Washington State Health Care Authority

School Employees Benefits Board Meeting

August 29, 2019

Washington State Health Care Authority

School Employees Benefits Board

August 29, 2019
9:00 a.m. – 12:30 p.m.

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

Table of Contents

TAB 1

Washington State Health Care Authority

AGENDA

School Employees Benefits Board
August 29, 2019
9:00 a.m. – 12:30 p.m.
Sue Crystal Rooms A & B

Cherry Street Plaza
626 8th Avenue SE
Olympia, WA 98501

Call-in Number: 1-888-407-5039 Participant PIN Code: 60995706

9:00 a.m.*	**Welcome and Introductions**		Lou McDermott, Chair	
9:05 a.m.	**Meeting Overview**		David Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information
9:10 a.m.	**Approval of May 16, June 12, July 18, July 25, and August 1, 2019 Meeting Minutes**	TAB 3	Lou McDermott, Chair	Action
9:15 a.m.	**School District Optional Benefits**	TAB 4	Cade Walker, Executive Special Assistant, ERB Division	Information/ Discussion
9:35 a.m.	**Long-Term Disability (LTD) Benefit Strategy**	TAB 5	Beth Heston, Contract Manager ERB Division	Information/ Discussion
9:55 a.m.	**Contractor Implementation Progress**	TAB 6	Lauren Johnston, SEBB Senior Account Manager, ERB Division	Information/ Discussion
10:15 a.m.	**School Employees SmartHealth Wellness Program**	TAB 7	Justin Hahn, Washington Wellness Program Manager, ERB Division	Information/ Discussion
10:30 a.m.	**Break**			
10:45 a.m.	**SEBB Continuation Coverage Implementation**	TAB 8	Renee Bourbeau, Manager Benefits Accounts Section, ERB Division Alisa Richards, Customer Service Operations Manager, Benefits Accounts Section, ERB Division	Information/ Discussion
11:10 a.m.	**SEBB Training and Benefits Fairs Update**	TAB 9	Jesse Paulsboe, Outreach and Training Manager, ERB Division	Information/ Discussion
11:30 a.m.	**SEBB My Account Testing**	TAB 10	Jerry Britcher, Chief Information Officer, ETS Division	Information/ Discussion
11:50 a.m.	**SEBB My Account Contact Center**	TAB 11	Alisa Richards, Customer Service Operations Manager, ERB Division	Information/ Discussion
12:05 p.m.	**Public Comment**			
12:20 p.m.	**Wrap Up**		Dave Iseminger, Director Scott Palafox, Deputy Director ERB Division	
12:30 p.m.	**Adjourn**			

***All Times Approximate**

The School Employees Benefits Board will meet Thursday, August 29, 2019, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8th AVE SE, Olympia, WA. 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 August 27, 2019.

Washington State Health Care Authority

SEB Board Members

Name	Representing
Lou McDermott, Deputy Director Health Care Authority 626 8th Ave SE PO Box 42720 Olympia WA 98504-2720 V 360-725-0891 louis.mcdermott@hca.wa.gov	Chair
Sean Corry Sprague Israel Giles, Inc. 1501 4th Ave, Suite 730 Seattle WA 98101 V 206-623-7035 sean.corry@hca.wa.gov	Employee Health Benefits Policy and Administration
Pete Cutler 7605 Ostrich DR SE Olympia WA 98513 C 360-789-2787 pete.cutler@hca.wa.gov	Employee Health Benefits Policy and Administration
Patty Estes PO Box 76 Eatonville WA 98328 C 360-621-9610 patty.estes@hca.wa.gov	Classified Employees
Dan Gossett 603 Veralene Way SW Everett WA 98203 C 425-737-2983 dan.gossett@hca.wa.gov	Certificated Employees

SEB Board Members

Name	Representing
Katy Henry Spokane Public Schools 200 North Bernard Spokane WA 99201 V 509-325-4503 katy.henry@hca.wa.gov	Certificated Employees
Terri House Marysville School District 4220 80th ST NE Marysville WA 98270 V 360-965-1610 terri.house@hca.wa.gov	Classified Employees
Wayne Leonard Assistant Superintendent of Business Services Mead School District 608 E 19th Ave Spokane WA 99203 V 509-465-6017 wayne.leonard@hca.wa.gov	Employee Health Benefits Policy and Administration (WASBO)
Alison Poulsen 12515 South Hangman Valley RD Valleyford WA 99036 C 509-499-0482 alison.poulsen@hca.wa.gov	Employee Health Benefits Policy and Administration

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KatyK1@atg.wa.gov

5/17/19

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

UPDATED SEBB MEETING SCHEDULE

2019 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 24, 2019 - 9:00 a.m. – 5:00 p.m.

March 7, 2019 - 9:00 a.m. – 5:00 p.m.

April 10, 2019 - 1:00 p.m. – 5:00 – p.m.

May 16, 2019 - 9:00 a.m. – 5:00 p.m.

June 12, 2019 - 9:00 a.m. – 5:00 p.m.

July 18, 2019 - 9:00 a.m. – 5:00 p.m.

July 25, 2019 - 9:00 a.m. – 5:00 p.m.

August 1, 2019 - 9:00 a.m. – 5:00 p.m.

August 29, 2019 - 9:00 a.m. – 5:00 p.m.

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

Updated 11/27/18

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
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DATE: November 27, 2018
TIME: 3:36 PM

WSR 18-24-024

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

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STATE OF WASHINGTON
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DATE: July 09, 2019
TIME: 1:24 PM

WSR 19-15-021

TAB 2

Washington State Health Care Authority

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

Washington State Health Care Authority

D R A F T

School Employees Benefits Board
Meeting Minutes

May 16, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 p.m. – 4:00 p.m.

Members Present

Sean Corry
Patty Estes
Dan Gossett
Pete Cutler
Alison Poulsen
Katy Henry
Wayne Leonard
Terri House
Lou McDermott

SEB Board Counsel

Katy Hatfield

Call to Order

Lou McDermott, Chair, called the meeting to order at 9:04 a.m. Sufficient members present to allow a quorum. Board self-introductions followed.

Agenda Overview

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda. TVW was present to record the Board Meeting.

April 10, 2019 Board Meeting Follow Up

Dave Iseminger, Director, ERB Division. The Board had questions on eligibility enrollment policies and the value-based formulary. Rob Parkman and Marcia Peterson have embedded answers to those questions in their presentations.

I want to respond to public comment from Troy Andrews of Local Laborers 252 in Tacoma. He presented the Board with an interpretation that he and others had about statutory authority. They believe this Board has authority to carve out or waive entire groups or subsets of SEBB Organizations. We provided a written response to Mr. Andrews, in addition to meeting with him in person, since the last Board meeting. I told him HCA's understanding and interpretation of the statutes is the Board has the ability to allow and establish terms and conditions for individual school employees to waive individually, and the Board has already established those criteria. The Board does not

have authority to carve out an entire sub-component of a SEBB Organization or an entire SEBB Organization. Mr. Andrews presented his questions about individuals being able to waive, but a lot of it was language talking about exempting an entire subset of the population. I want to remind the Board and the public that even if an individual waives, the way the funding structure is set up, an employer still pays because the funding rate represents an average of funds that are needed for the entire Program.

As our communications team says, "waiving isn't saving." It doesn't save money at an individual district on the employer contribution for an individual who waives. There were some underpinnings of the questions about there being savings in the system. The funding rate is an average that has a projected number of people who will waive benefits. So waiving isn't saving and an exemption or allowing an entire group to not be part of the SEBB Program wouldn't save money in the system per se. We continued those conversations. I just wanted to give the Board the discussion and update because there were assertions about this Board's authority.

Lou McDermott: Dave, can you dumb it down a tick and tell us whether or not it still has a negative impact on him? If his individual members waive, does it fix his problem?

Megan Atkinson: Dave, do you want to phone a friend?

Dave Iseminger: I would love to phone a friend who's going to come up here next anyway.

Megan Atkinson, Chief Financial Officer Health Care Authority. When you talk about waiving isn't saving, the funding rate has been set for both budgeting purposes and invoicing purposes for a district. Having members waive does not save. It doesn't help an individual district. Now, when you take a step back up to the 35,000 foot or 50,000 foot level, if in our funding rate assumptions, we have an assumption about what percentage of the population will waive, we currently are using 8%. If we end up post-open enrollment with a larger number of employees waiving coverage, that does impact the modeling of the global funding rate. Likewise, if we have a lower number of members who choose to waive, that also would impact the global funding rate.

So your question, Chair McDermott, about what's the takeaway? When we're in a year and a funding rate has been established, having a larger or lesser number of the employees at a district level waive doesn't impact that district's invoice. When we are doing modeling for a subsequent year, having an open enrollment behavior of waiving does impact the assumptions we will use in subsequent funding rates.

Lou McDermott: So if I recall, the individuals in his group are concerned because by going into SEBB benefits, they'll no longer be in their insurance, accumulating hours and time. That was going to translate into a sort of retirement. They were going to have a very low premium when they retired. Are they no longer able to go into that benefit or can they waive their medical through the district, continue to do what they're doing, and then reap that benefit at retirement? Or would that be up to the district to fund both?

Dave Iseminger: I can't speak to the exact benefit structure. What Mr. Andrews was definitely wanting was clear information so the employees in his bargaining unit would understand the rules of the road that they were about to go into. They would be able to make decisions related to either retiring before the SEBB Program is in place and be able to access the benefits they currently understand, versus continuing employment. He was looking to make sure that if there was not an ability to be exempt or fully waived out of the program, at least his members would know the information up front to be able to make decisions over the next few months. I believe they have the information they need to make decisions. But I can't speak to the exact benefit structure and choices that each of them have.

Alison Poulsen: I want to make sure I understand what Megan is saying - in the first biennium, it's not going to matter if we ended up with 14% of people waiving to an individual school district. They're going to be on the hook for the amount. Where it could potentially have cost savings to a district would be the next time you're calculating eligibility, you might see less of a financial cost?

Megan Atkinson: There are key points in time when funding rates are set. The percentage of employees who waive is a key assumption in building the funding rate. We'll talk about it more in my presentation.

SEBB Finance 2019-2021 State Operating Budget

Megan Atkinson, Chief Financial Officer. I have a late addition to this presentation which is in the pocket of your binder.

As Dave indicated, the Legislature adjourned on time, no special session. A budget was passed, but we're still awaiting the Governor's action on the budget. We'll walk through the budget as it was passed. If there are vetoes that impact the program, of course we'll update you at a subsequent Board Meeting.

We will walk through the legislative update on the operating budget, key funding rate assumptions, budget language about the flow of funding rate dollars, decision package action impacting the Program, and different budget language. There is SEBB language in section 200 of the HCA budget, language in section 500 of the K-12 sections, and language in section 900 of the Collective Bargaining Section. You have to piece it all together. This is what we've found so far. There is always the caveat that possibly we've missed something; but if any member wants a packet of the language, let us know and we'll get it for you.

Slide 3 – Monthly Funding Rate Comparison. This is a very high-level look. We are comparing Fiscal Year 2020 and Fiscal Year 2021 on this slide. The green line is the funding rate we provided in early March, feeding that into the legislative budget deliberations. The yellow line is the funding rate in the final budget.

Dave Iseminger: Some of you may remember in the April Board Meeting, Megan explained a number that's $1,114 instead of the $1,096 you see on Slide 3. Those numbers are functionally equivalent. It was how the administrative loan was accounted for.

Megan Atkinson: There is the funding rate and then there's the net funding rate. The funding rate is typically what ends up in an enacted budget. Not always. The net funding rate is the actual amount needed to cover the projected expenditures of the plan. We often have surplus spend, especially on the PEBB Program side. I would anticipate that happening, also, on the SEBB Program side once we're more mature as a program. Either surplus spend from previous years where we have overestimated the funding rate, or if we end up in a situation where we're projecting to have a deficit, that can also impact the funding rate.

Let's look at the two-sided handout the front of your binder. Side 1 has "SEBB Funding Rate" in large print at the top of the page and a column entitled "Conference Budget (Funding Rate)."

Side 2 has no header and a column "HCA Update – 3/1/19." The total in the HCA Update column is $1,096. The list on Page 2 is all the funding rate components that totaled $1,096. That was the funding rate discussed in a previous Board meeting.

The Conference Budget Funding Rate on side one totals $994. The differences are on the K-12 remittance. We previously modeled $67 for the K-12 remittance. It is now at $70. It's a modeling change referenced in the budget. Per the Collective Bargaining Agreement, as well as budget language, paying for the K-12 remittance is an employer responsibility that goes into the funding rate. The funding rate is used for driving funding out to the district for state funded staff and by HCA for invoicing districts for all eligible staff, including those who waive.

There are three differences listed at the bottom of the chart on side 1. The K-12 remittance is different. It was $67, now it's $70. Administration and other costs was $32, now it's $26. The surplus and deficit spend was $18, now is $116. That increase in the deficit is the impact of the Legislature choosing a funding rate of $994 versus the funding rate we provided of $1,096. The $994 is the current net funding rate for the PEBB Program. Essentially, that represents an adequate funding rate currently modeled to be an adequate funding rate for a similar benefit program, for a similar set of public employees for a mature program.

The net PEBB funding rate doesn't take into consideration the startup cost on the SEBB side, like the loans we have to repay to the General Fund. The other significant startup is going from zero reserves to a 7% medical and 4% percent dental. That's a fairly large component of our initial projected funding rate on the SEBB side. Whereas on the PEBB side, you're just funding the marginal increase or decrease each year of those reserves based on enrollment and claims fluctuation on the self-insured population.

What the Legislature has done, if you take everything we put together - the benefit offering and the funding rate specified in the budget, budget language directing the agency, and the SEB Board, as well as the lack of any change in the statutory authority for the benefit program and eligibility - in Section 938 of the budget it says "funding to provide provisions of the 2019-21 Collective Bargaining Agreement and for procurement of a benefit package that is materially similar to benefits provided by the Public Employee Benefits Board Program as outlined in policies adopted by the School Employees Benefits Board." The Legislature is essentially saying to keep doing what

you're doing. Keep implementing the program that you're implementing. They only put forward a $994 funding rate and we will go forward if needed, with a supplemental budget package.

We want to take away from this that the Legislature funding the $994 funding rate in fiscal year 2020, and $1,056 in fiscal year 2021, it doesn't change the modeling HCA is doing on the program now. Our modeling will be wrong, 100% guaranteed. Will it be off to this degree? That's unlikely but the next big updates in modeling will be later this summer when we update for final bid rates, and then after open enrollment in the fall when we update for enrollment.

The enrollment update is important because it gives us actual information for two large assumptions. One assumption is the percent of employees who waive. Remember we collect the funding rate for a waived employee, but we have no expenditures for them. If a larger percentage of employees waived than what we are currently modeling, that puts a downward pressure on the funding rate. If a larger number of employees enroll, that's upward pressure on the funding rate. We'll lock down that assumption after open enrollment.

The second significant assumption that we will lock down after open enrollment is how employees enroll across the tiers, and their plan selection. Do they enroll in a managed care plan where we just pay premiums every month? Do they enroll in a self-insured plan where we have claims risk? We currently have them spread similar to the PEBB Program population for waiver assumptions and enrollment assumptions across the tiers. We'll get actual information post-open enrollment that will feed into modeling that we do for the Governor's supplemental budget. That will feed into an update on what our funding rates should be, based on enrollment information. That's when we'll have the first solid funding rate for the program.

If I were in a school district and being conservative, I would budget a number larger than the $994 we were funded because it is not what we're modeling or what we believe will be the cost. If we continue to model a funding rate in excess of $994, the agency will go to the Legislature with a supplemental budget package. I don't know what action the Legislature will take or how that action will play out in funding the program. I think it's reasonable to assume the action in the next legislative session would most likely be focused on state funded staff only. If you're trying to budget at the school district level, the most conservative approach would be budgeting a funding rate in excess of $994.

Dave Iseminger: Megan, just to clarify, for the months related to fiscal year 2020, HCA will invoice at $994 and the Legislature is unlikely to retroactively raise the $994? If they need to increase, they would increase the fiscal year 2021 funding rate to be more than $1,056 to account for the deficit that needs to be filled. Is that correct?

Megan Atkinson: I'm going to say with certainty, we will invoice districts for the funding rate that's specified in the budget, the $994. I'm less certain the Legislature won't change that funding rate mid-year in the 2020 supplemental budget. I didn't anticipate being in this situation, but I don't know what remedy the Legislature will choose. A mid-year adjustment to a funding rate would be highly unusual. If they did adjust that, would it be the same funds flow with the money going from OSPI through apportionment to the districts, back to the HCA through our monthly invoicing? An additional complication is

the Legislature did not address our cash flow needs. We're starting the fund with just a few million dollars in balance. We don't have sufficient cash in the fund to manage our month-to-month cash flows. The agency will be working with the State Treasurer on how to manage the benefits fund going negative every month as we pay bills and then wait for the districts to pay their invoice. The benefit fund sort of has two pressures on it. One is a month-to-month cash flow pressure and one is an overall funding for the program pressure. It's an unusual situation and I don't fully know how it will be addressed next year by the Legislature. They could leave fiscal year 2020 funding rate untouched and make it all up in the fiscal year 2021 funding rate. To my knowledge, there's not a parallel in the PEBB Program that we can go back and look to see how that was addressed.

