initial implementation and operation of the School Employees Benefits Board Program. The study must be completed by November 15, 2020.

Slide 5 – 2019 – 2020 Timeline. The process has begun. Last fall HCA began the discussion and started talking about and evaluating what some of the program differences are between the PEBB and SEBB Programs. We are entering a phase of looking at the enrollment experience, now that we have that information, and beginning to develop a consolidation roadmap and different phases of how that might work. We'll prepare the draft report over the summer to submit in November.

Dave Iseminger: You might think that October to February is a long time for identifying and evaluating the programs, but there are many large differences between the programs. An example being an eight-hour maintenance rule in the PEBB Program and no maintenance rule in the SEBB Program. Another big example is SEBB Program eligibility reboots every fall. No such concept exists in the PEBB Program. Collective bargaining is bargaining a single flat dollar amount of a specific plan versus a tiered weighted average in the other program.

There are also many small differences catalogued, like the tier ratio. In the SEBB Program, the family tier is 3.0%. In the PEBB Program, it's 2.75%. There's also an additional \$10 at the spousal level that happens in PEBB.

There's an amazing number of differences between the programs, all of which have to be catalogued, identified, and talked about when and how consolidation of the various components could even happen. It's a very long exercise. Every day we think of something else that's different between the two programs.

Marcia Peterson: I try to emphasize and remember the study is about potential cost savings and improved efficiency. Not just how they are different. What would it take to combine them, but also is there any cost savings or efficiency by doing that? That's going to be the focus of what we do.

Slide 6 – Key External Events. As we map out the phases of how consolidation could work, there are a few things we need to take into consideration as they can impact how it rolls out. In other words, there are a number of constraints we need to keep in mind, like collective bargaining is going to occur in 2020, which impacts the 2022 and 2023

plan years. We also need to take into consideration the potential impact of the 2021 legislative session and the budget beginning in July 2021. The point of noting those constraints is there are certain things in the authority of the Board, certain things in the authority of the Legislature, and things the program has authority over. Going back to the consolidation deadline in the bill of 2022, there are many ways to do that. We'll be talking about how that might be phased in the report, providing different options. We will have to keep in mind this timeline and those constraints that we live under.

Slide 7 – Report Discussion Topics. Dave already mentioned some of these, but we will be studying plan offerings. There are some big differences, and in some instances, they're absolutely identical. We'll look at how premiums are calculated, the tier structures, invoicing cycles, and Board composition.

We are in the beginning phase of preparing this report. Our actuarial company, Milliman, is working with us to identify what those cost savings might be of different aspects of consolidation.

Dave Iseminger: Again, the directive to write the report doesn't define what consolidation means. Consolidation might mean different things to different people. We are talking about what a phased approach would be. What could we do by 2022? By 2023. What's already done? All of those different pieces in the discussion.

Several actions considered as consolidation would require a legislative act. For example, establishing a single board, which can only be initiated by the Legislature. As the individual sitting at the table to help present at all Board Meetings, it is one of the more inefficient areas of the two programs. We often have very similar conversations back to back. At some point, efficiencies are gained.

It's very hard on all of the managers. Connie and Katy Hatfield can attest to this. We are sitting and talking about the March, April, and May Board Meetings simultaneously for both Boards. We're often in a meeting and we constantly have to, at every meeting, orient ourselves as to what will have happened. You will even hear it sometimes in our presentations! When I was doing the agenda overview, I was thinking, "Didn't we have this discussion already?" I had to tell myself, "no, we originally thought we'd do it in January, but then it became March." It's very complicated to just keep straight the conversations that are had at the Board Meetings. It's definitely an area with some inefficiencies. Especially with the start-up of the program, there were big differences to be addressed. It's another area for thought.

Marcia Peterson: In some legislative reports, we provide a recommendation. For this report, we will not. We will simply report the findings.

Terri House: Will the Board see your study when you get ready to submit it?

Marcia Peterson: You will be able to see it at the same time the public does when it goes out on November 15, 2020.

Dave Iseminger: Terri, I'll consider that a request for it to be sent to the Board once it's sent out for public consumption.

SEBB Program Appeals Update

Mike Brown, Manager, Office of Legal Affairs Section. Going back to the 2016-2017 year, HCA started designing the appeals program for both the PEBB and SEBB Programs.

Slide 2 – SEBB Eligibility and Enrollment Appeals Steady State Process. A revised appeals process was implemented last year in the PEBB Program. The shift was from a 30-day platform to a 10-day platform. Some adjustments were made last year and this steady state process is ready for implementation this year for the SEBB Program.

The process starts with employees contacting their benefits administrators for most issues. Through that process, if they can't come to a resolution, the subscriber can appeal to the Health Care Authority.

Slide 3 - Transition to Steady State Appeals Processing. As of February 29, 2020, we started transitioning to this standard process for the SEBB Program, sending appeals we received directly at HCA back to the subscribers. They were instructed to contact their benefits administrators to work through the appeals process. That transition has worked very well. There has been a decline in appeals received at HCA. The benefits administrators are working those issues and then we expect to see fewer appeals coming back. We are pleased with the transition so far. The benefits administrators are to perform all of the duties they were trained to do and they continue to receive training on appeal-related activities. If the benefits administrators are unable to resolve an issue, subscribers can appeal to HCA.

Slide 4 –As of February 25, 2020, we have received 7,700 appeals. Of those, 1,250 came since February 18, 2020. The types of appeals we are receiving primarily are dependent verification, which is about 27.5%. Dental confusion with the dental plans is about 40%. All other subscriber issues have been 30%. Approximately 80% of the appeals have been fully adjudicated, keyed, and a confirmation letter sent to the subscriber. We are continuing that work now. Since we have shifted into the steady state appeals process, we no longer receive a high-volume of appeals so we're able to work through what's remaining at a quicker pace.

Dave Iseminger: Mike has described the steady state standard appeals process in rule. We took a different approach with the open enrollment appeals, in part because if you go through the WACs on the appeals process, you start your appeal where the original action was taken, which is generally by the employer. During open enrollment, the Health Care Authority stepped in and did about three-quarters of the dependent verification work. HCA wanted to avoid a scenario where appeals crisscrossed in several directions. HCA decided to directly complete the appeals for all dependent verifications related to the open enrollment time. The exception was made to move them up to the second level appeal at HCA for that bubble, which HCA is still managing. This slide is describing the open enrollment bubble that exists for appeals postmarked through February 29, 2020. After that date, it goes to the steady state that Mike described.

As of yesterday, HCA had about 8,350 appeals received related to that open enrollment bubble. That denominator should be stable at this point because there's very little coming in postmarked after February 29, 2020. February 18, 2020 was the benchmark

because after President's Day, we saw another bubble of about 400 or 500 appeals. Shortly thereafter, we started communicating the transition starting February 29, 2020. We anticipated HCA would have another wave come in once the communication went out about HCA no longer processing initial appeals after February 29, 2020. The bubble from President's Day on was about 1,600 to 1,700 appeals.

There is an uptick in dental appeals, around 3,000, or about 44% of appeals received. These are easy to process because we worked with Delta that the plan switch is from Delta Care, the Dental Maintenance Organization (DMO) Plan into the Preferred Provider Organization (PPO) Uniform Dental Plan (UDP). HCA is honoring and keying those appeals quickly and entering into the system.

Pete Cutler: On Slide 2 it mentions the benefit administrators unable to resolve, the subscriber has 30 days to appeal. Is there something that clearly documents when that 30-day period begins?

Mike Brown: The 30-days starts whenever the action is taken by either the SEBB Organization or HCA and a notice is provided to the individual.

Pete Cutler: I foresee situations where there will be vague conversations and the employee will feel like the employer doesn't think it rises to the level of being a formal appeal, and then things drag on.

Mike Brown: Our HCA forms force the issue. It requires the employer to provide a response on the form. Once the employee has that form, they are able to appeal to the Health Care Authority. Also, in that situation, if their employer hasn't responded, after 30-days, the employee can appeal directly to the Health Care Authority.