Alison Poulsen: I don't logistically understand the difference between what it's going to cost, what is allocated, and who's going to make up that gap, whether districts have to make it up in an interim period until it gets fixed? I understand they're not going to change things midway, but if we think it's going to cost this, there's a deficit. Who holds the deficit in the short term?

Megan Atkinson: Great question. The agency and the benefit funds hold the deficit in the short term. The state manages that across the state treasury in cash flowing a state fund that's going to go negative. Our benefit fund is in the state treasury and it will go negative every month as we pay bills, and spending from that fund will be at a rate to drive the fund into a negative by the end of the fiscal year. We will work that cash flow mechanism out with OFM and the State Treasurer because the State Treasurer manages all state funds held in the treasury. How the Legislature will address that negative in the benefit fund next session is unknown.

Pete Cutler: I have three questions. Dealing with this most recent issue, it seems to me that the budgeting risk to the school districts most likely is for their staff that are not state funded --

Megan Atkinson: I agree.

Pete Cutler: -- and that's where it would be prudent to budget, or expect a higher funding rate than the $994 for beginning either mid fiscal year, or no later than the beginning of fiscal year 2021. Because of the McCleary Decision, it seems very likely they will fund. They will not leave the school districts having to backfill or they won't increase rates without providing the money for the state funded positions along with that funding increase. For all other positions, the districts are going to have to plan accordingly.

On the $994, I think you used a term, the "current PEBB rate." Is that a reference to current fiscal year PEBB Program rate? Is that what is built in the budget for PEBB Program beginning July 1?

Megan Atkinson: Yes. Again, the net funding rate. It doesn't benefit from any expenditure of surplus. The budgeted PEBB Program funding rate is less because we're spending some surplus. The net fund rate, the funding rate necessary to cover the current projected expenditures for the PEBB Program, is $994.

Pete Cutler: If we go to the budget watch, we'll see a lower number but the net funding rate after adjusting for the use of surplus would be the $994. I guess it had to do with the waivers and I wanted to clarify. If you have a bunch of people waive more than what's expected, that actually reduces a fiscal pressure on the state because the employer's been sending in money for those employees but they're not actually incurring the expense. Thank you.

Wayne Leonard: Megan, the preferred outcome from what I'm hearing is the Legislature would have a supplemental budget item next year to take care of the deficit in the Program. What if they don't? This Program obviously can't continue to run in a deficit position. It seems like the only alternative is either to require the employer or the employee, or both, to contribute more to the Program.

Megan Atkinson: There are a couple of things, and in the Legislature's defense, the modeling we're doing has many assumptions. A couple of things could materially change our modeling and the expenditures for the Program. Some of them are within the Legislature's authority, and for some, we need to see what actually happens. A portion of the funding rate assumes we will repay the General Fund-State loans. The Legislature could take that off and forgive it by saying it was a grant of startup money to the Program and it doesn't need to be repaid. That would permanently change and lower the expenditures for the program.

The other assumption is the employee behavior could break our way. We could have a higher percentage of employees waive. We could have a larger percentage of employees enroll on the single subscriber tier. We could have better than anticipated claims experience on our self-insured program. We will know the number of waivers and how employees enroll across the tiers before the Legislature is back in town. They will have the benefit of actual information and the financial impact. We won't have significant claims experience, however.

There are things the Legislature could do. For the loan experience, once we update our modeling, it could change the amount of funding needed to fully fund the SEBB Program and not have the program modeled to be in a deficit situation.

If the Legislature doesn't take action, there are a couple of things we could do. Again, unless the Legislature changes eligibility, we also have for this upcoming fiscal biennium a Collective Bargaining Agreement the Legislature took action to fund. It's funded in the budget. There's language around it being funded and approved. That also puts structure around this. In the years that I've been in state government, I've seen the Legislature defer funding action until they have solid known information. That's one of the purposes of a supplemental budget in our two-year budgeting cycle. I've never seen the Legislature run programs into deficit at the end of a fiscal biennium. I'm not a budget law expert, but I think it would be difficult and perhaps even unprecedented, for the Legislature not to take action to fund a program it authorized and has left in place statutorily. I expect a supplemental budget solution. I just don't know exactly what it'll look like. Does that answer your question?

Wayne Leonard: Yes and no. I know it's probably an unanswerable question in terms of what if they don't. But, part of the difficulty in the school district budgeting world is

we're all trying to adjust to a new model of the new financial structure now. You'll probably see around the state there are school districts making fairly large budget cuts. Part of the difficulty is the SEBB Program and trying to get a handle on what this is really going to cost at the local level. It's a bit beyond just the non-state funded employees because there are policy decisions in terms of the number of hours worked, including subs as eligible. All of the things that add to an unknown. Just as we, at the SEB Board level, won't know what this Program actually costs until people enroll at the local level, it's the same problem.

The State Treasurer has a backstop to fund a deficit. By saying we're going to budget a higher level than the $994 means we're going to lay more people off or cut more programs. That's not going to fly with most of our school boards. It's difficult not knowing. If next year additional costs could be pushed out to the employer, when I had some discussions earlier in the year with legislative staffers, their suggestion at the end of our conversation is that we would just have to allow school districts to raise their levy to help pay for this. They did do that, allowed districts to try to go out and raise levies. But in our world, those levies aren't to pay for legislative policy.

Megan Atkinson: Not all districts have the same levy ability. I have been thinking about what information, as the HCA CFO, share to help provide clarity to the degree that I can. I can provide clarity around when our modeling gets updated. I can share the legislatively authorized funding rate for state-funded staff, the revenue for the school district, and the invoicing we'll do. The state model will pick up $994 and drive $994 times the benefits allocation factors (BAF) out to school districts. We will invoice for the $994 per eligible employee. Those will be aligned. But we know that based on the current modeling we have for health care, the $994 seems low.

If a school district budget officer is wondering when they will have updated information, I would watch for the model and funding rate that we model this summer after we lock down bid rates. That will give an indication of how good our procurement is. That's the next significant known that will go into our model and we'll bring those funding rates to you. Then I would look at what the modeling is that we do for the Governor's budget post-open enrollment, which is a significant model update. If those two funding rates continue to be higher than the $994, and more like the $1,096, then the only logical conclusion I think a school district business officer could make is that they're going to have to pick up additional cost for their locally funded staff, whether that would be in fiscal year 2020 or fiscal year 2021. That's still unknown until the Legislature takes action. If all of our modeling updates continue to show a needed funding rate more to the $1,000 and less to the $994, then I think the school district's only reasonable budget assumption would be there's going to be a bill due. On the state-funded staff, I'm less certain because the Legislature has an obligation to fund those staff.

Wayne Leonard: When you say this summer, are those the meetings scheduled at the end of July and the first part of August? I understand the schedule for state timing. But as a point of reference, many school districts adopt their budget in July. Even that's pretty late in the game to be making budget adjustments for most K-12 school districts.

Dave Iseminger: The rate setting process we'll bring to the Board will be to present the resolutions and rates at the July 17 meeting for voting at the July 25 meeting, or present them on July 25 for voting at the August 1 meeting.

Megan Atkinson: Slide 4 – Funding Rate Assumptions as of April 27, 2019 shows the different assumptions in terms of how the Legislature chose to fund. We submitted a model with a large number of assumptions, all detailed and modeled out for legislative staff to use in briefing members. Some of those key assumptions are on this slide in the column on the left. The column on the right is what we know was included in the budget. We didn't receive a model back from the Legislature so we have no direction from them to change any assumptions. As I said earlier, we have language in the budget bill essentially telling us to stay the course. The only key assumption that we're changing with legislative direction is our loan repayment schedule. The column on the right goes into detail about the fact the Legislature uses the PEBB net funding rate.

Slide 5 – Flow of Funding Rate, which provides additional directions around the flow of dollars. Again, in the SEBB world, it's different than what we've been doing in the PEBB world. The K-12 health benefit funding will be allocated through OSPI through the apportionment process. It goes out to the districts and then the districts will send the payments back to the Health Care Authority. When you're thinking about how the districts are pulling together the money, the state funding is the state employer funding for state-funded staff. The districts still have to pull from employee pay the employee contributions. And then, of course, the districts have to provide the employer contribution for locally funded staff. Those three buckets of money get combined and sent to the Health Care Authority for the monthly invoice we send out.

There was conversation during the legislative session about the cash flow for the SEBB Program benefit fund. The only action taken was language in the budget directing the districts to provide payment to Health Care Authority within three business days of receiving the January 2020 allocation. In addition, HCA is directed to provide a Late Payment Report per Section 213 of the budget which says, "by February 5, 2020, the Health Care Authority shall report…for school districts, ESDs, and charter schools that have not remitted payment for January coverage as of January 31, 2020."

In anticipation of this presentation, I was pulling together different pieces of information to try to thread together budget direction the districts paying within three business days of receiving the 2020 allocation, which I interpret to be the January 2020 apportionment. The OSPI apportionment schedule for 2020 is not available yet.

Wayne Leonard: Last business day of the month?

Megan Atkinson: If the last business day of the month ends up being January 29, January 30, or January 31, the school districts won't receive their apportionment until that last business day. They then have three business days to remit to the HCA, which could put us into February. We're directed to provide a report if we haven't received the coverage payment as of January 31. A district could meet the direction to provide the payment within three business days but still be called out as a late payer in our late payment report. Obviously, what HCA will do is put the right verbiage around this depending on how the apportionment schedule, the three subsequent business days, the receipt of the payment, all works so we aren't using a legislative report to shame a district when they followed the directions they received.

Dave Iseminger: Megan, if you look at the calendar, the last business day of January 2020 is Friday, January 31, which means three business days is February 5, the day the report is due. So you could have a district that perfectly pays within three business days, didn't have the money until the day that it was owed.

Megan Atkinson: We want to meet the intent of the legislation, be responsive to the Legislature, and be good partners. We'll figure out a way to verbalize that.

Pete Cutler: I'm picking up the impression that the only thing the Legislature asked you to look at is that deadline for the first month of 2020. They're not asking you to track timeliness of payments throughout the year?

Dave Iseminger: I think it's fair to say, Pete, they only asked us to report on that first payment, but we will track invoicing on a monthly basis.

Pete Cutler: It seems to me that would be more relevant, in addition to making the technical change. Obviously, it's ridiculous if your allocation is getting to the districts on the last business day of a month to expect payment turnaround within three business days.

Megan Atkinson: Pete, that was a lot of the conversation we had with OSPI and with legislative staff, a better understanding of the apportionment flow, the invoicing, etc. It's my guess the cash flow varies by district and how much a district uses apportionment that comes at the end of January for January bills versus for February bills. There are different cash flow considerations that go into operating a district.

Slide 6 – Decision Packages. The decision packages we submitted, all but two were picked up and there are reasons why two others were not. I'll let Dave explain the online decision tool.

Dave Iseminger: We put forward an agency decision package to have a perpetual tool to help employees navigate the number of plans they have and make suggestions on plans they may want to enroll in. When the decision package wasn't picked up in the various budgets, we proceeded with creating a pilot program. We used variance that existed in the start-up funds for the current fiscal year in our administrative budget to buy the licensure for the fall 2019 open enrollment. The experience we get from the pilot project will help us determine whether this is something we ask for perpetual funding in the future. Knowing there will be a large number of plans that new school employees will have, there will be a decision support tool this fall, despite the systemic ongoing request not being funded. We will have a pilot for this open enrollment.

Megan Atkinson: The only other decision package is the Pay1 replacement. We had a request for funding to do additional research around a system replacement project. It wasn't picked up by the Legislature on either side, not for the PEBB or the SEBB Programs.

Dave Iseminger: Pay1 is our backend accounting, invoicing structure system. Our overhaul of SEBB My Account, the frontend enrollment piece is going full steam ahead. We'll have an update and a new demo at the next Board Meeting. Think of the Pay1

replacement as the backend accounting side. Everything that matters to Megan and the districts. It's from 1977.

I have two pieces of clean up. I said the July 17 and July 25 meeting. It's July 18 and July 25 meetings. And there was a piece Megan mentioned earlier about eligibility. Nothing changed in the statute. I'm going to revise that to nothing materially changed in the statute. There is a piece Cade will talk about in a few minutes. There was a delay of non-represented ESD employees passed by the Legislature. As we had been modeling that, we didn't have any material changes to the financial projections because of the number of employees that were attributable to that population. So there's that change, but not a material one.

2019 Legislative Session Debrief

Cade Walker, Executive Special Assistant, ERB Division. If I could take a small point of personal privilege to say hello to Mrs. Walker's elementary school class who's tuned in as they've been learning about state government. They're watching us via TVW to learn how our process works.

I'm here to give the last update on legislation from the 2019 session. We ended up doing a grand total of 336 bill analyses within the ERB Division. That's accounting for thousands of hours by our analysts looking through 336 bills, and providing important information for us to help the legislative process move forward this session. This is an increase of about 115 bills from last year.

House Bill 2140 did not make it into our materials today, but it's the bill Dave just referenced. This bill passed, and the primary policy behind HB 2140 was about the local levies. It also carved out the non-represented Educational Service District (ESD) employees from participation in the SEBB Program until January 1, 2024. That does leave in all the represented employees from the ESDs, which we know there's approximately 300 employees who will be coming into the SEBB Program starting 2020 and approximately 3,000 or so employees who will be entering in from ESDs in 2024. HB 2140 also has a requirement that HCA produce a report on ESDs that goes through some of the funding aspects of benefits for their employees, as well as the different funding sources for the ESDs. We are responsible for producing the report to the Legislature by November of next year.

Slides 3 – 5 – Passed Legislation. All of the bills I'll review passed and have been signed by the Governor, except 2SHB 1065 is waiting to be signed. HB 2140 has yet to be signed by the Governor, but he has until Tuesday of next week to act.

2SHB 1065 passed. This legislation has been circulating around the Legislature for the last five or six years. It's to protect consumers from out-of-network health charges, specifically when have an emergency procedure at a hospital, your hospital bills are covered, but you may receive a surprise bill from the anesthesiologist that is out-of-network and you owe them a substantial dollar amount for the out-of-network charges. This bill helps protect against that and allows the consumer to pay the in-network rate for those services that occur in those emergency type settings, including anesthesiology, laboratory, pathology, etc., that were unavoidable. We were in support of this legislation.

EHB 1074. This bill raised the purchasing age for tobacco products from 18 years of age to 21 years of age. This bill may have implications to some degree on the tobacco surcharge that's assessed. The bill included language on vaping products being included in that age range that adjusts upwards. In the tobacco surcharge we will be assessing for the SEBB Program population, it does not include vaping products in the tobacco definition. That may be a consideration in the future. Do we change to align with this legislation?

Dave Iseminger: We're not anticipating bringing anything to the Board this season for changing or evaluating the surcharge for 2020. How the regulatory environment continues to change with regards to vaping products is something the agency has been monitoring since the tobacco surcharge was implemented 2014 in the PEBB Program. At some point there will be a fulcrum tipping point in the regulatory environment where we may come to both Boards asking you to consider evaluating and changing your tobacco product definition to include vaping products. This is another piece of the puzzle of the regulatory environment and seeing how things are changing. We will continue to monitor.

Cade Walker: House Bill 1099 provides additional protections to adult children on their parent's health insurance plans who are over the age of 18. They're defaulted to the same communication and privacy other adults are regardless of whether or not they are a dependent on a plan or they're the primary subscriber. We supported this legislation.

Pete Cutler: On Engrossed Substitute House Bill 1099 dealing with requiring carriers to provide network information for mental health providers, I presume it applied to our insured plans with Kaiser. Does it apply to Uniform Medical Plan as well, or for the SEBB Program?

Cade Walker: Engrossed Substitute House Bill 1099, I conflated that with SSB 5889. I apologize. ESHB 1099 is the legislation requiring expanded notification for network adequacy and provider availability, specifically related to mental health services. A constituent testified before the Board about this bill. It has passed and been signed by the Governor's Office. Because it is within ESHB 1099 and it's an OIC regulation, our analysis is the Uniform Medical Plans are exempt from that requirement although they already display that type of information on their website. The provider search for Regence does have the availability of mental health providers, if they're accepting new patients, and providing a listing of those providers within the service area.

Dave Iseminger: Voluntary compliance, Pete. It doesn't squarely hit the self-insured plans, but typically, we try to implement the same --

Pete Cutler: It's great to know that Regence administration of the UMP already includes the ability to verify whether a given provider is accepting new patients. And that's great. Thank you.

Cade Walker: Engrossed Substitute Senate Bill 5526 is the Cascade Care/Public Option. You may have seen this on national news. The agency was tasked with certain responsibilities in the procurement efforts for the public option that will be

provided on the exchange. We're still looking at where that will be landing and the Employees and Retirees Benefits Division's involvement. We will provide technical assistance for the public health option.

Dave Iseminger: This doesn't have a direct impact on either the SEBB Program or PEBB Program, but as your program has significant influence on the commercial market, so does your sister program, and so will this. We wanted to keep the Board apprised of other activities in the commercial market that are also influenced by this agency.

Cade Walker: 2SSB 5602 related to preventive services and women's reproductive services. It provides protections for gender and gender expression. It expands some of the service requirements that health carriers and student health plans are supposed to offer. It expands coverage under certain reproductive treatment and services for all populations. Our plans will be in compliance.

Dave Iseminger: ESSB 5526 and 2SSB 5602 have been signed by the Governor.

Cade Walker: SSB 5889 is the bill I confused with ESHB 1099. This is expanded protections for adult children on their parents' coverage, ensuring they have the privacy they're otherwise afforded. It also allows children over the age of 13 to request to have all their health information from the health carrier and provider sent to them upon written request. For over 18, the expectation is the carriers communicate directly with the member regardless of their status of the subscriber on a plan.

Slide 6 – Passed Rx Legislation. Two pieces of pharmacy legislation passed. Engrossed 2 Substitute House Bill (E2SHB) 1224 and ESHB 1879. In E2SHB 1224, health carriers and pharmacy benefit managers (PBM) must report to the Health Care Authority prescription pricing data and advanced notice before increasing prices of certain drugs. The Health Care Authority must analyze the data and provide an annual report to the Legislature on pharmacy pricing. It's a transparency bill related to the cost of prescription drugs.

ESHB 1879 requires clinical review criteria that's used to establish a pharmacy utilization management protocol. It must be evidence-based. If a health carrier or pharmacy benefit manager uses restrictions, they must provide clear, readily accessible and convenient processes to request an exception. This bill establishes requirements and timelines for step-therapy exception requests.

Pete Cutler: On ESHB 1879, it says they have to use evidence-based prescription drug utilization management criteria. Does it require them to disclose what criteria they used, both to the consumer and to the Health Care Authority?

Cade Walker: I don't have the answer and will follow up with you.

Pete Cutler: That would be good because I know when I was working with that issue, there was quite a bit of push-back from carriers claiming they were prohibited, the different entities they used as organizations to provide them with criteria, made it a condition they couldn't disclose what the criteria was. I'd be very curious to hear whether that transparency issue was addressed.

On E2SHB 1224, were there any questions or issue about legal challenges based on this was something that states can't require organizations to do? There again, that was something that was claimed in the past. I'm not sure if that legal context, in terms of requiring PBMs or health carriers to provide cost data, whether there's greater clarity now than there used to be about what a state could do. Do you have any idea about that?

Dave Iseminger: Pete, E2SHB 1224 limits the disclosure of the transparency information to purchasers and the Legislature. I don't believe the final version has a forum by which any member of the public can go and find the information. The disclosure is more limited in the final bill than the original versions of the bill. My understanding was part of that balance may have related to the very things you're bringing up.

Pete Cutler: So subject to same exceptions from public disclosure as the actuarial analysis and that kind of stuff.

Dave Iseminger: Yes. It's a somewhat soft spotlight. It's not as bright a spotlight as maybe for the entire public.

Pete Cutler: It's only a select few have access to the spotlight.

Dave Iseminger: Purchasers and the Legislature.

Cade Walker: Slide 7 – Newly Required Reports for ERB. I wanted to give a brief overview of the new reports required of the agency or our program this session. We have six reports we're responsible for, four of which I've listed.

November 1, 2019 we are required to report in a more formalized manner to the Legislature addressing the Medicare eligible retirees, the rising cost of prescription drugs, and member premiums. The ERB Division has been working with the Legislature and providing that information this last session. Now we're required to have a more formal report provided to them in November 2019.

As Megan mentioned, by February 5, 2020 we need to tell the Legislature if districts were timely in paying us.

November 15, 2020 there is a report due to the Legislature about the feasibility of a consolidation of the SEBB Program into the PEBB Program by January 1, 2022.

Dave Iseminger: The Legislature gave us a timing assumption to use in the report. The report will describe challenges and benefits, the pros and cons of a consolidation, and a target date was given as a framework for that report. I don't know if legislative action will be needed during a subsequent legislative session to authorize the actual consolidation of programs. It is a timeline established for the agency to put together the report and give guardrails for assumptions included in the budget provision. It is clear, however, that there are two pieces in the budget provision – it's not the PEBB Program and the SEBB Program into something new. It's not the PEBB Program into the SEBB Program. The framework is the SEBB Program into the PEBB Program. The

Legislature gave us that assumption and a starting date assumption. I don't want people assuming something is definitely happening in 2022.

Sean Corry: Will this Board be part of the discussion? How will we be informed about that work?

Dave Iseminger: This report was added in the late aspects of the budget process. We are thinking how we're going to create the report and timeline. There will be intense interest from many parts of the public, stakeholders, and both Boards. I can't answer exactly how it will happen yet because we've only known this report existed for two and a half weeks. We will be working through the process of how that report will get completed and delivered. I have no details yet. For a decision of this magnitude, we will make sure there are ways for people to be included in the stakeholdering process.

Cade Walker: The last report, which is due December 31, 2020 is on the current costs and health plans offered by ESDs, comparison on those costs, and the benefits offered currently by ESDs. Of those who were to participate in the SEBB Program and the revenue sources for ESDs.

One point I did want to mention about House Bill 2140 and the ESDs, the ESD non-represented employees are eligible to participate voluntarily in the PEBB Program. We made sure that option was available to them. We currently have three ESDs accessing PEBB Program benefits, I believe.

Dave Iseminger: Five.

Cade Walker: Five ESDs currently participating in the PEBB Program and they'll be allowed to voluntarily remain in the PEBB Program until 2024 when they're compelled to migrate to the SEBB Program.

Pete Cutler: On the November report, it says benefit options available, Medicare eligible retirees. Do I understand that correctly to mean what are some options the Legislature could enact to create new options for Medicare retirees? I guess it's all offered through the PEBB Program. In terms of the PEBB Program retirees, is it to remind us what you currently offer as options in the PEBB Program or is it a give us more options? What are our different opportunities?

Dave Iseminger: It's about a reminder of what the entire Medicare portfolio looks like in the PEBB Program, as well as options for changing that portfolio - likely adding to that portfolio, additional plan options for the future.

Lou McDermott: What class does Mrs. Walker teach?

Cade Walker: She's in first grade at McLean Elementary School.
Lou McDermott: First grade! Thank you for all your work, Mrs. Walker.

[break]

Policy Resolutions

Rob Parkman, Policy and Rules Coordinator, Employees and Retirees Benefits Division. There are two policy resolutions for action today. SEBB 2019-09 – Error Correction Recourse and SEBB 2019-10 – Error Correction Premium Responsibilities. Slide 3 is language from RCW 41.05.740 which connects the policy decisions today to the Board's authority.

Slide 4 – Policy Resolution SEBB 2019-09 – Error Correction Recourse. Changes made since the last review are: a period was added after "identified" in the third row from the bottom. We added "Health Care Authority approves all error correction actions," second and third row from the bottom. The resolution you saw at the April meeting is in the Appendix for your reference. Stakeholder feedback: one stakeholder commented they support this resolution with concerns. The concerns included issues around retroactive coverage and the process and interaction required between the SEBB Organization and the Program. There were no other comments.

Vote on Policy Resolutions

Lou McDermott: **Policy Resolution SEBB 2019-09 - Error Correction Recourse**

Resolved that, if a SEBB Organization fails to provide notice of benefits eligibility or accurately enroll a school employee or their dependents in benefits, the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified. The Health Care Authority approves all error correction actions and determines if additional recourse is warranted.

Pete Cutler moved and Alison Poulsen seconded a motion to adopt.

Sean Corry: In my firm's experience working with the carriers and school districts, it's very common to retroactively correct errors that occur in enrollment. Was there discussion about liability for the districts due to less flexibility? The carriers have always been kind to fix eligibility, at least in our experience, missed eligibility dates, retroactively enrolling. This is apparently not going to occur if this passes. Was there a discussion at the Board level or among people here representing school districts about the shift or increased risk of liability for claims that might have been paid by carriers had enrollment occurred properly? I'm wondering if that discussion occurred and what the result of that discussion, what effectively is a transfer of risk to the districts with this going forward.

Dave Iseminger: This resolution states that at least the error is corrected prospectively. It does not prohibit a retroactive enrollment. In fact, in the PEBB Program, additional recourse - this last sentence where the Health Care Authority approves all additional recourse - often the additional recourse warranted is a retroactive enrollment that is necessary under the circumstances. There are many instances where that action is ultimately part of a recourse. We want to be very clear because there have been instances as in the PEBB Program about prioritizing immediately getting the prospective piece fixed and then everybody getting together and deciding exactly what the correct retroactive additional recourse might be. In some instances, an employee might have had insurance elsewhere and so they're not interested in that coverage. They are not asking for that recourse. We didn't want to set up mandatory retroactive enrollment. The next Resolution SEBB 2019-10 talks about where some of the liability might be based on mistakes that happen. That would

be incorporated either prospectively or retrospectively, as well. This language doesn't prohibit retrospective enrollment. It prioritizes, gets prospective enrollment sorted out first, and then additional error correction that's warranted would be approved by HCA. Sometimes the agencies in the PEBB Program proactively ask for that and other times HCA says, "you need to look at this recourse." We approve the type of recourse needed. We maintain that authority at HCA to ensure consistency across all employers and for the integrity of the program. Did that help, Sean?

Sean Corry: Somewhat.

Dave Iseminger: Why just somewhat? I don't like just being somewhat helpful.

Sean Corry: I said somewhat because what you explained is much more than what is in this last sentence.

Pete Cutler: I'll just weigh in. For one, I'm highly fixated on trying to promote administrative simplification. I'm generally in favor of having administrative changes take place prospectively. But what Sean has said about carriers being willing to extend enrollment retroactively also sounds vaguely familiar from my past career. Because that's actually much simpler in terms of tracking than if you try and retroactively take away coverage. I was wondering if there'd be any problem with just saying on that last sentence after the word "additional recourse," if it would be any problem with adding "which can include retroactive enrollment." Insert something like that to make it explicit that is an option the HCA could take.

Dave Iseminger: I think it's fine if somebody wants to make a motion to amend and add, as you said, Pete, something similar to, if it would read "if additional recourse, which may include retroactive enrollment, is warranted." I would just use the word "may" instead of "could." We tend not to use "could," or "would," or "should." We use "may," or "must," or "shall," or "will."

Pete Cutler: I move that the resolution be amended to add after the word "recourse" on last sentence at the very bottom of the page, insert ", which may include retroactive enrollment,."

Pete Cutler moved and Sean Corry seconded a motion to adopt the amendment.

Voting to Approve: 9
Voting No: 0

Lou McDermott: Proposal to amend Policy Resolution SEBB 2019-09 passes.

Amended Policy Resolution SEBB 2019-09 – Error Correction Recourse

Resolved that, if a SEBB Organization fails to provide notice of benefits eligibility or accurately enroll a school employee or their dependents in benefits, the error will be corrected prospectively with the enrollment in benefits effective the first day of the month following the date the error is identified. The Health Care Authority approves all error correction actions and determines if additional recourse is warranted, which may include retroactive enrollment.

Katy Hatfield: So the clause is actually supposed to be inserted between "recourse" and "is warranted," technically. Does everybody understand it? (The Health Care Authority approves all error correction actions and determines if additional recourse, which may include retroactive enrollment, is warranted.)

Dave Iseminger: We'll let the record reflect that the chair said it as needed instead of the other way when we finalize the minutes, Connie.

Voting to Approve Amended Resolution: 9
Voting No on Amended Resolution: 0

Lou McDermott: Amended Policy Resolution SEBB 2019-09 passes.

Rob Parkman: Slide 5 - Policy Resolution SEBB 2019-10 – Error Correction Premium Responsibilities. Changes since last introduced: The last part of the resolution was changed from "without rescinding the insurance coverage" to "the error will be corrected prospectively with termination of benefits effective the first day of the month following the date the error is identified." This was added at the request of the Board at the last meeting. You can see the actual resolution presented at the April meeting in the Appendix. Stakeholder feedback: One stakeholder supported with concerns. Their concerns included the negative impact on the staff that made the mistake.

Lou McDermott: **Policy Resolution SEBB 2019-10 – Error Correction Premium Responsibilities.**

Resolved that, if a SEBB Organization errs and enrolls a school employee or their dependents in SEBB insurance coverage when they are not eligible and there was no fraud or intentional misrepresentation by the school employee involved, premiums and any applicable premium surcharges already paid by the school employee will be refunded by the SEBB Organization to the school employee. The error will be corrected prospectively with termination of benefits effective the first day of the month following the date the error is identified.

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2019-10 passes.

Annual Rule Making 2019

Rob Parkman, Policy and Rules Coordinator, ERB Division. I'm going to provide a high level briefing on this year's rule making. I will highlight the most significant changes in rule making activities. No action needed from the Board.

Slide 2 – Rule Making Timeline. Next week we will file our CR-102 and conduct a public meeting for that CR-102 on June 25. We will file the CR-103, our final rules, if all goes well. Those rules will be effective October 1 in support of open enrollment.

Slide 3 – Focus of Rule Making. We are on a two-year rulemaking plan. This year's focus is to add the rules generated during this phase. Last year, we generated about 85% of our rules. This year we're generating the other 15%. We found a couple additional rules we thought we needed to support Go Live. We'll look at the administration and benefits management, regulatory alignment, amendments within HCA's authority, and the implementation of the Board resolutions from last November through today.

Slide 4 – New Sections Added This Year Within the WACs we created, this reflects a little more than an inch of rules, about 212 pages, double sided. That's what the Board accomplished in the last year and a half. I wanted to show you we actually have a product. A lot of work has gone into this over the last two years.

Within the Enrollment Chapter WAC 182-30, there are currently 16 sections. Six sections were added this year. One of those sections is a new one we didn't anticipate, but it was for this first open enrollment because it won't be like our normal open enrollment. We had to have a special rule because it will be an active open enrollment, not our normal anticipated passive open enrollment.

Within the Eligibility Chapter, WAC 182-31, we currently have 19 sections seven of which were added this year. We added one we didn't originally plan for and that was based off those more generous eligibilities the Board passed for Go Live. You passed a resolution in January and a couple in March that caused us to create a new section.

Then we have the Appeals Chapter, WAC 182-32, which has 44 sections. We only added one section this year based on the wellness resolution you passed.

We have a total of 79 sections.

Slide 5 – Administration and Benefits Management. From the administrative and benefits management point of view, we amended and created new definitions. We defined what a "week" is. When the Board passed the more generous eligibility with that kind of mid to late-year hire, we talked about six of the last eight weeks. We needed to define what a week is so that we can do the counting correctly. We've made a number of other readability changes to other definitions. We've changed some sections to remain in alignment and consistent with the other program rules. These would include changes made to COBRA, salary reduction, and when subscribers enroll or remove eligible dependents.

Slide 6 – Regulatory Alignment. The state has a Paid Family and Medical Leave that starts January 1 so we have updated the rules to include that state law. We've made amendments due to the passage of Engrossed Substitute House Bill 2140. That will be ready to file next week.

Pete Cutler: Rob, can you remind me what ESHB 2140 is?

Dave Iseminger: ESHB 2140 is the bill referenced a couple times that has the delayed implementation of non-represented ESD employees until 2024.

Rob Parkman: Slide 76 - Amendments within HCA's Authority. We amended some special open enrollment (SOE) rules. These included clarifying that newly hired school employees get 31 days to make an election, not 60 days based on an SOE. We also amended the continuity of care rule to add clarity to this special open enrollment rule to allow plan changes based on continuity of care issues. We amended the dependent moves in and out of these United States of America provision and added "and that change in residency results in the dependent losing their health insurance." So we've added another requirement onto that SOE.

Dave Iseminger: These are things that help align or clarify pieces under IRS regulations. For example, that last one, if there isn't a loss of the health insurance, if you picked a plan that has international coverage, for example, the Uniform Medical Plan, your change in residency doesn't change your ability to access the plan you're in, then it's not really an authorized IRS event.

I also saw a couple of puzzled looks with the first one. We'll have somewhere around 600,000 to 700,000 members between the two programs. There are often creative arguments that come up during appeal. This one was something generated because it's not expressly stated anywhere in IRS rules. We had an individual who missed their 31-day period and questioned why she didn't get another 29 days because, technically, she had a new job and changed enrollment and under the IRS rules, because she had a change in job, she argued she got 60 days. We told her not when you're *starting* your job. We talked with our tax advisors about this particular rule and they said it's inherently obvious but nobody stated it. We added it so we don't have any more creative arguments. We learn all the time in our appeals processes of creative arguments and where we can eliminate risk.

Pete Cutler: Can you at least steer me to the chapter that has the continuity of care rule?

Rob Parkman: We have it in a couple places. The first place would be WAC 182-30-090.

Slide 8 – Implement SEB Board Policy Resolution. We have implemented 17 SEB Board resolutions that are already in rule. They are in the Appendix if you want to see the full list. It also shows which rules support those Board resolutions.

Affordable Care Act (ACA) Reporting

James Koch, Management Analyst, Benefits Accounts Section, ERB Division. I'm here to provide information about the Affordable Care Act (ACA) reporting requirements and penalties, and to describe how the Employees and Retirees Benefits Division helps support school district ACA reporting.

Slide 3 – ACA Background. In 2010, Congress passed the Patient Protection and Affordable Care Act, which was intended to expand access to insurance, increase consumer protections, emphasize prevention and wellness, improve quality and system performance, expand the health workforce, and address rising healthcare costs.

Slides 4 – 5 - ACA Provisions Include: Some of the well-publicized provisions you're likely familiar with include coverage for children up to age 26, the tax treatment of children under age 27, no pre-existing condition exclusions, no lifetime limits, and no rescissions of coverage. Health plans now have to provide standardized summaries of benefits and coverage, and W-2s must report the full cost of employer coverage.

The ACA also created health benefit exchanges or health insurance marketplaces in every state. They can offer reduced premiums to qualifying subscribers who meet household income criteria and who don't have disqualifying offers of coverage. It established the individual mandate, which requires or required most individuals to have health insurance or pay a penalty. It established the employer shared responsibility requirements, which require large employers to provide certain employees with medical coverage or pay a penalty.