Pete Cutler: Okay, so the form or the email, there'll be some documentation they could point to.

Mike Brown: Yes. There are avenues for them.

Pete Cutler: On Slide 4, it says, "Three primary types of appeals," but the math adds up to 100%. Is it true 100% of the appeals received so far have been in one of those three categories?

Dave Iseminger: HCA put everything into one of those buckets, with one exception. There were approximately 40 to 50 Medical Flexible Spending Account (FSA) appeals, not accounted for here. Those have been handled, but not tracked in this volume because that's a direct interaction we have with the carrier. All other appeals are in those three categories.

Pete Cutler: I was expecting it to come out to 98% or 97%.

Katy Henry: When were the benefit administrators trained on the appeals process? Was it prior to the SEBB implementation or after?

Jesse Paulsboe, Outreach and Training Manger, ERB Division: Because the appeals process was evolving, training evolved with it. The initial training was in August and

September 2019. Once open enrollment was over, much of our training was one-on-one through FUZE and the phone where people asked questions and we were answering appeals questions on an individual basis. Once we decided to transition into more of a steady state, we initiated a webinar training on February 21, 2020.

Dave Iseminger: One of the reasons we wanted to have that training on February 21, 2020 is because we were about to turn the appeals keys over to the districts. We had been communicating that February 29, 2020 was the last day HCA would accept appeals postmarked with that date and moving the process back to the districts. We did that training on February 21, 2020 and then the functionality within SEBB My Account, which had been much more limited since open enrollment was redeployed. Benefits administrators had more functionality that was similar to, or in addition to, things they were able to do during the open enrollment period. Benefits administrators were extremely happy to have that ability within the system again.

Dave Iseminger: Since we are so far ahead of schedule on the agenda, while we wait for Marty to arrive, let's have Jesse Paulsboe present on stakeholder training.

Stakeholder Training Update

Jesse Paulsboe, Outreach and Training Manager, ERB Division. Slide 2 – Benefits Administrator Training: Pre-OE outlines the training already conducted. The initial training started in August 2019. With limited time to train prior to open enrollment, the primary goal was to provide a working knowledge of open enrollment related administrative responsibilities to ensure the SEBB Organizations could successfully assist their employees as they enrolled in SEBB Benefits. 99% of the SEBB Organizations had representatives attend these trainings across the state.

Slide 3 – Benefits Administrator Assistance: FUZE. The December 2019 - February 2020 timeframe focused on providing one-on-one assistance through FUZE, which is an online secure email correspondence program that allows the SEBB Organizations to securely communicate with Outreach and Training. The primary questions received were enrollment related discrepancy resolutions, SEBB My Account troubleshooting, and appeals related questions. Since November 1, 2019, we processed more than 10,000 unique messages in FUZE.

Dave Iseminger: Many of you have heard from school employees who were asking about the appeals volume, and from districts and benefits administrators related to FUZE. Our staffing model was not designed to address 10,000 FUZES at the same time. We recognize that was another challenge. We still have a pretty high volume of FUZES, somewhere between 500 to 600 at this point. We had yet to be under 600 January 1, 2020 until sometime this past week. We understand benefits administrators were very frustrated about the response time. Our standard response time is within one to three business days, but it was not uncommon, in the first couple of months in 2020, to take two to three weeks.

The original fiscal note developed for the SEBB Program was based on the PEBB Program staffing model. We did not account well at that time for the additional volume of issues that would come up in areas like FUZE. Over the last two months, we've been asking who in HCA has access to Pay1 and already understands it, and started pooling different resources creatively for a slew of different needs. I really appreciate parts of

this agency that traditionally have not helped with the PEBB and SEBB Program being able to provide resources, even if it's for a few days. HCA has received a lot of feedback from districts. We found the lowest volume time for calls and turned off the phones briefly so there's not an influx. Districts have generally appreciated this because then they get their FUZES answered.

So we will be working on a decision package to add to our staffing in those areas that are understaffed, such as FUZE responses. We're also looking to see if we can hire some non-permanent staff as we go forward asking for permanent staffing funding.

Jesse Paulsboe: As the SEBB Program continues to transition into a steady state, our strategy shifts back to external training. We will start with a series of webinars to address topics and issues benefits administrators are likely to experience as the SEBB Program moves forward. The training is currently under development and includes the event that we just had on February 21, 2020, which is the appeals process. Tomorrow we're scheduled to have a refresher on SEBB My Account. There have been a lot of updates in SEBB My Account and we want to go over those changes, and some of the new permissions the benefits administrators just received.

We will work on training about changes using special open enrollments. Now that people are making changes, adding, terminating, retirements, the upcoming summer break, we want to address these topics in the webinar. These webinars will also be recorded so they can be referenced at a later date.

Slide 5 – Benefits Administrator Training: Workshops. In the early June timeframe, we conclude the webinar series and focus on workshops. These workshops will be in-person events, hosted across the state similar to the initial training done in August – September 2019. However, these will be a four-hour training. In-person training allows our benefits administrators to interact directly with our training staff, as well as with the administrators from the neighboring districts. This in-person training is to focus on preparing them for the upcoming school year. The training environment will allow for collaborative discussions, sharing tips, techniques, and lessons learned. The dates for this training are still pending.

Due to COVID-19, our training schedule is uncertain. When the schedule stabilizes, I will provide that to the Board.

SEBB Program Implementation: Medical Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP)

Marty Thies, Account Manager, Portfolio Management and Monitoring Section, ERB Division. Today is to brief the Board on the SEBB Program Medical Flexible Spending Arrangement and Dependent Care Assistance Program benefits available to SEBB Program subscribers.

Slide 3 – Authority and Benefits. By statute RCW 41.05, the Health Care Authority is tasked with offering and implementing a salary reduction plan, making it possible for employees to reduce their salary through payroll deductions in order to participate in tax-advantaged accounts. For SEBB Program subscribers, two such benefits are available: the medical health care flexible spending arrangement (FSA), whereby

employees can deduct up to \$2,700 from their paychecks, for eligible out-of-pocket medical expenses.

The Dependent Care Assistance Program (DCAP) works the same way, but comes with a \$5,000 annual maximum election for eligible dependent care expenses.

Slide 4 – How a Medical FSA Works. For the FSA, employees annually elect a pre-tax amount to defer from their pay up to the limit set by the plan sponsor. On the first day of the plan year, the total amount of the annual election is available for use. Claims can be a debit card or submit a claim to the FSA administrator for reimbursement. Any unclaimed funds are forfeited to the plan sponsor if not used during the time period allowed. The SEBB Program allows up to another two and a half months into the next plan year to incur out-of-pocket costs and claim funds leftover from the previous year's FSA, per IRS rules. Any unspent dollars at the end of the grace period is forfeited.

Slide 6 – Dependent Care Assistance Program (DCAP). DCAP is similar to the Medical FSA except it covers eligible dependent care expenses up to \$5,000 a year. Unlike the Medical FSA, however, the total annual election amount is not available the first day of the plan year. Reimbursements of eligible expenses are limited by what has been contributed to date. There is no grace period in DCAP.

Slide 7 – Pros and Cons. For most people, the advantages outweigh the disadvantages of these arrangements as identified on this slide. Employees would owe less income tax but deferred earnings could be forfeited.

Slide 8 – FSA/DCAP Logistics. There are four stakeholders involved in the ongoing financial flows associated with the tax advantaged accounts: the employee; the administrator, Navia Benefit Solutions; the Health Care Authority; and the employers, the SEBB Organizations. During open enrollment, employees have the option to sign up for these accounts with Navia. The SEBB Organization sets up the payroll deductions for the year. As deferrals are drawn each pay period, they are sent to the appropriate account held by the Health Care Authority. Then employees incur costs, claim expenses with Navia. Navia bills the Health Care Authority, which reimburses Navia from the deductions in our account. On the backside, monthly, the Health Care Authority pays Navia a per-participant per month fee to cover administration, an amount that can be partially offset by annual forfeitures.

Slide 9 – SEBB Program Implementation. Implementation was fairly smooth but challenging. I can't understate the complexity of many of the moving parts, dealing with hundreds of organizations which maintained their own tax advantaged accounts for their employees, using different administrators with different portals, different timeframes, different 12-month plan years, and with divergent design elements like carryover, grace period, or neither. There was a lot of variety in the employees and employers HCA brought into a single benefit.

Communications were a huge part of this effort for both employees and employers because HCA is doing the payroll deductions. This included many publications, guides, emails, fact sheets, and Intercom articles. There was a booth in our Virtual Benefits Fair, and Navia had a table at all of the physical benefits fairs. HCA also presented two live webinars with a live Q&A, which were recorded and posted for employee access.

Slide 10 – Inaugural SEBB Program Enrollment: FSA. About 10,500 FSA accounts opened, totaling approximately \$16 million in deferrals for 2020. The average deferral was about \$1,500. At a 12% tax rate, this will save SEBB employees nearly \$2 million in income taxes, another \$1.2 million in FICA taxes, for a total of \$3.1 million in employee tax savings.

Slide 11 – Inaugural SEBB Program Enrollment: DCAP. Well over 1,600 accounts opened, totaling \$7 million deferred with an average \$4,200 deferral, for approximately \$1.4 million in employee tax savings.

Slide 12 – Inaugural SEBB Program Enrollment. The inaugural enrollment had 31 districts with 100 participants or more enrolled. Those 31 districts counted for over 60% of all accounts opened. The total savings based on \$23 million in deferred payroll, is \$4.5 million in total savings for SEBB Organization employees, another \$1.75 million in SEBB Organization FICA savings, for a total savings of almost \$6.3 million for SEBB Organizations and employees.

Slide 13 – 2020 Debrief After Open Enrollment. There were challenges. Communicating the benefit design, coordinating with hundreds of employer payrolls, and bringing everyone into a single program, all accomplished. For the SEBB Program, the 2019 inaugural enrollment focused on medical, dental, and vision. Supplemental benefits were not primary and HCA can emphasize supplemental benefits more next year.

HCA will continue to debrief open enrollment and identify needed emphases in communications for next fall. HCA is working through about 70 appeals.

Slide 14 – Going Forward. Navia has been our vendor since 2014, and the company is based in Renton. HCA completed a Request For Information where we interviewed a number of industry administrators to ask an array of issues we'll want to address in a possible future RFP for a new contract. Issues like marketing and communication strategies, how they would implement a large new client, system security, and rate calculations. After this RFI is completely processed, an RFP may follow.

Dave Iseminger: The current contract with Navia goes through December 31, 2021. I believe HCA can extend it for at least one more two-year increment. But we've had a lot of changes just in the benefits we manage under that contract. We also use the contract for the state's Compact of Free Association (COFA) Islander Program, and there's a debit card used there. HCA has utilized this contract for a variety of services in addition to FSA/DCAP. That's why we're going out for a Request for Information (RFI). The original procurement was long before the SEBB Program was even a glimmer in anyone's eyes. There's a natural tendency to go out for procurement when there are significant changes in the work being performed.

As HCA is looking at a possible new contract, we will be looking at the benefit design features and determining if there is anything warranted to change. When many school districts came on, some districts had carryover, some had grace periods, some had neither. Nobody had both because that's the one thing you can't do. I remember specifically going to some benefits fairs and that was the number one topic a few people

wanted to talk about - the loss of the rollover rule for FSA. If we go out for procurement, we'll look at that as a possible time to evaluate benefit design changes.

Marty Thies: And Navia Benefits Solutions did manage the FSA benefits for about 35 school districts prior to the implementation of the SEBB Program. About 70% of them had the carryover, as opposed to the grace period. That's what they were used to.

Pete Cutler: Given the complexity of the school district situation, the number of differences and the number of districts, I think it's quite impressive just to be able to get them all on the same platform. I'm curious how the take-up rates compare between SEBB employees and those, I don't know whether it would be the whole PEBB population or just the state employee population under the PEBB Program, that would be the comparable comparison group. Did you have a sense of how the numbers compare in terms of take-up?

Marty Thies: The PEBB Program is between 16,000 and 17,000 and the SEBB Program is between 10,000 and 11,000.

Dave Iseminger: The denominator of employees eligible in the SEBB Program is greater than the denominator in the PEBB Program. I have too many numbers in my head to say for sure what the denominator is. In the PEBB Program, it is state employees and higher education employees. The employer groups, about 16,000 employees combined, are not eligible to leverage the state's cafeteria plan. The employer groups can only contract with HCA for medical or the combination of medical, dental, life insurance, and LTD.

Also, the forfeiture that ultimately happens at the end of the plan year does go to the plan's sponsor, which here is the Health Care Authority. I want to make sure it's clear what those forfeitures are used for. We don't have any data yet about the possible forfeiture amounts for the SEBB Program, but I can tell you a little bit about the PEBB Program scenario. The forfeitures are used primarily in one of two ways. One is to offset plan costs throughout the year. In FSA, for example, with a prefunded amount that's available on the first day of the plan year, there are circumstances where an individual has claimed more than they've submitted at the point of year and they may lose or leave their employment. That is a risk taken on by the overall plan. The individual does not owe contributions after they have left their employment even if what they have incurred exceeds what they contributed. These are offsets that need to happen. That's the first place where the forfeiture is used.

The second is to buy down the monthly admin rate. HCA has never, in the PEBB Program, gotten to a point where we've bought down the full admin rate. What Navia has told us is we have a very low forfeiture rate, given the size of our population and participation. I believe the forfeiture rate is usually somewhere around 1% to 2% of total contributed funds. Their experience across their book of business is more like 5% to 7%. HCA actually does active communications to prevent forfeitures. The number of communications with that information increases during open enrollment and at the beginning of January during the grace period. At the end of March, Navia does those communications. HCA also does targeted communications to individuals who have even one penny left as we get into January through March. The newsletters go out and

the one sent out in winter has a call to spend down your FSA dollars. We do a lot of proactive communication to avoid forfeitures whenever possible.

Annual Rate Process and Resolution SEBB 2020-03

Tanya Deuel, ERB Finance Manager, Financial Services Division. Slide 2 – SEB Board Authority. This slide is included as a reminder of the SEB Board's authority as a reference.

Slide 3 – Resolution SEBB 2020-03 Rate Development Procedure. HCA did stakeholder this resolution, which included HCA's fully insured carriers.

Dave Iseminger: Stakeholder feedback was included in the email you received with your meeting materials.

Tanya Deuel: Two fully insured carriers had comments about the resolution. HCA is still exploring options of what can be done in the annual rate negotiation process, the annual RFR that goes out, and what further steps HCA can take during that process to help protect from what happened last year. We believe this resolution is not directly tied to what we can do in the RFR process. We recommend that we do move forward with this resolution. In addition, we received two other comments that were not from our carriers who supported us moving forward with this resolution.

Dave Iseminger: One of the carriers suggested other ways to approach the underlying concerns. HCA determined the proposed idea and this resolution are not mutually exclusive. The outcome of one doesn't determine the outcome of the other. Both are being evaluated for possible implementation and will continue to be evaluated for possible implementation regardless of the outcome of this resolution. We recognize that almost everybody sitting on the Board now, and on the phone, was here in July 2019 and may have a very heavy interest in getting the clarity on this piece now, while the agency evaluates and decides what can be done legally within the procurement documents for the suggestion received from the carriers.

Pete Cutler: I have to admit, I'm really confused. What I remember from reading the email was it's basically this resolution, but modified to tie it down even a little tighter in terms of at what point would the rates be considered final, for lack of a better generalization. I really don't get if this can be handled through the RFP process, even though we adopt a board policy or resolution. I'm confused about what significance the resolution has.