These three provisions significantly impact employers to enable enforcement of the individual mandate and employer shared responsibility provisions. Regulations require certain medical insurance coverage data be reported to the federal government to prove compliance, and penalties were established to incentivize compliance. It's really complicated so I'll provide a high level, systems level overview of the ACA coverage reporting requirements.

Dave Iseminger: I want to make sure it's clear to people, obviously the individual mandate has changed since the original legislation was passed by congress, but the reporting requirements that underlie the enforcement ability were unchanged. Even if the individual mandate to individual consumers and individual citizens isn't being enforced or doesn't have an actual dollar amount penalty, the reporting behind all of it is unchanged and there's still reporting obligations.

James Koch: Slides 6 – 12 - ACA Medical Coverage Reporting, shows the requirements that currently exist for these different systems. In red is the health benefit exchanges (HBEs). Slide 6 - HBEs report enrollment across the big curvy line. Enrollment and premium subsidy information of taxpayers, in this case, it's the subscribers, specifically. They report enrollment and premium subsidy information to the IRS and they report premium subsidy information to employers. HBE reporting requirements are important because enrollment of certain employees at a health benefit exchange is what actually triggers employer shared responsibility penalties.

Slide 8. In purple, we have two groups: health insurance issuers of fully insured coverage and government sponsored programs like Medicaid, Medicare, and Tricare. Each of these groups report medical enrollment to both the IRS and taxpayers, again, specifically to subscribers on the taxpayer side.

Slide 9. In green, we have employers. Large employers, those with 50 or more full-time equivalent employees must report information about offers of coverage to both full-time employees and the IRS. All employers, regardless of size must report self-insured medical enrollment to employees, subscribers, and the IRS.

Slide 10. Finally, in blue, we have taxpayers. All of us around the table, we have to report medical enrollment of all family members to the IRS. This is what we do annually

on our tax returns. And as Dave mentioned, even though that penalty has been zeroed out through the most recent legislation, the reporting requirement does remain. Whether it will remain next year or not remains to be seen.

Slide 11. Together, these reporting requirements give the IRS and taxpayers a complete picture of medical coverage offers to full-time employees and enrollment for all covered individuals. Basically, taxpayers get a full picture of enrollment and the IRS gets a full picture of enrollment and offers of coverage.

Slide 12. With all this data, the IRS can then assess shared responsibility penalties if applicable. For taxpayers, these are the individual mandate penalties we've discussed. And for employers, these are employer shared responsibility penalties. I'll discuss employer penalties in the next couple slides. As Dave mentioned, the individual mandate is currently zeroed. That didn't affect employer shared responsibility penalties.

Slides 13 – 20 - ACA Reporting. These next few slides we'll look at the regulations behind the reporting requirements. We'll review reporting regulations for fully insured health plans and employers who offer self-insured coverage and reporting regulations for employer offers of coverage and the related penalties. I'll show you a few 1095 report samples.

Slide 14. Health insurance coverage reporting is required under Internal Revenue Code Section 6055. It directs that health plans and employers with self-insured health plans must report health plan enrollment to covered individuals on forms 1095-C or 1095-B, and report the same information to the IRS. Under this requirement, school districts report self-insured Uniform Medical Plan enrollment, speaking of the future SEBB Program benefits.

Dave Iseminger: Remember the Uniform Medical Plan is statewide so it is possible there could be at least one person in every district enrolled in the Uniform Medical Plan; and therefore, all school districts are likely to have at least some self-insured reporting they need to do if they're not already doing it today.

James Koch: Fully insured plans will report their plan enrollment. It really is a straightforward reporting requirement. It's a monthly enrollment summary done once a year.

Slide 15. The employer shared responsibility reporting is required under Code Section 6056. Under this regulation, large employers must report offers of coverage to full-time employees on a form 1095-C and report the same information to the IRS.

Slide 16 – Code Section 4980H establishes the penalty structure for employers who fail to offer medical coverage to certain employees. This regulation establishes that small and large employer penalties may apply if a large employer fails to offer full-time employees medical coverage that is affordable and provides minimum value. As described on this slide, the underlying words are terms of art. They're specifically defined by the regulation. Large means 50 or more full-time employees or full-time employee equivalents. If you had 100 half-time employees, that would meet the standard of 50 full-time employees. Full time generally means an employee who

averages 30 hours a week or 130 hours a month. Affordable means the lowest cost of self-only coverage available to the employee. It doesn't exceed 9.5% of the employee's household income. The 9.5% is an annually adjusted measure. Minimum value means the plan share of the total allowed cost of benefits is 60% or greater. Under this framework, regulations further established the small and large penalties, which are influenced in part by that second criteria, the degree to which the employer offers full-time employees medical coverage.

Dave Iseminger: To be clear, it's not about whether an individual employee, at this point, elects the coverage. It's whether there's actual coverage that meets these criteria *offered* to the individual.

Pete Cutler: On the beginning of the Internal Revenue Code Section 4980H, I want to clarify that the adjectives small or large are intended to modify the penalties, right? Not the word employer?

James Koch: Correct. Exactly.

Pete Cutler: It's not like we have different penalties for that. There are employer penalties that may be large penalties or smaller penalties.

James Koch: Exactly.

Dave Iseminger: Pete, that's actually James' next set of slides, walking through what a small penalty is and what a large penalty is.

James Koch: Thank you for that distinction. Slide 17. Under this regulation, a small penalty is assessed when the employer offers coverage to 95% or more full-time employees. The employer does not offer coverage to a particular full-time employee from the remaining 5% or less of the employees. The employee not offered coverage enrolls in a health benefit exchange or marketplace coverage, and that employee receives a premium tax credit for the coverage they enrolled in. If all four of those conditions occur, the employer is assessed s per employee per month penalty. The small penalty rate is adjusted annually. It began in tax year 2014 as a $250 per month penalty. And in 2019 it's been annually adjusted to $312.50.

Slide 18 – Small Penalty Example. We all work for the same large employer. Our company had 100 full-time employees. 95 employees are represented by green faces and were offered qualifying coverage. Five employees, represented by red faces, were not offered qualifying coverage. If one of those employees not offered coverage enrolled in coverage through the Washington Health Benefit Exchange for the entire tax year and qualified for a premium subsidy for every month of the tax year, then the small penalty would be $312.50 times 12 offending months for a total of $3,750.

James Koch: Slide 19 is an example of a large penalty. The large penalty would be assessed when the employer offers qualifying coverage to less than 95% of full-time employees and one full-time employee not offered coverage enrolls in an HBE or marketplace coverage, and that employee receives a premium tax credit for coverage. In this case, because the employer failed to offer at least 95% of full-time employees an

offer of coverage, the penalty rate is the monthly penalty rate multiplied by the count of all full-time employees for each month that the criteria is met. This large penalty rate began at $166.67 in tax year 2014. It's been annually adjusted up to $208.33 a month in tax year 2019.

Slide 20. The same graphic is used here as we did for the small penalty. The penalty is dramatically larger than the small penalty. If all employees work for the same large employer and the company still had 100 full-time employees but only 94 full-time employees were offered qualifying coverage that leaves six full-time employees who were not offered coverage. Only one employee was enrolled in the HBE and received the premium subsidy each month. The large penalty is $208.33 times the 12 offending months times the 100 full-time employees in the organization, or about $250,000 for that employer.

Alison Poulsen: If there were two employees, does that have an exponential impact or is it a maxed out --

James Koch: No, because the calculation is just on one or more. It's a threshold of one or more if you're under 95%. But, if in the small penalty example there were two employees who enrolled in the HBE, the small penalty would have been doubled.

Slide 21 is an example of 1095-C. It's used by large employers to meet one or both of the ACA reporting criteria applied to large employers. Slide 22 - Large employers have to issue the form to employees or former employees who meet one of two criteria: Criteria 1 - employees determined full time for one or more months of the year; and/or Criteria 2 - employees or former employees enrolled in self-insured coverage for one or more months of the year. Slide 23 - if you're receiving form 1095-C because you met the Criteria 1, you were determined full time for one or more months, then Part II is completed. It basically reports information to IRS about the employer's offer of coverage to the employee using specific codes described by IRS.

Dave Iseminger: James is showing you examples of the 1095-C that was created by the Health Care Authority for use in the PEBB Program. The coding used is explained on the back of the form.

James Koch: If you're involved in this, you appreciate the directions on the back of the form are very limited. You'll get all kinds of questions from employees because it is a complicated code set.

Pete Cutler: The Board doesn't really get a flavor for the complexity here unless you do look at those code sets and realize how granular the different distinctions between different situations have been split up. But for our sake, I'm glad you didn't.

Dave Iseminger: If you want to think about the complexity and I always think of the 1095 as your health W2. We all know our W2s are complicated, have a lot of different coding. It's the same exact thing. This is your health insurance enrollment and offer of coverage W2.

James Koch: Slide 24 is an expanded view of Part III of the 1095-C. If you're receiving a 1095-C because you meet Criteria 2, you were enrolled in self-insured coverage for one or more months of the year, Part III will be competed as well. Any employee who's enrolled in self-insured coverage for SEBB, that would be Uniform Medical Plan coverage, will have Part III filled out. If an employee waived coverage or they elected non-self-insured coverage, that section will be empty.

Slide 25. An IRS 1095-B looks very similar. Part IV of the form is used to report covered individual enrollment. Slide 26 - Fully insured plans report covered individual enrollment on a 1095-B. Small employers with less than 50 full-time equivalent employees, like some school districts, report self-insured enrollment of employees and former employees. Former employees would be like retirees who continue to remain enrolled in self-insured coverage. I would say that in 2018, we had 88 school districts that had 50 or fewer employees. We've had a fair number that would likely use a 1095-B because they're not required to use a 1095-C. They're not a large employer. You don't want to be filling that form out if you're not required to. They would use the 1095-B to report only those employees who enrolled in Uniform Medical Plan coverage. Some large employers choose to report former employees' self-insured coverage enrollment using a 1095-B. They may choose to report their full-time employees on the 1095-C and then report their former employees enrollment only on a 1095-B. That is allowed under regulations. Government sponsored programs, Medicaid, Medicare, Tricare, should be using this form to report enrollment as well.

Slide 27. The Employees and Retirees Benefits Division has an important role in supporting school districts' ACA reporting. It's been going on since 2015. Since then, we've provided PEBB Program enrollment data to all school districts except those with no Uniform Medical Plan enrollment. In 2018, we only had nine school districts who didn't receive an enrollment data file from us. We distributed 302 data files to school districts who had one or more employees enrolled in the Uniform Medical Plan.

Dave Iseminger: If you're wondering why everyone got this information, it's because there are retirees who have always had eligibility under the PEBB Program, and the bulk of enrollment in the PEBB Medicare portfolio is UMP Classic. The bulk of retirees from the K-12 system, of which there's roughly 50,000, have been enrolling primarily in the Uniform Medical Plan. As a result, we have been giving that data back to the school districts so they can do their employer responsibility reporting for those retirees. The state did not pick up and complete the reporting requirement on behalf of school districts. We provided the data necessary for them to complete the report. The data flow has been in existence for four to five years and that's what we'll be leveraging to continue to give the data that we've already given for retirees, and in the future for the SEBB Program enrollment as well.

James Koch: There are two categories of districts we've worked with. Participating districts are those who contract with the PEBB Program for their employees. They receive the employee enrollment information and former employee enrollment information for their retirees and COBRA enrollees. Nonparticipating districts are those who don't contract with the PEBB Program and only receive the retiree enrollment information Dave described, specifically for Uniform Medical Plan enrollment. Beginning in 2020 under the SEBB Program, every school district will be in our participating district category and receive data.

Slide 28. To prepare a school district for our annual data distribution, we verify the data distribution contacts for every school district in writing. We make sure to validate who we're communicating with is still valid about a month before we start to produce those data files. We provide sample enrollment data files and guidance documents so they can take a look at examples before they have the actual data files. And we provide group and individual trainings for school district staff on how to use and apply our data.

Slide 29. We securely distribute enrollment data. It's an ongoing process. Prior year enrollment data is distributed every year in early January. January 7 of this year we distributed 2018 enrollment data files. Rapid data distribution is important because employer reporting requirements by regulation are January 31 of every year. Every year since the beginning, the reporting requirement has either been completely relieved for 2014 or delayed beyond that January 31 date. But we've always distributed data in January because some employer groups who we distribute data to choose to do their reporting sooner than that extended deadline.

Dave Iseminger: Typically, that extension is a last minute extension. We never want to rely or put a district in a position where they don't have the data and the IRS doesn't grant an extension.

James Koch: After the January distribution where we've distributed the prior year's data, monthly thereafter, we distribute any corrections. These include additions due to retroactive enrollment, changes due to corrections, or deletions due to retroactive terminations. Of course, more files change near the front of the year and very few files near the end of the year.

Slide 30. After they receive their data, the school districts are responsible for ACA reporting. They will use the SEBB Program and the PEBB Program enrollment data provided by the ERB Division, along with their own district payroll data and their own district's established method under the federal rules for determining full-time status of employees to complete their ACA reporting. That includes forms 1095-C to employees or former employees and copies or data transmissions to the IRS.

Anecdotally, districts have some supports in this process just by my experience talking with them. We provide a lot of guidance in terms of the data that we provide. We help point them to the right places in the regulation where their questions can be answered. The educational service districts do a great job with helping school districts both understand the data and how to do data reporting requirements. WSIPC plays a role in helping districts understand how to use that data and provide reporting guidance. Many districts use a third party to actually perform the reporting requirements.

Pete Cutler: My recollection, at least from three or four years ago, was the IRS rules for determining who is a full-time employee were really complex and had specific additional complexities related to people who worked on a school year, academic year type basis. My recollection then was there was concern that if you guessed wrong about whether your employees were full time, you could end up missing that 5% standard and be at risk of huge penalties because you thought certain people really weren't full time and the IRS could determine they were. Has there been additional guidance? Has that been a problem for school districts or state agencies in terms of getting clarity on which employees are full time?

James Koch: I can't speak to whether it's been a challenge for individual districts. It is a complicated system for determining full-time employees. There are special provisions that apply to educational organizations like the school districts whereby, essentially, the regulations are neutralizing the effect of not working over summer months. The termination of full-time status is based on the calculation of the hours of service relative to the full-time standard of 130 hours a month. Those protections were in place so school districts weren't caused to disproportionally determine employees as not full time.

The regulations themselves haven't changed since they were initiated. There was a surge of conversation and education that occurred in 2014 in the lead up to the regulation. Since then I think there's been a calming because there haven't been any changes. As an employer, you really had to make the right steps on the front end to be able to set yourself up for ongoing measurement of full-time status for those employees. I'm not aware that people have changed their measurements after that first year. I know for the state we haven't.

Dave Iseminger: There is so much complexity on the third bullet it could be it's own hour presentation. Even you and I who are interested in this, are barely interested in that level of detail. We know there are multiple ways to determine full-time status and the districts have chosen different ways. There's no uniformity in how districts are determining full-time status. They've chosen different subsets of that regulation. We see all of this data on the PEBB Program side with state agencies to monitor proper eligibility determinations. It's one of the tools in our toolbox to indicate an agency is bordering on the 95% threshold and could be going about to triggering a large employer penalty. What's going on in that setting? Is there something about the types of employees that prompts us to look and bring to the PEB Board a recommended change on eligibility? Or it gives us insight as to where we prioritize our Outreach and Training Unit with that home HR department to make sure they understand how eligibility requirements work and to ensure determinations are being done correctly.

The third piece is an area James and his team spent a lot of time looking at to determine if there is something wrong in how the data actually flows. Are there mix ups in the data and how are people coding things? We use it in an auditory function to determine how rules are being implemented. I imagine we will do the same with districts. That will give us insight to determine if we need to bring back to the Board possible changes in eligibility to help people be in more compliance, or do we need to assist individual school districts that are the furthest away from the 95 percentile? We want to help them avoid penalties as best we can.

James Koch: I would just clarify that 95 percentile is determined by the specific districts. It's not a function of the Health Care Authority. Through conversation with them, we can help and engage in that conversation the same we way we do for state agencies.

Pete Cutler: That is useful to know there is an active monitoring process now taking advantage of this data that's required to be reported and collected. As a SEB Board Member, I'm not that worried about it because with our eligibility criteria, 630 hours in a year, I think there's very little risk you'll have a district having somebody work 130 hours a month over nine months, or however long it is the feds require, who hasn't met the

630 hour requirement. I think given our eligibility criteria in the SEBB Program, it's probably going to be low-risk for the districts. It had the potential, at least, if the IRS had wanted to be vigorous on auditing and enforcement of causing a risk of high penalties in certain situations. I'm glad to hear about the monitoring, so thank you.

Dave Iseminger: On the monitoring standpoint, it's very hard. We're talking about the SEBB Program on 2020 being reported in 2021. In 2019 we gave 2018 data and the IRS just sent their 2016 letters. You're talking about six to eight year spans at the same time. I think we've only had one full cycle of penalty letter discussions on the PEBB Program side and we haven't identified something that systemically needs to be brought either to the Legislature or the PEB Board about eligibility. Offers of coverage has shown there are various training opportunities but not something systemic to change. It's going to be several years down the road because of the lags that it takes for the IRS to decide when they're going to send enforcement letters.