Dave Iseminger: I can address that. The proposal put forward by carriers is to have the best and final offer process within the bid rate submission exchanges that happen in May and June. Remember, we show all the carriers the UMP rates, which helps them judge how they're going to assess risk relative to UMP by seeing how we're assessing risk. We don't share the other carriers rates with each other. They know their own numbers, they know our number, but they don't know each other's number. Their idea is to see if there is a way to show everybody's cards at some point in the process, presumably near the end of that process, as part of a best and final offer process.

The point of this resolution is to address what happened last July. There was a lot of conversation about why we brought forward unsolicited bids received late in July during

the rate development process. The agency said the rate development process ends with the Board's authority acting on setting the premiums. Part of the question this resolution addresses is that once the materials are published with rate numbers, unless this Board or the agency asks for additional information, it is locked in from a public perspective. HCA felt we were in a bind as an agency with having information the Board could act on. We felt we had an obligation because the Board had not yet exercised its authority. But you as a Board can pass this resolution and say that once materials are published on HCA's website, that is the point at which "final becomes final" from a public perspective. There were lots of questions about when does final mean final. This would say, from a Board perspective, once it is out in the public view, we really aren't going to accept anything unless we ask for it.

Pete Cutler: Do we expect public testimony at some point today?

Kari Karch: Yes, after I read the resolution.

Resolution SEBB 2020-03 Rate Development Procedure

Resolved that, beginning with the rate development process in 2020 (to set employee premium contributions for plan year 2021) and annual rate development processes thereafter, the SEB Board will not review or consider unsolicited revised rates after proposed employee premium contributions are published publicly by the Health Care Authority on its website.

Katy Henry moved and Terri House seconded a motion to adopt.

Wayne Leonard: I think this resolution captures what we talked about last July, although I'm not sure about the summary at the beginning, that the rate development process isn't complete until we take action. We could still find ourselves in the same position of rejecting lower premiums for members if someone comes in and makes a revised proposal like last July. I guess I don't care as much about the resolution and people not being able to revise their rates as I care about there being a fair process. I don't want to be put in a position of rejecting lower rates by setting an artificial timeline. I want to ensure we have a fair process. Does that make sense?

Dave Iseminger: It does, Wayne. The difference I think the resolution would make, this year versus last year, is last year when the Health Care Authority received those unsolicited rates, we had them in our hand asking ourselves what we were going to do with them. Here, as a Board, you have the authority to curtail your own power, and set your own deadline. HCA would convey up front, do not send anything to us as of this date when we plan to publicly publish rates. If something is sent to HCA, we will not consider it, nor bring it to the Board because the Board or agency did not ask for it. There is no opportunity once rates are published to try to get lower.

Wayne Leonard: The bids I'm familiar with are when bids are due at 2:00 p.m. on Friday. Then they wouldn't necessarily be published on the website so they wouldn't necessarily be known by the other vendors. We will not accept a bid after 2:00 p.m. on Friday. There wouldn't be an opportunity then to submit revised rates because there wouldn't be published information about what's public.

Tanya Deuel: What we normally do in our process is set up multiple rounds of bid rate negotiations with the carriers. When we believe we've had significant conversation, we've gone through all the assumptions, we are generally ok with where the rates have landed, we give the carriers an email that states we are considering this round your final rates, and these are the rates we will be presenting to the Board. We let them know well in advance of them being published those are the final rates. There are a few weeks between when we get those final rates that we internally deem as final and when they're published, because we obviously have to make all the Board slides. We have to make multiple iterations of those rates, especially in the PEBB Program where we have all the non-Medicare and Medicare rates that go along with them. There is a period in that process where the carriers know what we are considering as the final round.

Dave Iseminger: HCA provided a lot of the email exchanges as part of the materials last July. We've learned there are ways for us to be even clearer in that language and the procurement language, which are process enhancements we are incorporating within the future state of the procurement process, in addition and independent of anything that happens with this resolution, or the idea proposed by the carrier. HCA tried hard to do that last year. We learned some lessons about language to refine that as well to be even clearer.

Sometimes between when we think rates are locked and when we get to the Board, things happen. I think it was three years ago, there was an instance where there was a pending court order that was going to drop any day for almost four months related to Hepatitis C coverage. In that instance, we ended up sharing a very complicated resolution with the PEB Board that said if X happens by August 10, the rates are Y. If X happens after August 10, the rates are Z because we had to have a point at which we knew final rates and couldn't account for that litigation risk any longer.

There could be a legislative act at the last minute and HCA has to go back and say, "there's this new thing that came up at the last minute that everybody needs to account for in their risk modeling and there might be a little revisit there." There is some flexibility in the system if things like that happen because June is a very busy month in odd calendar years.

Wayne Leonard: Thanks for that clarification.

Voting to Approve: 8

Voting No: 0

Kari Karch: Resolution SEBB 2020-03 passes.

Public Comment

I'm **Julie Salvi** representing the Washington Education Association. I wanted to give just a little feedback today on the SEBB/PEBB study that is going on and then talk a little bit about the legislative process. In terms of the study, I wanted to raise a caution that we are concerned about change fatigue right now in K-12 and that we would really recommend putting a pause on any expected changes. You put in a herculean effort. We just launched SEBB. We are still working out the kinks. There are enough significant differences between the program that any merger would not be simple. It

would be another upheaval in the land of K-12. We're still dealing with the mass of appeals that just came in. We really highly recommend that anything considered would be a longer period of time. I also hope that as the agency looks at this that they are documenting the efficiencies that are already in there between the programs. Many of the contracts are written where if one carrier is in SEBB they can be offered in PEBB and vice versa. So we think a lot of that maximizing of purchasing power has already occurred.

We recognize the administrative burden on the agency of having two boards, but we are hoping the agency will also look at other ways to create efficiency without merging boards, such as you could hold more dual meetings with the PEB Board and SEB Board to cover common topics and then have time for each board before and after to cover the individual items that are relevant to that board.

So today I'm here to just raise caution, and especially to talk to the board members who are living this in the K-12 world that we hope you continue to raise your voices and share your experience and ask questions about how this would happen. Because we have concerns about the very massive change that we just went through and putting us through that again, there's exhaustion in the field. And there are concerns about continual change out there. So thank you for your time with that.

In terms of the legislative session, which is coming to an end, I did want to let the Board know about one area that I am working as of this week, because as we all know, the world continues to change with the COVID outbreak. And so questions were being asked at the Legislature about eligibility, if schools are changing service delivery. And we were particularly concerned if there are significant school closures, and then a lot of waivers of days where certain staff may not have their hours made up, or if there are changes like we're seeing in Northshore where there are districts going to more online delivery, and what would that mean. We want to avoid having members lose benefits at a time of a health crisis. So we have been talking with legislators about some very narrow language that would be linked with the emergency declaration and related to school closures or changes in school operations related specifically to that emergency and the COVID outbreak that anyone who had benefits as of February 29, 2020 would be able to maintain those benefits.

And for Wayne, I will indicate we are also working with the Legislature to ensure that districts do not lose any money if there are enrollment number changes. We want to ensure that districts have sufficient resources and employees are not losing benefits because of unforeseen circumstances. I just wanted you to be aware of that. Time is short in the Legislature. I am hoping something like that will be added to one of the bills that are out there. If it is not, that may be something we bring to the Board at your next meeting. We may all know more about how school operations are affected by then. So thank you for your time.

Dave Iseminger: HCA has given some technical assistance on drafting possibilities for the pieces Julie was just referring to. I'll just say that if something doesn't happen legislatively and the world continues to evolve, as I said at the beginning on my COVID-19 references, you may be hearing from me. We'll see if April 5, 2020 is the appropriate timeline or if something more appropriate is in order. I wanted to be open and

transparent that we have provided technical writing assistance on the bill language Julie was referring to in her comments.

Pete Cutler: In response to Julie's comments about the SEBB/PEBB study, I think her point is well taken. I have to admit, since the collective bargaining statutes provide for funding rate to be set through basically sometime in 2023, that in my own mind is just another reason to not assume an implementation before that point. I sure hope that the Health Care Authority and the ERB Division will be including the employee representatives and the school district context in your fact finding and implementation kind of questions. I do think these concerns about change whiplash are good ones to get input on.