Lou McDermott: The Board will meet in Executive Session during the lunch period pursuant to RCW 42.30.(1)(d) to review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs and pursuant to RCW 42.30.110(1)(l) to consider proprietary or confidential non-published information related to the development, acquisition, implementation of state purchased healthcare services as provided in RCW 41.05.026. The Executive Session will conclude no later than 1:00 p.m. The public portion of the meeting will resume no earlier than 1:00 p.m.

[break]

Procurement Benefits Refinement Update

Lauren Johnston, Senior Account Manager, Employees and Retirees Benefits (ERB) Division. Slide 3 – Procurement Update. The table on this slide shows the contracts that have been signed in the left-hand column, and ongoing contract negotiations in the right-hand column. The signed contracts include: three self-insured medical contracts, which include the UMP Achieve 1, UMP Achieve 2, and UMP High Deductible; all Centers of Excellence contracts; all dental contracts; two vision contracts (Davis and iMed); the Long-term Disability contract; Life and AD&D; the plan selection tool contract; and a contract for dependent verification to be used in the initial launch.

Ongoing contract negotiations include the UMP Plus networks, all fully insured medical, the medical Flexible Spending Arrangement and Dependent Care Assistance Program (DCAP), and the MetLife vision contract. Officially, Aetna has withdrawn as a potential carrier after confirming they cannot participate in the state-based exchange for individual market coverage.

Dave Iseminger: The carriers we are still under negotiations with are Kaiser Permanent Northwest; Kaiser Permanente Washington, their HMO product lines; Kaiser Permanente Washington Options, their PPO products; Premera; and Providence. We have the Uniform Medical Plan, administered by Regence, for the medical side and MODA for the pharmacy side.

Lauren Johnston: Slide 4 – Future Board Actions. On June 12, the Board will need to finalize plan designs based on direction provided today. Either at the July 25 or August 1 meetings, the Board will need to approve final plan offerings, service areas, and the monthly employee premium.

Slide 5 – Finalizing Fully Insured Medical Benefit Design. To finalize the fully insured medical benefit design, we need final guidance from the Board today in order to make modifications to the plan designs by all of the carriers, which needs to occur before the June 12 meeting. The Not to Exceed (NTE) rates on the plan designs endorsed at the November 18 Meeting may limit those changes. Any potential changes must be within the current NTE rates.

Dave Iseminger: I've said the long standing analogy is 90% of your work was done before the legislative session, 10% of your work after legislative session. This is that time for any refinement. Any changes within any part of the benefit design must be locked in by June 12 because from June 12 until July, we'll be in the final rate setting process. Any benefit changes would impact that rate development process. We are not anticipating at this point that you have specific requests.

Lauren Johnston: Kaiser Washington Options submitted a change yesterday to their plan design. The comparison sheet was updated to reflect this change. It is included in their NTE rates. Under Kaiser Washington Options Plan One, the diagnostic tests, labs, and X-Rays, currently it says 20%. It's really 20% over $500. That means the member would have a $500 allowance and then they would pay 20% of anything over the $500. So just an update on that one.

Dave Iseminger: Lauren, that means the box on the comparison chart would look exactly like it looks for plan two?

Lauren Johnston: Exactly.

Dave Iseminger: Every time we release the latest version of the comparison chart, somebody finds something. It never fails. We're assuming the Board doesn't have concerns with accepting that change because it's not a takeaway. It advances things and was already built into the rate. We're just planning to auto-incorporate that in future documents.

Lauren Johnston: Slide 6 – Default Considerations. In setting the statewide default plans, HCA will consider: the monthly employee premium - or planned rates for benefits that are 100% employer paid, like vision - and the actuarial value of the medical plans; the extent of the service areas; and the provider network and access. We will set a statewide default plan to ensure equity and administrative simplification.

Dave Iseminger: I want to remind the Board, you took action at a previous meeting to say that when people don't interact during the open enrollment process, they will be defaulted into employee-only coverage for medical, dental, vision. They would have the basic life insurance and basic long-term disability plan and be defaulted as a tobacco user. There was a question of which plans for medical, dental, and vision. We described there would be a process where the agency identifies those plans. I

committed to the Board that although we are taking the steps as an agency to set those plans, we would engage with you and have a discussion on those. This presentation is highlighting the considerations we plan to use in selecting different plans. Lauren will go through the timeline process, but in that good faith, I said we would talk about what the process would be with you, bring you the types of things we plan to focus on, and see if there are things you want us to take into consideration.

Lou McDermott: How's HCA looking at the actuarial value? I get the monthly employee premium. You want to try and put them in something they can afford. I understand that, but when you're looking at actual value, what's your initial thinking?

Dave Iseminger: For example, and I'll use UMP as the examples because those are the plans that have the most discussion and the most robust information on all three of these points. You might get to a point where you believe UMP Achieve is the most appropriate default plan. Should it be 1 or 2? Should it be the 82% AV plan or the 88% AV plan? If you were to set the default plan as UMP Achieve 1, it comes with a lower premium, but it also comes with a lower AV, meaning lower claims cost paid by the plan in the long run. That's why it's listed as a single bullet point because they are intimately related. We wanted to acknowledge the amount the plan pays on the backend is something to focus on as well. Anything else you think we should focus on?

Pete Cutler: I just remembered that this is something the agency believes is an agency decision as opposed to a Board decision. Now I've taken more interest in what you were just talking about, that interplay between presumably wanting a low employee premium, but also wanting to balance that against the level of out-of-cost sharing. The higher the AV number, the lower deductible, the lower out-of-pocket cost at point of service. But the trade-off then is it's going to have a higher employee premium. I would be curious to know whether the agency is going to look for a balance between those two or whether it thinks it should prioritize one or the other as being more important. And you can answer this next month if you want.

Dave Iseminger: Probably won't answer that today.

Katy Henry: I was going to add to what Pete said. One of the things I hope is considered is the maximum out-of-pocket costs. I think it's aligned to what he's saying but it's one of the biggest considerations people make when they select a plan on their own.

Dave Iseminger: I'd be curious of the Board's insight. If the choices come down to UMP Achieve 1 versus UMP Achieve 2, with the information we have now, that's a difference of a $34 a month premium or a $101 a month premium. The $34 a month premium comes with a deductible at the single subscriber level of $750, and a $3,500 maximum out of pocket. The $101 a month premium has a $250 deductible and a $2,000 maximum out of pocket. How would the Board weigh that difference? I think there are equally valid reasons for balancing either of those.

Lou McDermott: Dave, if someone is defaulted, can they get out of the plan?

Dave Iseminger: It is important to realize that once an individual is defaulted into a plan, they'd be able to change it at a subsequent open enrollment or if they had an

appropriate special open enrollment event. But they would be locked in until either the next annual open enrollment or that special open enrollment event.

Lou McDermott: What if the reason they didn't enroll was because they're getting insurance through their spouse and they believe this doesn't apply to them. All of a sudden, they're getting defaulted and now they're in two plans?

Dave Iseminger: They would have the advantage of dual coverage in that type of situation, but we're working to help people understand the implications of not acting. One thing we have learned over time is that, to some extent, people have not really understood what would happen if they didn't engage. They know what the default plans are. Some people just hate giving the government information and they'll just default because it's exactly what they wanted.

We make sure the communication is as robust as possible about what the implications are of not engaging in the system. But, ultimately, if they filed an appeal, we would figure out what the circumstances were. It's all individual circumstances. At the very least, even in the PEBB Program when someone is defaulted, we make sure to highlight to them when the next opportunity to either waive coverage or select a different plan will occur. We would continue that engagement with school employees.

Lou McDermott: Did the Board have any other considerations the agency should look at as it makes the decision? I would want to have better coverage even though it would cost me more per month because I don't want to get the big bill. But that's me.

Dave Iseminger: But we have a wide range of economic circumstances.

Lou McDermott: Exactly.

Dave Iseminger: I don't know how people would feel about being defaulted into a $101 per month policy when they could've been defaulted into a $34 a month policy.

Lou McDermott: Or if they didn't want the policy at all. They thought that by not engaging nothing was going to happen. Now they're paying $100 a month.

Dave Iseminger: I would encourage you, if there's anything you want to share today, great. But also be thinking about this because this will probably be the most robust part of the conversation we need to have as we come forward with what the agency plans to do and ask for your thoughts on what we intend to set as the default plans.

Patty Estes: Can we refresh on what we decided earlier on how we are going to default someone?

Katy Hatfield: Yes. I didn't find the tobacco surcharge resolution, but I did find SEBB 2018-54. The resolution is: "Resolve that, the default election for an eligible school employee who fails to timely elect coverage will be as follows: enrollment in employee-only medical coverage, enrollment in employee-only dental coverage, enrollment in employee-only vision coverage, enrollment in basic life insurance, and enrollment in basic long-term disability insurance." The only one of those that has an employee premium is the medical.

Dave Iseminger: The question to the Board was do you want people defaulted into coverage or not defaulted into coverage?

Patty Estes: And did we, in any discussion, define timely manner?

Dave Iseminger: Timely manner is set by, I believe it's resolution SEBB 2018-12, a 31-day enrollment period for newly eligible folks. For the initial program launch, it would be during the annual open enrollment.

Lou McDermott: Katy, was he right? Is it number 12?

Katy Hatfield: Maybe. . .it's not 12.

[laughter]

Dave Iseminger: 12 is a key one, though! Tobacco's somewhere around 14 or 15 then.

Patty Estes: My only concern is we have this brand new program. We have open enrollment. We have school districts that are overwhelmed with things that are happening, budgetary things. People get lost in that shuffle and miss the communication that they need to enroll and end up getting defaulted because they missed a timeline. I have concern with some of our lower paid, right on that cusp, 630 hour employees that maybe $100 is a pretty significant portion of their paycheck that we're defaulting them into for a year, or however many months until the next open enrollment. For me, that 82% AV is looking a little better because it's an average. It's something that's very manageable for any of our subscribers, I would think. But I'm definitely going to look at it a little further. That's where my concerns lie with going any higher than that.

Lou McDermott: Dave, with the initial rollout program, we're expecting an unusually high default rate from a standard year in the future? It would be higher than it would be in the future because it's year one? Is there any chance that we could change it from year to year? The first year, you default into the cheaper plan to take care of the initial wave, and for the next year default into the higher plan.

Dave Iseminger: We'll definitely look at that. There will be lots of different system issues we'll have to think about plus the communication challenges. That's partly why we bring this process about setting the default plans to the Board now because we're not actually setting them today. We still have a 45-60 day period to go through. We'll definitely bring back insight if we think it's a permanent setting versus something that can be revisited.

Pete Cuter: My recollection from my prior employment with Health Care Authority was that the UMP was selected as the default for the PEBB Program because it had the most enrollment. It's the one most people like. It seemed like a logical reason to say, on average, people would like to be defaulted into this rather than some other option. That option could be kept open for a second or third year. Obviously, going in, we don't know where people are going to go. But that might be something we can look at as an optional refinement in the future.

Dan Gossett: You also default with the $50 tobacco surcharge. Is that correct?

Dave Iseminger: $25 tobacco surcharge. There are two surcharges. Tobacco is $25 per month and the spousal surcharge is $50. Since you'd be defaulted into employee-only status, there's no way for you to get the $50 spousal surcharge because we can't default you in enrollment with dependents that we don't know.

Dan Gossett: So the do not exceed rate would be not $101, it would be $126, correct?

Dave Iseminger: That would be the real experience. We don't say that it is part of the medical premium. It's an addition to the premium, but the real-life experience would be a deduction of $101 plus $25, so $126.

Lou McDermott: The theory is the person would see that on their stub, the medical and the surcharge, and they would be able to at least do something about the surcharge if they didn't smoke.

Dave Iseminger: Unlike medical plan changes, you can prospectively change, first of the next month, your tobacco status. That does not require a special open enrollment event.

Katy, you're flipping. Do you have more?

Katy Hatfield: Yes. I have to talk numbers. So it's 2018-13 not 2018-12. [laughter] That is, "Resolved that, all school employees enrollment elections including an election to waive, if allowed, must be received no later than 31 days after the date that the school employee becomes eligible for the employer contribution." And that is driven in part due to IRS regulations.

And then, 2018-18 is, "Resolved that, the subscriber's account will incur $25 monthly premium surcharge if he or she fails to attest that any member 13 or older does not engage in tobacco use."

Wayne Leonard: What does the default look like to the subscriber since enrollment will be through the SEBB My account. Do those default things automatically populate when they set up their account or are all the selection options blank?

Dave Iseminger: That's a great question. I think I know the answer but I'm going to wait for Jerry Britcher, our CIO, to answer that question when he presents the SEBB My Account demo next month. Wayne, I think your question is when somebody signs into SEBB My Account, is it going to auto populate the default positions so somebody has to affirmatively change, or are all the radio buttons going to be blank and then on the backend after November 15 anybody who's blank, our system fills it in. I'll make sure that we're able to answer that question from a technical perspective next month.

Patty Estes: I think, too, when looking at the funding rates, it was a funding based on the 82% or 88% AV?

Dave Iseminger: Under the Collective Bargaining Agreement, the benchmark is the 88% UMP Achieve 2 plan.

Patty Estes: That might be something to consider when we're looking at school districts who are getting less funding, or defaulting somebody into a plan. What does that look like from the school district's perspective on having to pay for those locally funded versus the state funded versus all the other stuff.

Dave Iseminger: I'll just clarify that the $994 will be invoiced for all people regardless of what an individual actually enrolls in or waives. Whether the default is set, the invoicing to districts will be $994. We will charge eligible employees based on the funding rate.

Patty Estes: Okay, now I get it.

Dave Iseminger: It could influence the future enrollment mix evaluations that result in changes to the model for future funding rates, but it would not, in the short term, immediately impact the employer amount a district pays for either the state-funded or locally funded FTEs for staff.

Wayne Leonard: I have a follow-up to my last question. What does it look like in terms of the default, but what it also looks like if someone is not eligible because they may try to enroll and they may not be eligible. Is that something the school district has to affirm? Would they go in and say these employees are not eligible or how is that going to work? Jerry could answer that next month as well.

Dave Iseminger: I can give a little bit more insight to that one in advance, but we can do some follow-up as well. This fall, the districts will send a file that is uploaded into SEBB My Account for people that are eligible. If somebody tries to log into SEBB My Account and they can't log in, the first question that will be evaluated is, are they in the upload file or not? If they're not in the upload file, then the question is, why did the district determine they aren't benefits eligible. And then the next question is, does the employee believe that was an erroneous eligibility termination and want to file an appeal of that process? If they are in the uploaded file, it's an IT problem of what's mixed up in the login process that the individual isn't actually able to access their account. Only people who are eligible for benefits will be able to log into SEBB My Account. But just because you aren't in the upload file doesn't mean you might not appeal why you were determined as not eligible.

Wayne Leonard: Are those upload files then transmitted monthly as we hire new employees throughout the year?

Dave Iseminger: Now we're getting too far out in my swim lane and I will make sure we can answer that type of question next month with the SEBB My Account demo.

Lauren Johnston: Slide 7 – Default Setting Timeline. During the final rate setting, between the June 12 and July Board meetings, the HCA will identify a default plan for medical, dental, and vision benefits and will present the intended default plans, along with final rate information, to the Board at the July meeting for discussion. HCA will finalize the default plans once the Board endorses the medical plan monthly employee premiums.

Dave Iseminger: When we come back in July with the resolutions on the employee premium contributions, that's when we'll show you the intended default plans. You have 60 days to think about the debate we were just talking about a few minutes ago, the mix between the AV and the employee monthly premium, to gather thoughts if there are constituents or stakeholders you want to talk with. That would be the best time for that guidance.

Lou McDermott: Sean Corry, one of our Board Members had to leave after the Executive Session. He had to get back to Seattle. He's going to call in for this next discussion.

Dave Iseminger: He may or may not join.

UMP Pharmay Benefit

Molly Christie for Marcia Peterson. I am bringing the UMP Pharmacy Resolution to the Board for action. The PEB Board approved the UMP Value Formulary at their April 24, 2019 meeting. Both Boards need to approve this resolution in order for it to be implemented in January 2020.

Slide 2 – Follow Up from Last Meeting. There were questions we wanted to address most of which relate to understanding the impact of the value formulary on SEBB Program members.

There was a question about the different formularies available to school employees. We've provided a comparison at the high level pharmacy benefits structure for some formularies under Kaiser Northwest, Kaiser Washington, Premera, and Providence with the UMP Value Formulary. We addressed evidentiary standards and required documentation for those who have gone through an exception process in the past. We provided additional information on how the transition period will work, and information on HCA's website regarding the exception process for the current Tier 3. And how many preferred drugs a member must try under that existing process.

Slide 3 – Pharmacy Benefit Comparisons. We selected these carriers for the analysis because school employees are likely to have had experience with them. However, these are not necessarily the formularies we'll be using in the SEBB Program. There is a lot of variation in formularies. This is an illustrative example. The formularies go by different names. We're using Value. Today we'll look at the Essentials Formulary, Drug Formulary, and Formulary B or F.

Slide 4 – Tiered Pricing and Copays. You'll see they have a lot in common. They all have some form of benefit design that uses tiered pricing to encourage use of preferred or high value drugs and to discourage the use of non-preferred or low value drugs. Each tier has a member cost share designed to steer members to the lower tiers before trying something like a Tier 3 drug that might not provide an added benefit.

Slide 5 – Pharmacy and Therapeutics (P&T) Committees. They all use a Pharmacy and Therapeutics Committee, made up of physicians and pharmacists, to establish what drugs are included on the formulary and how to place new drugs according to safety, efficacy, and other rigorous evidentiary standards.

Dave Iseminger: Although they all have P&T Committees, they're all different. Reasonable minds might come to different conclusions about what tier an individual drug is, but the process is all similar.

Molly Christie: Our preferred drug list under UMP has a Pharmacy and Therapeutics Committee that oversees the list, as well as MODA's Pharmacy and Therapeutics Committee, which oversees drugs not covered or not reviewed by the preferred drug list Pharmacy and Therapeutics Committee. Experts review this for us.

Slide 6 – Drug Exclusions and Exceptions. All of these plans have drugs not included on their formulary. They are usually very high cost, low value drugs. For non-covered prescription drugs, they all have an exception process like what we've been talking about where the prescribing provider works with the plan to establish whether there's a medical necessity that merits the use of a non-covered or non-formulary drug.

Slide 7 – Pharmacy Benefit Comparisons. All of these plans appear to be using a similar approach. They're using an evidence-based formulary to encourage the use of high-value drugs to address out-of-control pricing for some new drugs and existing brand drugs, and to retain access to non-formulary drugs for members who have a medical necessity.

Ryan Pistoresi will walk through the next few slides of specific examples. This group of drugs treats diabetes and we want to show you how different plans manage their formularies. We've chosen diabetes because it tends to be the highest spending class for employer plans. There are a lot of drugs that treat a lot of things. Just for diabetes alone, there are 60 drugs within four drug classes. There's a lot of variation in what plans cover; and even if they're not covering certain drugs, they're still treating a condition their members have effectively. We've talked about pharmacy trend in specialty drugs. We are seeing this trend where plans are transitioning to more formulary management to try and control volatility in spending and to drive better value. Again, for all of the plans we looked at, there is an exception process that allows members to access non-formulary drugs if there's a medical necessity.

Dave Iseminger: Pete, you asked a question last meeting about trying to compare all the formularies of all the plans. We started down that path and quickly realized because of the variability and complexity and the extent of drugs for even a single disease state, trying to do something that was totally comprehensive was going to become extremely unmanageable. In an attempt to answer your question, Pete, we identified a high-cost drug area and did a deep dive on one example. Instead of trying to do a mile-wide and inch-deep, we went a mile-deep on one-inch wide. This is our attempt to answer that question knowing it was getting unmanageable to try to do it for the entire formularies.

Pete Cutler: I appreciate that Dave. I understand trying to cover every drug class and all the details was not something that was going to be realistic within the scope of our decision-making timeline. Having said that, I also believe that it'll be important to get to that detailed level with actual school employees before you hit January 1 to know for those, that are covered, say, under Premera now, are covered under whatever other plan, I guess Kaiser would be another one. If covered by Kaiser or Premera, they'll have the option of staying with those drugs. Aetna would be a better example. They're not going to be on the Aetna formulary. How many of them will be forced off of the drug

they're using now unless they use an appeal process and engage with they can start discussions with their doctor to figure out what they can do before they are facing a big price increase as part of the overall move into the SEBB Program on January 1. I think it'd be worthwhile to spend time trying to identify those situations as much as possible in advance so you can proactively initiate communications to help people avoid a last minute surprise. But for policy making briefing, I think this is great.

Ryan Pistoresi. Slide 8 – Formulary Comparisons. I'm here to walk through a detailed example on one of the many different drug classes. We chose the diabetes drug class because there are a number of different drugs and management styles. It also happens to be the number one drug spend for the commercial world. On the left of the chart are the different formularies we reviewed for this example. Across the top are the number of drugs in the drug classes and the bars with the different colors represent the number of individual drugs within these subclasses. At the bottom of the chart you see the four different subclasses we reviewed. There were a total of 60 drugs that could be covered within these drug classes. Two of the plans, the Premera K-12 and the UMP 2019, have all 60.

I want to draw your attention to the Premera essentials and the UMP Value Formulary. From doing this research, we were able to hear from Premera that they are planning on moving what would be the K-12 population from the 2019 formulary to Premera Essentials. They're also looking at moving towards a value formulary for 2020. Premera Essentials, Providence, UMP Value Formulary, Kaiser Tier 3, and Kaiser Tier 2 are the ones we would anticipate the K-12 employees would see at 2020 or beyond.

If you look at the different colors, you'll notice the bars are all different sizes between the different plans. That's because within these drug classes are multiple options that work in the same way. They target the same receptors, but may have slightly different characteristics and different prices. The P&T Committee evaluates the drugs and helps make recommendations. They may say for these drug classes, we'll have two or three options. For the other ones, we may have all 20 but we'll want to manage that through preferred and non-preferred status, which is the key on Slide 9.

Slide 9. We have it broken out by the total number of excluded drugs, the total number of non-preferred drugs, and the total number of preferred, generic, or value drugs. They are split between the two Kaisers at the top, the two Premeras in the middle, and the two UMP formularies at the bottom. For each set, the number of preferred generic, or value drugs are the same within each of those carriers. But they have different managing strategies. For example, with the Premera K-12 to the Premera Essentials, some non-preferred drugs are now excluded, which helps direct members towards the higher-value drugs. Same thing with UMP. We do this not only to direct members to higher-value drugs for a lower out-of-pocket cost, but to help members who are paying more for drugs when they don't necessarily know there is an alternative. There are exception processes for all of these plans in case they do try some of these preferred medications, they aren't appropriate, and they need to step into those drugs. The key takeaway from these slides is to show that all of the different plans have some strategy in place that is to manage the different drugs given there is so much variation.

On Slide 8, there were about 20 different insulin drugs. All of those insulin drugs work on the same mechanism of action in the body. They have slightly different properties

with how fast they work, but as you'll see, all plans offer the availability for those drugs, and then the exception process in case they need to step into what would be an excluded drug. This would be similar to what you would expect in other drug classes with a lot of brand products, or a lot of high spend.

Dave Iseminger: I want to assure the Board, when you see the word "exclusion," I'm sure that invokes some concerns. The exception process we described before is the way in which an individual would access something in the purple bar under the UMP formulary. It's much easier for you to get something that's in the brown, a drug designated by the brown bar. You have to go through the exception process to get something excluded. If you have medical necessity reasons and go through that exception process, you would still be able to access that drug covered at an in network rate.

Molly Christie: Slide 10 – Evidentiary Standards. Regarding the process for new members to get an exception for a non-formulary drug, prior to the January 1, 2020 benefit start date, new UMP members will receive an initial communication about their prescription drug coverage that describes what happens if your drug is not part of the UMP Value Formulary, and what options are available to you. We have a link in this presentation (Slide 12) to the preferred drug list that will be updated to include all drugs on the Value Formulary. You can look by drug class to see what drugs are in an entire drug class. You can look by the drug you're on and it'll tell you what tier it's in. It'll tell you if there are lower cost alternatives. It's really useful and is a great tool for us to communicate to members about how they can manage and select a plan that's going to work for them.

If a new UMP member tries to fill a non-formulary medication, MODA will work with their provider to see if it's appropriate to switch them to a formulary alternative. If the member's provider determines it's not appropriate to switch, that's when they'll submit an exception request to MODA that includes rationale for why the formulary alternatives are not appropriate, as well as the names of the drugs the member tried.

Dave Iseminger: Molly, I think Patty had a question last time about whether or not they need to submit the negative complications. Does there need to be chart notes indicating what drugs the member tried that caused a reaction to where the drug was changed? Will the member be forced to try that drug again? No. Essentially the doctor's note suffices and it doesn't have to come with a deep chart review of the implications and impacts of negative consequences of trying a drug. We're going to rely and trust the provider based on what they submit, but it needs to come from the provider.

Molly Christie: Slide 11 – Transition Period. There was a question about the transition period for non-formulary drugs. We currently have a transition process in place for drugs on the formulary. We are working with MODA to create a transition plan to accommodate new members taking non-formulary drugs. The 90-day transition period that we've talked about applies to non-specialty drugs on the formulary but that have prior authorization or step therapy requirements. For members taking non-formulary drugs again, we're working with MODA to develop that transition plan.

Slide 12 – Exception Process Clarification. At the last SEB Board Meeting, a question was asked during public comment about information on the HCA website related to how many drugs a member must try before being approved for an exception under a current Tier 3 exception process. The information suggested there was a threshold of maybe two preferred drugs per drug class before getting the exception. We suspect the confusion was caused by looking at the Apple Health section of the HCA website. Apple Health is our Medicaid Program. That part of the website does discuss that for those plans, there is a two preferred drug threshold before any exception will be approved.

On the UMP web pages, we don't maintain a list of preferred drugs that a member must take before being approved for a Tier 3 exception. However, we do have the UMP preferred drug list so there's a link to that and members can review how their drug is covered, whether or not there are lower cost alternatives, and find other information about what's covered.

Pete Cutler: Do you have to be a member to sign onto that or is it available to the public?

Molly Christie: It's available to the public. It's a useful tool. Slides 13-14 – Proposed Change. This underscores the importance of having a single formulary for both the PEBB Program and the SEBB Program. We are proposing that you adopt a resolution where UMP would use a value formulary for the drug benefit. We're proposing this change because it's simpler and more consistent with other plans the SEBB Program members will be familiar with. It offers better value. It addresses an equity issue in the current UMP pharmacy benefit by allowing members approved for an exception based on medical necessity to pay a lower cost share. It could save members money at the pharmacy when a less expensive alternative exists. It could help protect UMP from extreme volatility in drug pricing. It allows members already taking drugs in refill protected drug classes to remain on their drugs. It could help stabilize the pharmacy trend in premiums. This is the best time to make this change to avoid member disruption a year from now. It also provides continuity for K-12 employees who will or may transition to PEBB Program benefits when they retire. This provides continuity between the PEB Board and the SEB Board in making sure we have a single UMP formulary consistent across those populations.

Dave Iseminger: The fourth bullet – protect plan from extreme volatility in drug pricing was discussed at length at the PEB Board Meeting when they passed this resolution. It passed with a vote of four-three. The most significant concern that resulted in no votes was concern about people who are already on drugs that aren't in a refill-protected class and the transition they will go through. Your Chair was Chair Pro Tem of that particular meeting, so he might have additional insights about the PEB Board Meeting from his perspective. If you pass this now and it's implemented at the same time as the start of the SEBB Program, you actually sidestep over that issue because you won't have people who jump into UMP for the first time, get used to a formulary in 2020, and then in the future, potentially change formularies. You wrap this transition into their overall transition into UMP if they select it as part of the Program.

Lou McDermott: When I was thinking about our discussion on this, I wanted to bring up the fact that the PEB Board grappled with this for three years. I think, fundamentally,

there's a bit of distrust in the agency that the agency is trying to do right by its members and that there isn't this behind the scenes, we're trying to save money. And so we're trying to pass a benefit which we're going to put a bunch of nice words on but what we're really trying to do is save money.

I think what's true is there are likely dollar savings associated with it, but there's also the member considerations. In the real world, there is a cat and mouse game going on between pharmaceutical companies and employers who are self-insured and control their benefits, and carriers and Pharmacy Benefit Managers (PBMs) because the pharmaceutical companies discovered a while back there are benefit designs that allow you to get the more expensive drug if you pay a higher cost share. So what they started doing is handing out coupons. You could be paying $300 a month for your medication, and if you call the pharmaceutical company, they'll send you a coupon for $300 so you pay zero. But your employer's paying $5,000. While you don't see that on your monthly tab as you go to the pharmacy, you pay your $300, and then you get your $300 back, you experience it in your premium inflation.

On the PEBB Program side, premium inflation is most acutely felt by retirees. Most of their retiree premium is based on pharmacy expenses. Retirees were getting hit with double digit increases year over year. As this benefit design was brought to the PEB Board, it was difficult to see that it wasn't a takeaway, that what we were trying to do is make sure people have the appropriate medication.

There's a fine line on how you implement. What I'd like to assure the Board is that our group of folks is trying to do everything they can to give people an opportunity to explain why they had a bad reaction in college to a certain medication, making sure I know further in the presentation I assume we're going to talk about the exclusions. There are medications we're excluding from being impacted by the formulary change, from having to try different medications. We're trying to have a thoughtful benefit which plays into that cat and mouse game but also make sure people get the right drug and premium balance. It was a tough, tough conversation. I started the conversation when I was the PEBB Program Director and Dave got it across the finish line three years later. But it was a long conversation. I know this Board isn't having the advantage of talking about this year after year. But there has been a lot of activity, and a lot of concerns with implementation especially.

Dave Iseminger: I want to make sure people don't latch onto when you said there would be exclusions. What you meant was there are refill-protected classes we're not touching. That doesn't mean drugs are excluded from coverage. We meant there are parts of the formulary that wouldn't be impacted by the value formulary implementation.

Terri House: That's what we reviewed last month, correct?

Dave Iseminger: Correct. The refill-protected classes, things like anti-psychotics, anti-epileptics. I believe there were a variety of others actually listed in the resolution.

Molly Christie: Slide 15 is the timeline we're looking at. If we want to implement the UMP Value Formulary by January 1, 2020, this Board will need to approve the resolution no later than June 12, 2019. The PEB Board did approve the resolution on

April 24, 2019. The resolution you saw in the last SEB Board Meeting has not changed. It hasn't changed from the resolution the PEB Board voted on and approved. This is the resolution language you are familiar with.

Lou McDermott: I'm interested in the Board's perspective on voting on the resolution today. I'll give my two cents before you give me your nickel. [laughter] I want staff to get started on this as soon as possible because both the PEB Board and the SEB Board will be going through it. It gives us more time to stakeholder, to vet, to really work through the issues. The sooner we hit the go button, I know we could hit it now but you never quite hit it until the resolution passes unfortunately. I want them to get started on this to make sure we uncover every stone and make sure we protect our members. It takes time to vet all those possibilities because stuff comes out of the woodwork during the process. That's my preference. But I am very interested in the Board's opinion.

Pete Cutler: I support all the comments that the Chair has made about this. I support both the importance of this issue and the hard work that's been put into it, the careful analysis and the need to go to value-based purchasing. Dysfunction in the market in terms of how pharmaceutical companies can distort market dynamics to their benefit in terms of profits at the loss to both members and employers or taxpayers that pay for their benefits. I think it's very important. And frankly, I'm ready to vote to support it now. My questions have been answered. I think the communications, the implementation roll-out, and the communications are very important. I don't know that there's anything that we can do to address that through the motion. But we will have to count on the Health Care Authority and the SEBB Program to really put the resources into that kind of communication and analysis to make sure the transition is explained as well as possible. I'm ready to act.

Terri House: I agree with Pete and Lou. I think we've talked about pharmacy several times over the last six, seven months and I think we're ready to move on this.

Alison Poulsen: I agree. I think we should move forward.

Lou McDermott: Sean, are you on the line?

Dave Iseminger: He texted me and he's worried about talking and stopping in traffic. He did not intend to call back in.

Dan Gossett: We've had a really high level look at this and to try to get in the weeds, I hate to admit this, but I've been reading PEB Board minutes. [laughter] And realized that it seemed like how much more detail, questions like how many members would be impacted by this. That was given to the PEB Board. How much they anticipated savings were going to be in the next year and the next year after that. That was given. And then the impact of what that would be on rates. With the school employee population and all the different plans, it is incredibly difficult to gather that information. I looked at what that information was for the PEBB Program. I know how much was going to be saved and the impact on premiums. I don't know if the impact on trend was there.

Dave Iseminger: Very lightly. Keep going.

Dan Gossett: But that information, I've looked at it but I don't know if that would make any difference with anybody else's opinion.

Lou McDermott: Dan, I think one of the issues within the PEBB Program is the UMP makes up two-thirds of the entire population. We are estimating that it'll be a much smaller percent here. I think the issue with the PEBB Program versus the SEBB Program is that there is the policy discussion as to what you're going to do and how it's going to impact people and why you want to do it. That discussion is the same at the PEB Board or the SEB Board. I hope when you read the materials, you saw the same analysis that was given. What's different is the PEBB Program has actual experience so the natural question for the Board Members is how many people does this affect? What are the dollar amounts? Is the juice worth the squeeze? And within the SEBB Program, unfortunately, most of our discussions are theoretical based on the PEBB Program experience. In theory, you could probably take the PEBB Program population with the estimated population that is going to be in UMP in the SEBB Program and you could downsize the numbers to come to that. But they're coming from different plans that already have formularies. It's really hard to tell.

Dave Iseminger: The other piece I was going to add is remember that on the PEBB Program side, as has been mentioned, for retirees, the Uniform Medical Plan is the primary payer for pharmacy benefits. This will have more potential impact on the trend in premium implications of the Medicare portfolio. The PEB Board, at one point, I think that was two seasons ago, was debating whether this should apply to both the non-Medicare and the Medicare piece. At that time, we were primarily focused on describing what the impacts would be to the Medicare population because that's where the brunt of the financial burden of drug cost is. That is a factor not present in your Program as a fully active employee program. That would be the other reason, in addition to the difficulties already described, the pieces that you see that we presented to the PEB Board also have a big lens of Medicare over it that is different and not present here.

Lou McDermott: One thing that's interesting is your decision here today is going to affect those retirees, a significant portion of which are schoolteachers, school employees. It's an indirect benefit. But the decision to go with the formulary today allows the PEBB Program to go with the formulary, which allows relief to those retirees. There is a ripple effect from this decision beyond the people we're modeling that are going to go into UMP from the SEBB Program. There is a ripple effect that will affect many people.