Mitch Thompson: My name is Mitch Thompson and I'm from Battle Ground Public Schools. Originally, I wasn't going to say anything to you guys but as usual, I just can't keep my mouth shut. So the first thing I want to say is I know the immense amount of work that's taken place and we really do appreciate everything that the Health Care Authority's done. They've done a great job. Do I think they could have done more? Yes. You know, when we talk about Outreach and Training, an hour-long session on taking on appeals is not enough because basically, it's here's the appeal timeline but not how do we deal with each type of situation. And one of the things as these sessions come up, we'd like to have the paper copies as well. You know, having a pdf and being able to click on the link rather than just seeing that there's a link in a presentation. And that's just a little bit of feedback for Outreach and Training. And I probably should've just talked to Jesse on his own.

From the employer standpoint, there's a lot that's being missed out there. There's a lot that's being put on our plates that we didn't have to deal with before. It really has become -- I've got a benefits coordinator and I've got a half-time benefits coordinator and then there's me. And before, I had 25% that I was dealing with them on a daily basis. And right now, it's over 100%. I'm putting in 10-, 12-hour days trying to balance statements, trying to figure out how to deal with the changes and the things that are coming in SEBB. So there is something to be said about waiting on making decisions. But the Legislature never waits.

And so the other thing is, I'm constantly looking for my cheese because it's constantly being moved. Change is inevitable and so as we find efficiencies and as we find better ways to do things, I would hope that we would do those. But thanks to Dave and his crew because it's a big undertaking and I wouldn't want to do it.

Preview of April 2, 2020 SEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the April 2, 2020 Board Meeting.

While we were in this meeting, the Insurance Commissioner issued an emergency declaration to require plans regulated by their jurisdiction to cover and waive copays and deductibles for COVID-19 testing. We will be working on the implementation of that order. There is at least one piece that needs to be sorted out with the IRS. You can't have first dollar coverage for certain things and have an IRS regulated qualified health plan for HSAs. We understand the Insurance Commissioner is talking with the IRS today and asking for guidance to come out along with other federal pieces. That

emergency order also requires early prescription refills. Good news, we're already doing that within our plans. And also suspending prior authorization for COVID-19 testing.

Those are things effective immediately for the plans regulated by the Insurance Commissioner. It does include everything in your portfolio except for the Uniform Medical Plan (UMP), but we traditionally align UMP with what happens on one side of the house with the other from a self-insured and fully insured standpoint. That order is effective through at least May 4, 2020. Those are emergency powers the Insurance Commissioner has in light of the Governor's declared state of emergency related to COVID-19.

Next Meeting

April 2, 2020

9:00 a.m. – 2:00 p.m.

Meeting adjourned at 11:37 a.m.

TAB 4



Prior Meeting Follow Up

Dave Iseminger, Director
Employees and Retirees Benefits (ERB) Division
July 23, 2020

July 16, 2020

“Supplemental Long-Term Disability (LTD) Benefit options” presentation

Replacement Slide 3

Three Types of Group Disability Coverage

Short-term covers an employee's salary

- During a short-term disability
- Prevents the employee from being able to work ***their usual job***
- Includes events such as a pregnancy, accidental injuries, and illnesses
- Replaced by the Washington State Paid Family and Medical Leave Program – 12 weeks off with pay

Long-term covers an employee's salary

- During a longer-term disability
- Employee is unable to perform ***with reasonable continuity*** the duties of their job
- Sickness, injury, or pregnancy, after the benefit waiting period (usually 90 days), through the employee's Maximum Benefit Period (which is specific to each claim)

Current Supplemental LTD Premium Insights

Long Term Disability Age-Banded Rates

| Age | Rate |
|----------|--------|
| Under 30 | 0.0014 |
| 30-34 | 0.0019 |
| 35-39 | 0.0029 |
| 40-44 | 0.0041 |
| 45-49 | 0.0056 |
| 50-54 | 0.0077 |
| 55-59 | 0.0093 |
| 60-64 | 0.0096 |
| 65+ | 0.0098 |

LTD Premium Calculation Example #1

Take your monthly earnings and multiply by the rate for your age band:

If you earn \$1,000 a month and are 40-44, your premium be \$4.10 per month.

| | |
|------------------------|-------------------|
| Earnings | \$1,000 per month |
| Age Band | 40-44 (\$0.0041) |
| Monthly Premium | \$4.10 |

LTD Premium Calculation Example #2

- Roy, a bus driver, earns \$29,454 a year. He is 37 years old, so his premium rate is 0.0029.

$\$29,454 \div 12 \text{ months} = \$2,454.50 \text{ monthly salary}$

$\$2,454.50 \times 0.0029 = \$7.12 \text{ monthly premium}$

TAB 5



Vision Benefit Design Resolution

Lauren Johnston
SEBB Program Procurement Manager
Employees and Retirees Benefits (ERB) Division
July 23, 2020

Resolution SEBB 2020-11

Davis Vision - Benefit Change

Resolved that, the SEB Board endorses Davis Vision's addition, with no rate increase to the SEBB Program, of a fourth coverage tier to the:

- Progressive lens benefit for which SEBB Program members will have a \$175 copay
- Anti-reflective coating benefit for which SEBB Program members will have an \$85 copay

Questions?

Lauren Johnston

SEBB Program Procurement Manager
Employees and Retirees Benefits Division

Lauren.johnston@hca.wa.gov

TAB 6



2021 Premium Resolutions

Tanya Deuel
ERB Finance Manager
Financial Services Division
July 23, 2020

Premium Resolution SEBB 2020-12 KPNW Medical Premiums

Resolved that, the SEB Board endorses the Kaiser Foundation Health Plan of the Northwest employee premiums.

Premium Resolution SEBB 2020-13 KPWA Medical Premiums

Resolved that, the SEB Board endorses the Kaiser Foundation Health Plan of Washington employee premiums.

Premium Resolution SEBB 2020-14 KPWAO Medical Premiums

Resolved that, the SEB Board endorses the Kaiser Foundation Health Plan of Washington Options, Inc. employee premiums.

Premium Resolution SEBB 2020-15 Premera Medical Premiums

Resolved that, the SEB Board endorses the Premera employee premiums.

Premium Resolution SEBB 2020-16 UMP Medical Premiums

Resolved that, the SEB Board endorses the Uniform Medical Plan employee premiums.

Questions?

Tanya Deuel

ERB Finance Manager

Tanya.Deuel@hca.wa.gov

Appendix

Employee Premium Contributions: Medical

Employer Medical Contribution (EMC)

Sample Illustration

UMP Achieve 2 Bid Rate

X
85%

EMC

=

Employee Contribution



Determining Employee Premiums

Sample Illustration

Plan bid rates



EMC

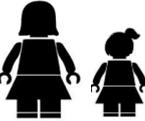
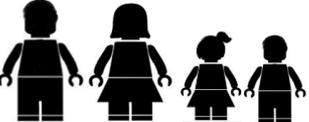


Employee contribution



Determining Employee Premiums by Tier

Sample Illustration

| Plan | | A | B | C |
|------------------------------|---|--------------|--------------|--------------|
| Employee contribution | | \$200 | \$150 | \$100 |
| Tiers |  | | | |
| Tier 1 |  | \$200 | \$150 | \$100 |
| Tier 2 |  | \$400 | \$300 | \$200 |
| Tier 3 |  | \$350 | \$263 | \$175 |
| Tier 4 |  | \$600 | \$450 | \$300 |

*Tiers 3 and 4 do not change when you have one child or multiple children covered.

Employee / Employer Premium Contributions

| | Proposed 2021 Employee Contribution (Single Subscriber) | EMC (Employer Medical Contribution) | Proposed 2021 Total Composite Rate |
|---|---|---|---------------------------------------|
| Kaiser Permanente NW 1 | \$39 | \$555 | \$594 |
| Kaiser Permanente NW 2 | \$52 | \$555 | \$607 |
| Kaiser Permanente NW 3 | \$119 | \$555 | \$674 |
| Kaiser Permanente WA Core 1 | \$16 | \$555 | \$571 |
| Kaiser Permanente WA Core 2 | \$21 | \$555 | \$576 |
| Kaiser Permanente WA Core 3 | \$91 | \$555 | \$646 |
| Kaiser Permanente WA SoundChoice | \$51 | \$555 | \$606 |
| Kaiser Permanente WA Options Access PPO 1 | \$66 | \$555 | \$621 |
| Kaiser Permanente WA Options Access PPO 2 | \$97 | \$555 | \$652 |
| Kaiser Permanente WA Options Access PPO 3 | \$146 | \$555 | \$701 |

- EMC is on a Per Adult Unit Per Month (PAUPM) basis
- Rounded to the nearest dollar

Employee / Employer Premium Contributions (*cont.*)

| | Proposed 2021 Employee Contribution (Single Subscriber) | EMC (Employer Medical Contribution) | Proposed 2021 Total Composite Rate |
|--|---|---|---------------------------------------|
| Premera Blue Cross High PPO | \$76 | \$555 | \$631 |
| Premera Blue Cross Peak Care EPO | \$37 | \$555 | \$592 |
| Premera Blue Cross Standard PPO | \$28 | \$555 | \$583 |
| Uniform Medical Plan (UMP) Achieve 1 | \$33 | \$555 | \$588 |
| UMP Achieve 2 | \$98 | \$555 | \$653 |
| UMP High Deductible (with a health savings account) | \$25 | \$555 | \$580 |
| UMP Plus | \$68 | \$555 | \$623 |

- EMC is on a Per Adult Unit Per Month (PAUPM) basis
- Total Composite Rate for the SEBB UMP High Deductible includes an employer HSA contribution of \$375 per year for Tier 1 and \$750 per year for all other tiers
- Rounded to the nearest dollar

Employee Premium Contributions

UPDATED 7/22/2020 TO INCLUDE ENROLLMENT

| | Subscriber | | 2020 to 2021 Change in Subscriber Rate | | Subscriber Enrollment |
|---|------------|---------------|--|------|-----------------------|
| | 2020 | Proposed 2021 | % | \$ | June 2020 |
| Kaiser Permanente NW 1 | \$28 | \$39 | 39.3% | \$11 | 823 |
| Kaiser Permanente NW 2 | \$41 | \$52 | 26.8% | \$11 | 1,825 |
| Kaiser Permanente NW 3 | \$106 | \$119 | 12.3% | \$13 | 2,093 |
| Kaiser Permanente WA Core 1 | \$13 | \$16 | 23.1% | \$3 | 2,325 |
| Kaiser Permanente WA Core 2 | \$19 | \$21 | 10.5% | \$2 | 9,366 |
| Kaiser Permanente WA Core 3 | \$89 | \$91 | 2.2% | \$2 | 2,305 |
| Kaiser Permanente WA SoundChoice | \$49 | \$51 | 4.1% | \$2 | 14,422 |
| Kaiser Permanente WA Options Access PPO 1 | \$39 | \$66 | 69.2% | \$27 | 3,313 |
| Kaiser Permanente WA Options Access PPO 2 | \$69 | \$97 | 40.6% | \$28 | 6,018 |
| Kaiser Permanente WA Options Access PPO 3 | \$116 | \$146 | 25.9% | \$30 | 8,223 |

Employee Premium Contributions (*cont.*)

UPDATED 7/22/2020 TO INCLUDE ENROLLMENT

| | Subscriber | | 2020 to 2021 Change in Subscriber Rate | | Subscriber Enrollment |
|---|------------|---------------|--|-----|-----------------------|
| | 2020 | Proposed 2021 | % | \$ | June 2020 |
| Premera Blue Cross High PPO | \$70 | \$76 | 8.6% | \$6 | 14,513 |
| Premera Blue Cross Peak Care EPO | \$31 | \$37 | 19.4% | \$6 | 887 |
| Premera Blue Cross Standard PPO | \$22 | \$28 | 27.3% | \$6 | 16,933 |
| Uniform Medical Plan (UMP) Achieve 1 | \$33 | \$33 | 0.0% | \$0 | 15,850 |
| UMP Achieve 2 | \$98 | \$98 | 0.0% | \$0 | 20,726 |
| UMP High Deductible (with a health savings account) | \$25 | \$25 | 0.0% | \$0 | 5,189 |
| UMP Plus | \$68 | \$68 | 0.0% | \$0 | 3,448 |
| Subscribers may be subject to the following surcharges | | | | | |
| Tobacco Surcharge | \$25 | \$25 | | | |
| Spousal Surcharge | N/A | N/A | | | |

Employee Contribution by Tier

| | Subscriber | Subscriber & Spouse/SRDP* | Subscriber & Child(ren) | Subscriber, Spouse/SRDP*, and Child(ren) |
|--|--------------|---------------------------|-------------------------|--|
| Tier Ratios | 1.00 | 2.00 | 1.75 | 3.00 |
| Kaiser Permanente NW 1 | \$39 | \$78 | \$68 | \$117 |
| Kaiser Permanente NW 2 | \$52 | \$104 | \$91 | \$156 |
| Kaiser Permanente NW 3 | \$119 | \$238 | \$208 | \$357 |
| Kaiser Permanente WA Core 1 | \$16 | \$32 | \$28 | \$48 |
| Kaiser Permanente WA Core 2 | \$21 | \$42 | \$37 | \$63 |
| Kaiser Permanente WA Core 3 | \$91 | \$182 | \$159 | \$273 |
| Kaiser Permanente WA SoundChoice | \$51 | \$102 | \$89 | \$153 |
| Kaiser Permanente WA Options Access PPO 1 | \$66 | \$132 | \$116 | \$198 |
| Kaiser Permanente WA Options Access PPO 2 | \$97 | \$194 | \$170 | \$291 |
| Kaiser Permanente WA Options Access PPO 3 | \$146 | \$292 | \$256 | \$438 |

- State-Registered Domestic Partner (SRDP)
- Rounded to the nearest dollar

Employee Contribution by Tier (*cont.*)

| | Subscriber | Subscriber & Spouse/SRDP* | Subscriber & Child(ren) | Subscriber, Spouse/SRDP*, and Child(ren) |
|--|-------------|---------------------------|-------------------------|--|
| Tier Ratios | 1.00 | 2.00 | 1.75 | 3.00 |
| Premera Blue Cross High PPO | \$76 | \$152 | \$133 | \$228 |
| Premera Blue Cross Peak Care EPO | \$37 | \$74 | \$65 | \$111 |
| Premera Blue Cross Standard PPO | \$28 | \$56 | \$49 | \$84 |
| Uniform Medical Plan (UMP) Achieve 1 | \$33 | \$66 | \$58 | \$99 |
| UMP Achieve 2 | \$98 | \$196 | \$172 | \$294 |
| UMP High Deductible (with a health savings account) | \$25 | \$50 | \$44 | \$75 |
| UMP Plus | \$68 | \$136 | \$119 | \$204 |
| Subscribers may be subject to the following surcharges | | | | |
| Tobacco Surcharge | \$25 | \$25 | \$25 | \$25 |
| Spousal Surcharge | N/A | \$50 | N/A | \$50 |

- State-Registered Domestic Partner (SRDP)
- Total Composite Rate for the SEBB UMP High Deductible includes an employer HSA contribution of \$375 per year for Tier 1 and \$750 per year for all other tiers
- Rounded to the nearest dollar

TAB 7



COVID-19 Follow up and Eligibility Policy Resolution

Rob Parkman, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
July 23, 2020

Presentation Objectives

- Follow up to public comment at the July 16, 2020 Board Meeting
- Provide additional stakeholder information on Resolution SEBB 2020-10

July 16, 2020 Meeting Follow Up

- During public comment, Tacoma Public Schools requested insight on how the eligibility provisions of ESSB 6189, responding to the COVID-19 pandemic, relate to benefits eligibility for the upcoming 2020-2021 school year
- Preliminary insights were shared at the June 24 Board Meeting on this topic

Section 5 - Engrossed Substitute Senate Bill 6189 (new section within Chapter 41.05 RCW)

- (1) A school employee eligible as of February 29, 2020 for the employer contribution towards benefits offered by the school employees' benefits board, shall maintain their eligibility for the employer contribution under the following circumstances directly related or in response to the governor's February 29, 2020 proclamation of a state of emergency existing in all counties in the state of Washington related to the novel coronavirus (COVID-19):
 - (a) During any school closures or changes in school operations for the school employee;
 - (b) While the school employee is quarantined or required to care for a family member, as defined by RCW 49.46.210(2), who is quarantined; and
 - (c) In order to take care of a child as defined by RCW 35 49.46.210(2), when the child's:
 - (i) School is closed;
 - (ii) Regular day care facility is closed; or
 - (iii) Regular child care provider is unable to provide services.