Wayne Leonard: I'm willing to move forward with this. I think it's consistent with other actions we've taken to try to have some cost containment in our health insurance premiums and keeping our premiums at a rate that's affordable to people.

Lou McDermott: We're going to proceed to a vote.

Policy Resolution SEBB 2019-11 – Self-Insured Value Formulary

Resolved that, beginning January 1, 2020, contingent upon approval of a value formulary resolution by both the PEB Board and SEB Board, all UMP plans require the use of a value-based formulary and:

- Non-formulary drugs are covered only when medically necessary and all formulary drugs were ineffective or are not clinically appropriate for that member, and
- Multi-source brand-name drugs including those in refill-protected classes, are covered only when medically necessary and all formulary drugs have been ineffective or are clinically inappropriate for that member, and
- Members who have been taking a non-formulary drug are required to switch to the formulary drug, unless:
  - they receive or have already gone through the exception process and been approved, or
  - their drug is within one of the refill protected drug classes which include: antipsychotics, antidepressants, antiepileptics, chemotherapy, antiretrovirals, immunosuppressives, and immunomodulatory/antiviral treatment for Hepatitis C.

Alison Poulsen moved and Terri House seconded a motion to approve.

Fred Yancey, Washington State School Retirees. We're indeed in support of this sort of change. We see the benefit for retirees. My only concern, and I've raised them before, is when you've got 20 generic drugs that treat diabetes. For making somebody try all 20 before they're allowed to move to a brand-name drug is problematic I guess. And whether they would have to is another issue. The only other issue I have, and I've raised this before, too, and so maybe I'm just inept and someone could argue that point. You use the term "exception." The website uses a different term. I mean, I can't find an easy explanation for me trying to find an exception. I think the website calls it prior authorization. That's my guess because it's as close as I can come to trying to find how I, as a consumer, could get an exception to the process. And I've said that before. It should be so easy, and it isn't, at least to me. So again, very supportive of the idea because we, meaning retirees, are being strangled as you well know by a disproportionate amount of prescription use with tremendous cost to us. So thank you very much for considering.

Dave Iseminger: Chair McDermott, I'll add additional context. The PEB Board asked for a follow-up response even after the resolution passed for a clear written explanation of the exception process. That is in the works that we'll be presenting back to them. We can bring that back to this Board for additional information as well, or context as follow-up. Also, House Bill 1879 discussed earlier this morning. One of the pieces of that is as of plan year 2021, formularies have to be evidence-based and you must have clear written exception processes. That dovetails with the work we'll be doing. We are committed to working on creating clear communications and making sure it is a robust and easy to follow step-by-step process which will then also allow us to comply in advance of plan year 2021 with House Bill 1879's requirements.

Like all other resolutions, SEBB 2019-11 went through the stakeholder process. We received one comment back that was in support of the resolution.

Pete Cutler: Since the communications around the exception process specifically, and around this change are so important for its success, will we have a chance to see what's being proposed for those materials or at least some kind of current draft before the end of our meetings scheduled this year? Or is it likely to not be ready until later?

Dave Iseminger: I'm not going to promise a specific date, but I understand the piece which both Boards and stakeholders in both populations are heavily interested in how this will be communicated. We will do our best to bring back at least the general nature of that process. Once it is in its final stages, we can get it out so people can see how we're going to be communicating it, even if it is outside of the Board season, possibly a follow-up email to the Board.

Pete Cutler: Please don't call a Board Meeting just for this. I'd be quite happy to go with the email distribution.

Before the vote, I think it's already clear, but want to make sure. We're talking about one single value-based formulary for all the Uniform Medical Plans, right?

Dave Iseminger: Yes.

Voting to Approve: 8
Voting No: 0
Absent: Sean Corry

Lou McDermott: Policy Resolution SEBB 2019-11 passes.

2020 Benefit Refinements Policy Development

Dave Iseminger. This is the culmination of the 10% homework after the Legislature has completed its work.

Slide 2 – Preliminary Considerations. This first piece is something Megan Atkinson discussed at the beginning. The funding assumptions in the final operating budget passed by the Legislature confirmed the longstanding assumption that the agency had been presenting to you; use the PEBB dollars as the proxy for what is going to be spent on this Program. In fact, as Megan highlighted in Section 938 of the budget bill, it expressly talks about the funds are to be used to purchase materially similar benefits to the PEB Board as already adopted by the SEB Board. This is why it was so important for this Board to act in advance of the legislative session because as I had foreshadowed, the Legislature needed to have a sense as to what could be bought. We kept legislative staff up to date on the workings and progress of the Board.

Outside of the legislative session, I know that many of those staff members listen in to these meetings, follow-up on them, or sometimes watch them when they are recorded by TVW. They had actual knowledge of the work you have done. Many times in budgetary documents, they don't give you the type of direction that was given here. This was a clear affirmation of the work that had already been done and a reassurance that because the funding rate of $944 came in, which is different than the modeled number from the Health Care Authority, there was not a direction to this Board that you needed to cut benefits to fit that funding level. That is an important piece.

There's not a requirement to decrease benefits. But on the flipside of that, there's also a definitive answer to one of a longstanding question from several Board Members: is there more money to spend to increase and enrich elsewhere? The answer to that is equally no. You are down to horse trading as I've described it over the last several

months. Any final changes you want to make in the portfolio would need to be done by the June 12 Board Meeting. They would have to essentially be budget neutral within the framework we described to the Board over the last year.

Slide 3 – Timeline for Decision Making on SEBB Program LTD Benefit. At the last Board Meeting, we described the Long-Term Disability Benegit (LTD) benefit because of all the areas within the benefit portfolio, that is something the Board expressed concerns and misgivings about. In fact, in recent weeks, I've had a variety of questions, one I thought I would share with the Board because it finally dawned on me why so many people struggle with this benefit. Many people have asked why the state isn't getting a good deal on LTD. What people see is it's going to be a $400 benefit. If I, in my own school district, am able to procure a better benefit, why isn't the state able to leverage its purchasing power across the entire state in a single pool to be able to get a better benefit? The answer is we do have a very competitive rate. But if you go back to the handout that was in your folder for Megan's presentation that broke down the funding rate, you'll see that only two dollars of that $994 is going towards LTD. When you're only spending two dollars per member per month, you're getting a $400 benefit because you're spending two dollars per month. Obviously, if you spend more than two dollars a month, you can have a better benefit. So it's not that the purchasing power isn't able to get a good competitive rate. It's the allocation is within the funding rate that's being attributed and spent on this particular benefit. That's where we've gotten to describing to you previously, a horse trade if you change the orthodontia benefit this way, it results in this amount of claims freeing up, which then converts to a dollar PSPM on LTD, which then increases the LTD benefit.

I think that was an aha moment when I described it to people. Two dollars of the $994 is going towards LTD. The bulk of that $994 is going towards medical. It's not that the state isn't getting a good rate. It's how much is being allocated towards that particular benefit.

Slide 3 is the discussion from last meeting about the long-term strategy on working on the basic LTD benefit. We are obviously right around that 2019 line that says Board decision point for plan year 2020. We're past the legislative session. We're towards the tail end of this SEB Board season. If there's anything the Board wants to change with regards to the program launch, it would need to be done by the June 12 meeting. I have slides in this presentation you've seen before about options that have not seemed appealing to a majority of the Board, yet, other options are, in some people's words, more draconian than these ideas. We have not found that magic benefit swap that seems to increase the LTD benefit with an appealing or palatable decrease. We wanted to continue to provide that context and say if there's something in this list that you want to proceed with, now is the time.

We aren't ending the conversation there. I said at the WASBO Conference last week that the elephant in the room is the basic LTD benefit. The districts don't like it. The employees don't like it. The agency doesn't like it. Everyone agrees that we don't like the benefit as it is now. It is something I am committed in my leadership role as the ERB Director to try and improve for both programs because it is a benefit we need to put some eyes on and be addressing. One of the pieces is the agency working on a decision package to make sure the Legislature and Governor's Office have information

about what it would cost to increase the benefit level for both programs. We're going to be working over the summer and in the fall to be able to submit a decision package that describes a range of options for potential funding mechanisms to see if there's a desire to increase the allocation from two dollars on LTD to another amount. There's no guarantees that anything will happen, but we would submit it and it would go through the legislative process. You would know this time next year whether that option was taken. If it wasn't, then you could further engage in benefit swaps for the 2021 plan year.

Lou McDermott: Isn't another opportunity making sure we express to our members what the optional LTD benefit is and what it isn't? Mostly pushing the optional LTD as I know we've already had a dry run at that through the PEBB Program.

Dave Iseminger: That's actually an excellent transition. Slide 4 – Strategies Relate to Long-Term Disability (LTD) Benefit. This is actually a new slide that we haven't presented to you before. We finished our negotiations with The Standard Insurance Company that during the fall open enrollment next year in 2020, school employees will have a second medical underwriting free bite at the apple in enrolling in optional LTD insurance. So everybody this fall gets a fresh bite of the apple. If you've been denied before, doesn't matter. You can get benefits. We know with the extent of changes happening this fall, many people are going to focus on medical and dental. We know because of the structural concerns about the quality of the basic benefit that people might be so focused on medical/dental they miss out on disability.

We worked with The Standard and it would not impact rates to do this one-time second bite at the apple. I am a bit concerned that school employees may think this would be available every year, which it won't be, so we're going to have to be careful about the messaging. It was another tactic to try to mitigate and prompt the ability to leverage that optional benefit. Again, that optional benefit is employee paid but it is a valuable opportunity to not have to go through medical underwriting. We were able to negotiate in a way that if somebody between fall of 2019 and fall of 2020 goes forward and submits medical underwriting and fails, they still get the enrollment opportunity in fall 2020. This is truly a second bite at the apple for anybody, even if they get denied sometime in the intervening year. I wanted to bring that to the Board because we thought it was a valuable component to bring as an opportunity for school employees to fit in with this LTD puzzle. Alongside of that, we're going to go through the decision package process.

We recently went through a one-time first time in 40 years, special open enrollment, no medical underwriting in the month of March, for PEBB Program employees because in that model right now, it's a paper-based enrollment system. We are still waiting out the keying period to get final numbers. But we had a large increase in an uptake of optional enrollment. We're somewhere around 33% to 34% participation, whereas we had been at 25% participation. We had somewhere between 6,000 and 7,000 employees sign up for optional LTD for the first time. We know that if we take time to emphasize this benefit in a special opportunity, we are able to educate people about it and get them to understand the importance of this benefit. We really did want to work with The Standard and we're glad we could partner with them to bring this second opportunity. This is another mitigation piece. We are leveraging the optional piece that Lou was just highlighting.

The rest of the slides are all things you've seen before. Slide 5 is this chart that describes adding a dollar, two dollars, etc. in dollar increments if you were able to find money in a benefit swap what you would approximately be able to increase the monthly maximum benefit from. The far left, the $400 is what is spent using that two dollar allocation in the funding rate and then the subsequent amount.

Slide 6 is about the income distribution of school employees. There are a lot of caveats to this. This is based on 2016-2017 data from the S275. It's before this past summer's infusion of funds into salary negotiations. This number doesn't reflect any of those recent developments, but it does give a proxy. We thought this was important just to be able to overlay and think about what salaries people have that they could be insuring and the maximum benefit level.

Slide 7 highlights the four different benefit pieces we evaluated last fall and continue to evaluate as options that were among the potentially more palatable benefit swaps the Board might want or be willing to consider. I'm interested in any further Board discussion. I'm reminded of that Einstein quote, "Don't expect different results if you keep doing the same thing." It's what we have for you to think about for benefit swaps because we've tried to have discussions here about other ideas, some of which were generated by Board Members. No other ideas have been generated by the agency, the Board, or others at the state. There's no silver bullet here on a potential benefit swap. That doesn't mean next year we won't find additional pieces. But for the 2020 launch, these are the things we've evaluated so far.

Slides 8-12 go into the detail of each of these different benefit swaps. I think the only one that had some discussion from Board Members was the basic life insurance, but it didn't seem that a majority of the Board was interested. You could decrease the basic life insurance from 35,000 to 25,000 and in exchange you'd essentially be able to raise the LTD basic benefit from $400 to $600. We highlighted how you could fundamentally change the dental benefits. When we went through those presentations in November, I saw grimaces just now, so I'm going to move on. But it was something that we presented to you and the implications.

There had been a question about capping fully insured orthodontia because the prominent enrollment is going to be in UDP, which is already capped. There's no juice to squeeze there. It wouldn't make any difference. That one, even if it was palatable, wouldn't change anything.

There was a discussion and we evaluated eliminating orthodontia, which could have a profound impact. It could raise the basic LTD benefit to $1,000; but at the same time, many of the Board Members were excited about having an embedded orthodontia in dental. We know some of the dental benefit impacts are that there are many plans in the K-12 world which have a way, that if you engage in your preventive care, you are able to get a lower out-of-member cost share and that is a structural difference that won't exist in the SEBB Program. I think many people saw incorporation of an orthodontia benefit as a helpful offset to the fact that you couldn't get to a lower cost share for those class one and class two covered benefits.

Those were the pieces evaluated before. The question before you is if there's anything you are interested in us bringing to you because your final opportunity for the program

launch 2020 benefit design changes is the June 12 meeting. If you think of something after that, we will evaluate it for 2021. We're coming up on the finish line for the 2020 program launch and my favorite word, iterative, we will continue to have an iterative process on rules and benefits from now until the end of time.

Lou McDermott: Very inspiring, Dave. End of time? Board Members, thoughts about engaging in the horse trading, or are we feeling comfortable with where the benefit has wound itself to?

Pete Cutler: First of all, I wasn't sure whether that comment about the iterative process going on for ever and ever was a threat or a promise. [laughter]

Dave Iseminger: It was both. Yes.

Pete Cutler: As everybody on the Board knows, I feel strongly about the long-term disability benefit and its important place. And just in case anybody had questions, I'm not looking for any tradeoff now. It's not like I think we have overly generous benefit provisions in any of the benefits we've approved so far. I think the issue is important enough that it should be addressed head-on by the employee organizations and state discussions going forward, and presumably in collective bargaining come next summer. It is not something I would want to do a little nibble at the edge here or there when in fact, it's something that deserves a good, hard look with all the players. I appreciate all the work that's been done by Health Care Authority staff and the information we've been provided. But for what it's worth, I'm not looking for any tradeoffs to enhance the benefit now.

Alison Poulsen: I would concur with Pete's comments and just thank the staff for the very diligent analysis and creative thinking. I would agree that the strategy around a decision package in a future legislative session is really the smart way to go and that I think we have had a very thoughtful process to get there. I am appreciative and looking forward to the future part.

Dave Iseminger: I guess what I would say is it doesn't look like we'll have much on the agenda about a final benefit refinement because there's not a specific request to bring something for potential action at the same time as you're hearing it. Essentially, your 10% homework looks like it's done as of today. I'm looking around and seeing head nods. So now begins the iterative process for 2021. A pat on everyone's back. Think about where you were as you were appointed back in September 2017 to now. You have finalized and the Legislature has funded a benefit package structure for the launch of a program that has been debated for three decades. Just take that in for a moment.

Pete Cutler: And I was there from almost the beginning. [laughter]

Dave Iseminger: And so was Barb Scott!

Lou McDermott: And I think we know why it took three decades then. [laughter]

Pete Cutler: I apologize.

Lou McDermott: Congratulations, Dave.

Dave Iseminger: No, thank you to the Board for all of the work that went into last November and the appreciation of the guardrails that are in place that lead you to the decision to not have any further refinements for 2020.

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

Marty Thies, Account Manager, Portfolio Management and Monitoring Section, ERB Division. The Board received an initial overview of the Medical FSA and DCAP programs in January of last year. My purpose this afternoon is to update the Board regarding the Medical Flexible Spending Arrangement (FSA) and the Dependent Care Assistance Program (DCAP) and describe for the Board what these benefits will look like in the SEBB Program.

These two supplemental benefits are often referred to as 125 plans as they are outlined in Section 125 of the Internal Revenue Code. This may be new terminology for SEBB Organizations and we're trying to navigate that and make it translate for them as they make the change. Today, I'll be summarizing what these two benefits look like, how they work, what our experience in the PEBB Program looks like since 2013, and a little bit about our implementation of this program within the SEBB Program. These benefits are administered by the Health Care Authority and do not require a Board vote.

Dave Iseminger: The authority, as Marty said for the salary reduction plan, which includes Medical FSA and DCAP, is agency authority. That's why we haven't done lots of presentations for you. We wanted to keep you apprised. The benefit design and decision making authority is with the agency and that's why there's no Board action.

Marty Thies: Our Cafeteria Plan includes a salary reduction plan, which will allow school employees to participate in Medical FSA and DCAP by reducing their taxable salary so they can spend pre-tax dollars through a Medical FSA or DCAP account for out-of-pocket medical expenses or eligible dependent care expenses.

Slide 4 – How a Medical FSA Works. During this upcoming and every annual open enrollment afterwards, school employees can elect a pre-tax amount to defer from their pay. The limit is set by the plan sponsor, Health Care Authority, but cannot exceed an annually designated IRS maximum. On day one of the plan year, January 1, January 2, whatever the first Monday is, the entire annual deferral is available to employees, though they haven't deferred anything yet. That's a great benefit. For instance, they could have a surgery on January 2 and use the entire year's deferrals. To claim, the employee uses a Medical FSA debit card or submits after purchase claims to the Medical FSA vendor using paper, email, fax, or a mobile app, after which the employee is reimbursed for those expenses. Annually, unclaimed funds are forfeited.