Section 5 - Engrossed Substitute Senate Bill 6189 (new section within Chapter 41.05 RCW) (*cont.*)

- (2) Requirements in subsection (1) of this section expires when the governor's state of emergency related to the novel coronavirus (COVID-19) ends.
- (3) When regular school operations resume, school employees shall continue to maintain their eligibility for the employer contribution for the remainder of the school year so long as their work schedule returns to the schedule in place before February 29, 2020 or, if there is a change in schedule, so long as the new schedule, had it been in effect at the start of the school year, would have resulted in the employee being anticipated to work the minimum hours to meet benefits eligibility.
- (4) Quarantine, as used in subsection (1)(b) includes only periods of isolation required by the federal government, a foreign national government, a state or local public health official, a health care provider, or an employer.

ESSB 6189 Eligibility Impacts

- It is unknown at this time when the state of emergency will end
- School employees, eligible as of February 29, 2020, will maintain their eligibility for SEBB Program benefits until the state of emergency ends, as long as they remain a school employee as described in RCW 41.05.011(6)(b)

SEB Board Resolution

- SEBB 2020-10 Amending SEBB 2018-36

RCW 41.05.740(6)(d)

(6) The school employees' benefits board shall [...]

(d) Determine the terms and conditions of school employee and dependent eligibility criteria, enrollment policies, and scope of coverage. At a minimum, the eligibility criteria established by the school employees' benefits board shall address the following:

(i) The effective date of coverage following hire;

(ii) The benefits eligibility criteria, but the school employees' benefits board's criteria shall be no more restrictive than requiring that a school employee be anticipated to work at least six hundred thirty hours per school year to be benefits eligible; and

(iii) Coverage for dependents, including criteria for legal spouses; children up to age twenty-six; children of any age with disabilities, mental illness, or intellectual or other developmental disabilities; and state registered domestic partners, as defined in RCW 26.60.020, and others authorized by the legislature; [...]

Background

- At the June 24 Board Meeting, the agency presented information about COVID-19 school closure impacts for the 2019-2020 school year as that school year relates to the two-year look back policy
- The agency recommended the Board not take action to adjust the current look back policy

Board Input Received

- Received input from Dan Gossett and Katy Henry on a resolution they would like to sponsor related to the COVID-19 state of emergency and eligibility impacts on the two-year look back eligibility method
- Although the agency continues to recommend no policy change, HCA provided support to draft and stakeholder a policy proposal to achieve Dan's and Katy's policy goals
- Stakeholder review of a draft resolution began on July 9

Resolution SEBB 2020-10

Amending Resolution SEBB 2018-36

Eligibility Presumed Based on Hours Worked the Previous Two School Years

Resolved that, SEBB 2018-36 is amended to add the following to a new third bullet: For purposes of this policy only, a SEBB Organization must count the 2019-2020 school year as having met the 630 hours' requirement if the school employee (a) worked at least 630 hours during the 2019-20 school year, or (b) worked at least 500 hours between September 1, 2019 and March 16, 2020. SEBB 2018-36 now reads:

A school employee is presumed eligible if they:

- worked at least 630 hours in each of the previous two school years; and
- are returning to the same type of position (teacher, paraeducator, food service worker, custodian, etc.) or combination of positions with the same SEBB Organization.
- For purposes of this policy only, a SEBB Organization must count the 2019-2020 school year as having met the 630 hours' requirement if the school employee (a) worked at least 630 hours during the 2019-20 school year, or (b) worked at least 500 hours between September 1, 2019 and March 16, 2020.

A SEBB Organization rebuts this presumption by notifying the school employee, in writing, of the specific reasons why the employee is not anticipated to work at least 630 hours in the current school year and how to appeal the eligibility determination.

Next Steps

- If resolution SEBB 2020-10 is approved
 - Issue needed guidance to SEBB Organizations on this subject
 - Incorporate resolution language into SEBB Program rules in 2021

Questions?

Rob Parkman, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
Rob.Parkman@hca.wa.gov

Appendix

Resolution SEBB 2018-36
As approved by the SEB Board on
November 8, 2018

Policy Resolution SEBB 2018-36

Eligibility Presumed Based on Hours Worked the Previous Two School Years

Resolved that, a school employee is presumed eligible if they:

- worked at least 630 hours in each of the previous two school years;
and
- are returning to the same type of position (teacher, paraeducator, food service worker, custodian, etc.) or combination of positions with the same SEBB Organization.

A SEBB Organization rebuts this presumption by notifying the school employee, in writing, of the specific reasons why the employee is not anticipated to work at least 630 hours in the current school year and how to appeal the eligibility determination.

TAB 8



Diabetes Management Program (DMP) RFI Results

Kat Cook, Benefit Strategy Analyst
Benefit Strategy and Design Section
Employees & Retirees Benefits Section
July 23, 2020

Diabetes Background

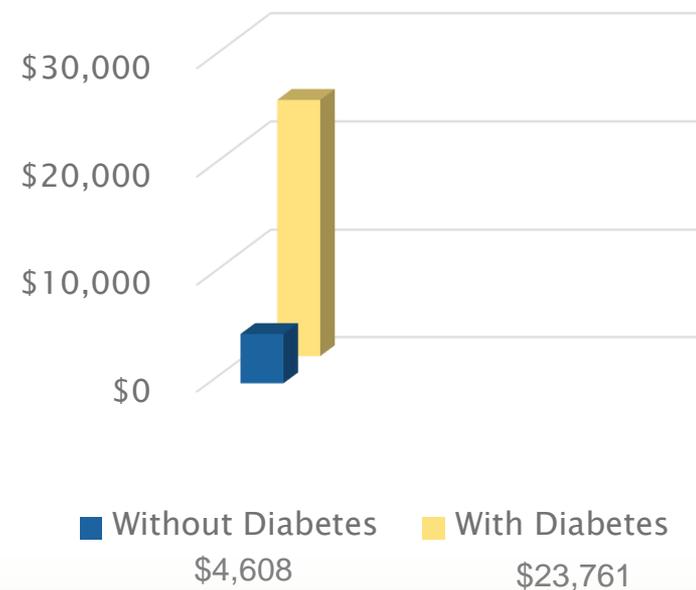
- Body does not regulate blood sugar
- Types of Diabetes:
 - Type 1 (5%), Type 2 (90%), Gestational (5%)
- In 2019 PEBB had 26,331 Diabetics
 - UMP 22,630, Kaiser 3,701
- Increases risk for additional, high-risk conditions
- 7th leading cause of death in Washington
- Health Equity Concerns

Diabetes Costs

Washington Statewide Costs in 2017

- Medical Costs
 - \$4.9 Billion
- Lost Productivity Costs
 - \$1.7 Billion total
- Total
 - \$6.6 Billion in one year

Average Medical
Cost/year



Source: 2019 DOH Report: "Diabetes Data Support"

Diabetes Prevention Programs

- Kaiser and UMP offer Diabetes Prevention via Omada (2019 PEBB Results below)
 - 36% of Omada participants met or beat the target weight loss goal of 5% loss
 - 2,945 participants
 - 1,060 met the goal of 5% or greater weight loss
- Premera will offer DPP via Livongo starting 1/1/2021
- SmartHealth Program

Sources: Omada report; ADA

Diabetes Management Offerings

- Kaiser: Diabetes One Stop
- Premera: Will offer Livongo 1/1/2021
- UMP: Traditional Case Management
- Washington Wellness trainings in 2018 and 2020
- SmartHealth education topic
- Traditional diabetes management and education via in person practitioners is covered by all plans

Diabetes Management

Daily Activities By Patient

Blood Glucose Checks

Carb Reduction

20 Minutes of Physical Activity

Medication

Activities by Care Team

Checking Feet for Neuropathy

Eye Exams

Nutrition Education

A1c, BP, and Cholesterol Tests

Source: CDC, ADA

Digital Diabetes Management Programs (DMPs)

What they Offer

- Blood Glucose Tracking
- Food Logging
- Coaching
- Education
- Activity Tracking
- Medication Tracking

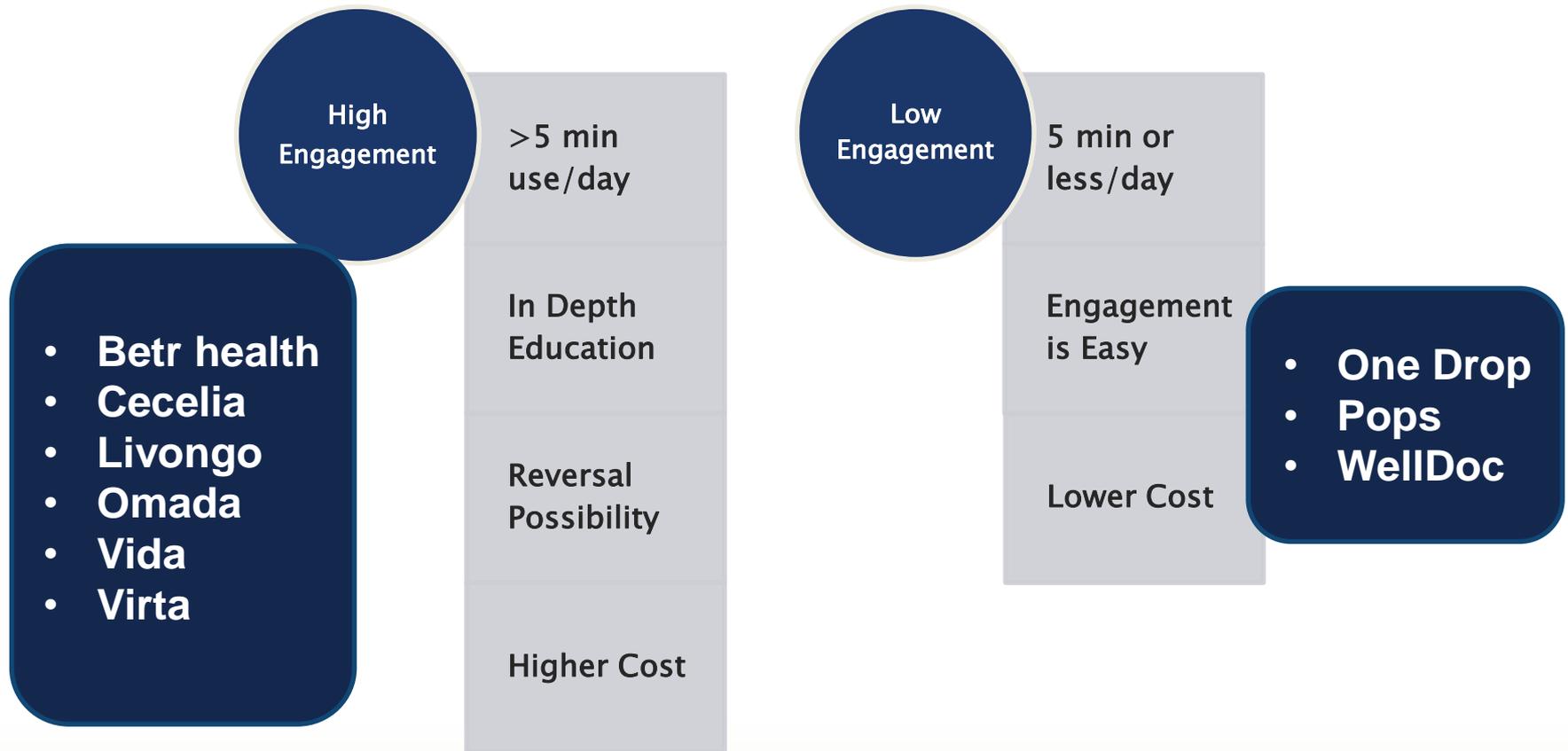
Benefits

- Lower A1c = Lower Risk
- Instant Feedback
- Motivational Engagement
- Documentation
- Possible reversal
- Cost reduction
- Accountability without fear of judgment

RFI Summary

- Released May 1, 2020 - May 22, 2020
- Respondents: Betr Health, Cappa, Cecelia, LexisNexis, Livongo, Omada, One Drop, Pops, Solera, Vida, Virta, WellDoc
- 3 of these respondents eliminated from report, out of scope

Two Types of Self-Directed DMPs



High Engagement Products

- PMPM* Cost Range \$65 - \$200
- One-time implementation fee for some vendors (Avg \$100/User)
- Requires more serious time and lifestyle commitment from member
- Program ends after 1-2 years

*PMPM = Per Member Per Month

Low Engagement Products

- PMPM Cost Range \$40 - \$60
- More Effective for a “casual user”
- Program has no end date
- Better than High Engagement for Type 1 and Gestational Diabetes

Next Steps

- Information for a future RFP
- Leverage SmartHealth for additional diabetes education/tools
- Support and promote plans' existing diabetes management programs

Questions?

Kat Cook, Benefit Strategy Analyst
Benefit Strategy and Design Section
Employees & Retirees Benefits Division
kat.cook@hca.wa.gov

TAB 9



SEBB My Account Enhancements

Jerry Britcher
Chief Information Officer
Enterprise Technology Services Division
July 23, 2020

SEBB My Account Enhancements

- Topics
 - New Enhancement Process
 - Enhancement Releases
 - Enhancements since Fall 2019 Open Enrollment
 - Enhancements Planned

New Enhancement Process

- Enhancement requests received by Outreach and Training from districts
- Stakeholder conferences (WASBO, WASWUG, PNWUG)
- SEBB employer stakeholder group
- Appeals/User Inquiries and Questions
- HCA Business and Technical teams

Enhancement Releases

- Prioritization of Enhancement Requests
- Release frequency
 - Planned every two weeks
 - A release is skipped, if development and testing duration spans more than two weeks
 - e.g., Large enhancements like Limited Open Enrollment
- No releases during open enrollments

Enhancements Done

- Lower limit – Benefits Administrators can make updates to subscriber enrollment and eligibility within two months of the current month
- Subscriber termination action/functionality – ability to reinstate a subscriber if terminated in error
- Limit Future dates – Reduce errors by not allowing future dates of birth or partnership dates

Enhancements Done (*cont.*)

- Language updates for clarity – Drop down for Anticipated to work 630 hours yes/no changed to Local eligible or SEBB eligible
- Add subscriber mailing address at same time as creating a subscriber
- Ability to ‘unlock’ subscribers that cannot recall their security questions attempting to access their SAW account
- Search by full SSN for quicker results

Enhancements Planned before Fall Open Enrollment 2020

- UI Enhancements for Supplemental LTD
- Re-verification of dependents who failed audit
- Report - Contact list of Benefits Administrators
- Add indicators of successful completion

Enhancements Planned before Fall OE 2020 (*cont.*)

- Tobacco attestation – Do not include dependents 12 years and younger
- Submit button enabled, only when data changed
- For new subscribers, dashboard shows Newly Eligible tile

Questions?

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