Dave Iseminger: That forfeiture is required under IRS rules. Sometimes there are employees upset that the money is forfeited to the plan sponsor or the employer. But that is a key component regulated by the IRS. It is required. What this agency has done with those forfeitures on an annual basis is use it to offset the administrative expenses for running the program.

Lou McDermott: Another benefit is people don't have to pay back, if they have that surgery on January 2, they use their entire Medical FSA, and they leave employment, that's also a benefit to them that they do not have to repay. Is that correct?

Marty Thies: That is built into the program. You could defer for the entire year and be gone in a month.

Dave Iseminger: Right. That is another key aspect to the forfeiture requirement under the IRS. Forfeitures also help mitigate the risks of somebody who has claimed all funds before they made all of their deferrals, left employment, and no longer have paychecks from which to defer. The forfeiture is used to offset those expenses in that instance, as well as administrative expenses.

Marty Thies: Slide 5 – Examples of Eligible/Ineligible Expenses. The column on the left lists examples of eligible expenses. These are common medical out-of-pocket expenses, dental, orthodontia, pharmacy. The first item, bandages and sunscreen, can't be purchased in large amounts to stockpile. There can be limits to what you can purchase at on time.

On the ineligible list is health insurance premiums. Also included as ineligible are maternity clothes, sunglasses, maybe special food. These cannot be reimbursed through a Medical FSA.

Slide 6 – Pros and Cons. Why do we offer a Medical FSA to employees? The primary benefit for employees is they can reduce their income taxes by deferring pre-tax dollars. For example, if an employee deferred the maximum of $2,700 and they paid taxes at a 12% rate, they'd save over $300. Already mentioned is the entire amount is available day one. You can essentially pay out of pocket against future deferrals. However, if the employee does not end up with enough eligible out-of-pocket expenses to claim, or they had those but didn't claim them on time, the possibility exists they will forfeit those funds. Also, reducing your taxable income along the way will impact the calculations for your social security checks, retirement, and otherwise. For SEBB Organizations, they are not liable to pay FICA on deferred earnings. Let's say you had that same employee defer $2,700 over a year. The SEBB Organization would save $207 if you multiply that by 7.65%.

Pete Cutler: That would be true for the employee as well. Both those contributions would not have to be paid on that deferred amount.

Marty Thies: That's correct and that's why it would impact social security calculations. End of year forfeitures go to the plan's sponsor, which helps reduce the per participant per member administrative fee.

Dave Iseminger: I want to be very transparent about a piece because I know many school districts have asked me personally and my staff. SEBB Organizations currently get all of this administrative stuff for "free" and now there's going to be a per participant per month (PPPM) administrative fee that's owed. That seems counterintuitive. What I've tried to highlight for people is those expenses exist somewhere in the system. You may not be writing a check for them but they are born somewhere in the system. As we

go forward with this centralized Cafeteria Plan at the state, those administrative pieces will be much more transparent. It's a cost in the system somewhere and now it will be very clear where and what they are.

Marty Thies: Slide 7 – Key Dates. These are key dates in the evolution of the Medical FSA benefit because by far, the greatest potential disadvantage of a Medical FSA account is the danger of forfeiting a portion of your income. It's been called the "use it or lose it" rule. In 2005, recognizing this, the IRS adopted the grace period, which gives up to two and a half months into the next plan year to both incur and claim additional eligible out-of-pocket expenses. In 2013, the carryover was implemented whereby a maximum of $500 can be carried over to the next plan year and it will be available to the employee for the entire next plan year. Now if that employee has $600 they haven't spent at the end of the plan year, they can still move $500 to the next plan year but they will forfeit that $100 over the $500 limit.

Dave Iseminger: With the grace period, it doesn't matter what the amount is that you're able to claim. If you hadn't spent $600, there's nothing forfeited on the first day of the next plan year. You have the ability to incur or claim the full expenses until the grace period is up. Another opportunity that people utilize the grace period for is you could deliberately not spend your money, save it up, and then double dip into your last year's grace period Medical FSA dollars and your next year's grace period dollars and immediately have access to a larger dollar amount to reimburse you for a major medical expense in January or February. You can utilize the grace period to be very thoughtful about when you're going to have services that are extraordinarily expensive with out-of-pocket costs and use it as a short-term bank account, essentially.

Marty Thies: A sponsor can offer a grace period or a carryover or neither, but not both. In the SEBB Program benefit, we'll have a grace period of two and a half months.

Dave Iseminger: As we move into implementation, it comes as no shock that roughly one half of the school districts do one way, half the school districts do the other way. There are a few that don't do either and so we know there have been concerns as we've moved forward in this implementation about people who are on carryover that have to go to grace. If we had done the other way, we would have had the other half of the room upset. We are aware there are many ways the districts have administered this benefit. Part of this is to get everybody onto the same page. Half of the room was going to be upset no matter what we did.

Marty Thies: We are doing our utmost to encourage people to spend their accounts.

Slide 8 – Medical FSA/HSA Incompatibility. An employee cannot have both. In other words, those enrolled in high deductible plans who thereby have an HSA cannot enroll in a Medical FSA. Each annual open enrollment, there are two to three dozen people who end up enrolled in a high deductible plan for the next year and they also try to open a Medical FSA. We flag those and alert employers so they can talk to the employees so they can make a choice. If we don't hear from people, they're disenrolled from the Medical FSA. We try to mitigate against that.

For the SEBB Program Medical FSA benefit, there will be a $2,700 maximum deferral for 2020, which is the maximum allowed by the IRS. The IRS usually announces

increases to the maximum in December, which is too late for all our communications. There will be a $240 minimum deferral that will likely remain constant. As I noted before, we'll have a grace period rather than carryover.

Slide 9 – Dependent Care Assistance Program (DCAP). The DCAP has the same basic structure as a Medical FSA, however, the maximum deferral is $5,000 and the employee has access only to funds that have been deferred. In February, they can utilize what they've deferred in January. There's no rollover or grace period for the DCAP account. Employees must incur and claim in the plan year. And like a Medical FSA, annually unclaimed funds are forfeited.

Slide 10 – Examples of Eligible/Ineligible Expenses. These expenses are work related. Work means being at work, looking for work, or engaged in work-related educational activities. Examples of eligible expenses are after school programs, child care, dependent or elder care, etc. Examples of ineligible expenses are dance or piano lessons, a babysitter when you're not at work, tutoring, etc. A caregiver cannot be a relative.

Slide 11 - Medical FSA/DCAP Vendor. Navia Benefit Solutions has been the vendor for HCA since 2014. They have national accounts but they're based in Bellevue. They serve several other states and between 30 and 35 school districts already, large and small, east and west of the mountains, accounting for more than 6,000 school employees.

Slide 12 – Medical FSA/DCAP Logistics. Employees sign up for an account with Navia during open enrollment. Deductions are set up by the SEBB Organization. Each pay period, the deferrals come to the Health Care Authority. As employees submit their claims to Navia, Navia reimburses them and then bills the Health Care Authority for funds used. Monthly, the Health Care Authority pays Navia a per participant per month administrative fee. Fees paid by SEBB Organizations will be offset by forfeitures.

Dave Iseminger: The enrollment that will happen this fall is a separate portal than SEBB My Account. SEBB My Account will have a directional link to provide information about the benefit. It will have a link to how to enroll. There is a separate employee portal for Navia to make the enrollment. There's also a paper-based option but there is a robust online enrollment process that people will be linked to through SEBB My Account.

Marty Thies: Slides 13-14 – Benefit Utilization. As far as utilization under the PEBB Program, you can see there's been a steady growth in the years that Navia has been our administrator, 6.7% annually. It fluctuates every year as people retire and new employees come on. Tens of millions of employers nationwide offer Medical FSAs to their employees. In the last five years, PEBB Program employees have reduced their taxes by approximately $18 million and agencies have saved in FICA expenses over $11 million.

Slide 15 – SEBB Program Medical FSA/DCAP: Implementation. We're now working with Navia to bring 300 plus SEBB Organizations into the fold. They're coming from programs that have different design features, plan years that don't coincide with the

calendar year as ours does, carryovers rather than grace periods. ERB Division communications, in
collaboration with Navia, is creating communications for bringing the SEBB Organizations and employees into this benefit smoothly. We're increasingly engaging the SEBB Organization staff to prepare for data sharing and payroll deductions.

Dave Iseminger: I was just going to add the transition to a calendar year plan took me by surprise. I'm sure many of you are aware the general medical plan enrollment is different for districts, but they tend to fall in November to October or October to September. Yet, the Medical FSA/DCAP has more variability. We were made aware recently that there is a May to April Medical FSA non-calendar plan year. It turns out that virtually every permutation of a 12-month cycle exists for Medical FSA/DCAP. So the conversion and transition to a calendar year plan is even more complex in Medical FSA/DCAP than it is in medical. I was rather surprised that one might have a non-calendar year plan that is a different non-calendar year plan from your medical plan. It has proved to be yet another kind of interesting little nugget within consolidation efforts.

Wayne Leonard: Is Navia also a TPA for the HSAs?

Dave Iseminger: The state does not have a direct contract relationship with an HSA account manager. They're subcontractors of the medical plans. For example, on the PEBB Program side, it is fortuitous that for the UMP (through Regence), KPWA, and KP Northwest the subcontractor is HealthEquity so it is the same administrator for all the PEBB Program members. On the SEBB Program side, the proposal before you, UMP, again, HealthEquity would be the subcontractor for UMP. Providence is the only other carrier who suggested having an HSA plan and I believe their subcontractor also happens to be HealthEquity. It looks like that would be uniform within the portfolio but it is not a direct contract relationship for the state.

Marty Thies: Navia does provide that service. A lot of the Medical FSA/DCAP administrators, that's part of their inventory of services. But we don't do that with them.

Wayne Leonard: A lot of school district employees have HRAs also. I know there's restrictions with their HRAs with coverage of spouses that may be on Medicare. Is there similar restrictions for HSAs and FSAs?

Dave Iseminger: We'll follow up with this at a future meeting, Wayne. But I do know that there are implications of HSA enrollment if you have a split account that includes one individual who is Medicare eligible. That's not the case for Medical FSA as far as I'm aware. But there are some nuances for a married couple where one is Medicare and the other not Medicare when it comes to HSA. We'll do a little bit of follow-up on that.

Wayne Leonard: I'm thinking primarily of our bus driver pool. A lot of retirees that drive bus either have Medicare or Tricare coverage so that question will probably come up.

Patty Estes: Wayne, I have an HSA and I have my daughter who is also covered. I had my daughter on my coverage who is also covered under her father's coverage. In order to use my HSA to cover anything for her, they wouldn't allow it. I would've had to

reimburse HealthEquity for any of those expenses. I ended up taking her off of my HSA because her coverage was better with her dad. I know they can't be doubly covered with an HSA plan.
Wayne Leonard: Right. I think with the HRAs, if someone's on Medicare, you have to put it in limited status.

Dave Iseminger: I know just enough to be dangerous. So we'll do some follow-up on the kind of Medicare split account situation and its implications for Cafeteria Plan benefits.

Public Comment
Julie Salvi, Washington Education Association. I will try and be brief today. I know the road is calling but I wanted to touch on two things. One was from early in the day when Megan was talking about the rates and when they might be adjusted. For those who don't know me well, I have a ten-plus year history of being legislative staff and OFM staff on K-12 budgets. There is a tried and true tradition in K-12 of not adjusting health care or other rates on school districts during an open school year. I would fully expect that it would hit in the 2020-21 school year any adjustment would be made, not during next school year. When this has come up before and the Legislature has thought about trying to make an adjustment mid-year, it is quickly brought up to them by their many staff who will remind them districts cannot lay off staff during a school year. Every May 15 is essentially the deadline. If they have contracts that won't be renewed for a full year, they need to notify staff by that time. So during the year, they cannot make reductions in their certificated staff. By the time legislative budgets are approved, the school year's essentially over and the Legislature also recognizes that to either push on the cost or take some other reduction that impacts school districts' bottom line, there's not room for the school districts to adjust within that school year window. That is why, based on that long history of how they have done things over the years, for pension changes, health benefits, and others. I would not expect it to hit until the second year.

And the other thing I wanted to touch on was Pete's comments related to getting information out about the value formulary. I think that is very important and I would emphasize that I wouldn't focus just on UMP. Knowing that some of these other plans will also have value formularies, it would be helpful to find some way to have information go out that would give people information on where they can go to look for the various formularies as they're considering plans in open enrollment, and as they're looking to transition to a new plan. Making that transparent because that will be new to many people in K-12. Thanks for your time.

Lou McDermott: Thanks for your insight and I appreciate the feedback.

Dave Iseminger: I had written a note to myself for things like the virtual benefits fair to ask carriers to be very explicit about where the members will be able to get information about the formulary. So similar minds thinking. I have one public comment I need to respond to that was submitted in writing.

In the front pocket of your binders is written testimony submitted to the SEB Board Correspondence and specifically noted to be presented as part of public comment at the next Board Meeting. We've never had that before on the PEB Board or SEB Board side. So the process that we're planning to go through is that we will give you a copy of

it, we will have it put verbatim in the minutes, but I'm not going to read it for you because if we get suddenly 6,000 of them, I don't want to read 6,000 word-for-word emails to you.
I would say about this one from Krista Hurling at the Wenatchee School District, the heart of her public comment is a question and assertion about, she is a substitute teacher and how substitute teachers are treated in the SEBB Program population. The underlying assertion is that individuals who meet the hour requirement aren't eligible for benefits. There's a couple of things that I want to make sure the Board's aware of. There were opportunities or ideas at the end of the legislative session in bills that would have exempted, or otherwise changed, the eligibility for substitutes. That did not pass so nothing changed with regard to eligibility of substitutes. If they are anticipated to work, or actually work, 630 hours, they are benefits eligible in the SEBB Program. This comment may have come up in the context of hearing about those legislative changes.

At the same time, we'll take the opportunity to ensure the Wenatchee School District is aware of how to apply eligibility requirements for substitute teachers and any school districts that have similar confusions about how this applies to substitute teachers.

From: Krista Herling <teacherkrista@gmail.com>
Sent: Monday, May 6, 2019 9:52 PM
To: HCA SEB Board <SEBBoard@hca.wa.gov>
Subject: Re: Public comment

Hello, I would like to submit this comment please!

To the Board of SEBB:
My name is Krista Herling and I am a substitute teacher in the Wenatchee School District. This is my first year back subbing after having my 4 children, who are now in school full time. Because it is my first year back I got a slow start in subbing this year, but I will almost reach the half-time mark with jobs currently scheduled through June and expect to easily reach it next year.

I recently learned that SEBB benefits will not be offered to subs because we "aren't guaranteed hours," even if we reach the threshold for part time employees. This feels patently unfair to me when we have the same credentials as the teachers and many of us work at least part time every month. Other part time employees are offered benefits when they reach the half time threshold (per your current guidelines), yet substitutes will be shut out of ever receiving any benefits. Many of us are unable to work as full time teachers either due to life circumstances or unavailability of jobs. There was one (1) full time position open to me in this area this year.

I understand it involves more paperwork, but it seems like we should be offered the same benefits as other part time employees and those should continue as long as we maintain the average of half time work. There has to be some way to make it work rather than just say we are shut out completely. School districts couldn't function without substitute teachers, some days I work all my classes plus the prep period because there aren't enough subs as it is.

Thank you for taking the time to consider that we are valuable employees as well and deserve the same rates of benefits.

Krista Herling
Pete Cutler: Dave, I want to be absolutely painfully clear. So this does mean if somebody in a school year -- is it based on a school year? Let's say they sub worked a bit in September through December. They hit 635 hours of being a substitute. As soon as it becomes clear that they're going to hit 635 hours, the coverage kicks in and it's good for the rest of that school year.

Dave Iseminger: That is true. There is at least one caveat. I don't remember the resolution number. They do not have to work but as long as their employment relationship is maintained, for example, a substitute teacher reached 630 hours by December and then didn't put forward any other hours, until the employment relationship is terminated, they remain benefits eligible until August 31. If for some reason a district or the employee severs that employment relationship, then the other Board resolutions that kick in for the termination of benefits, the first of the next month would apply. If a district decided come February they were not going to bring that substitute back and then severed the employee relationship, that might serve as a basis for ending benefits prospectively. But without any change to the employment relationship, the individual remains benefits eligible through the end of the school year, which is statutorily August 31.

Pete Cutler: So that's even better than the PEBB Program rule about requiring eight hours or whatever that standard was for continuing coverage. As long as the employment relationship, however that's determined continues --

Dave Iseminger: I think, Pete, a core difference between the PEBB and SEBB Programs is that maintenance rule. In the PEBB Program, there's a maintenance rule for eligibility. In the SEBB Program, eligibility is determined anew every school year, every September. There's a reboot of eligibility every year in the SEBB Program that doesn't happen in the PEBB Program; and conversely, there's a maintenance rule in the PEBB Program where there's no maintenance rule in the SEBB Program.

Pete Cutler: Great. Thank you very much.

Wayne Leonard: At the WASBO conference recently, there were questions and I just want to clarify. The next school year, the SEBB Program doesn't start until January 1. When does the 630 hours of eligibility start? Does it start January 1 or does it start September 1?

Dave Iseminger: It starts September 1, 2019. An important piece for districts this summer, in August or September, will be uploading into SEBB My Account the eligibility file of those individuals who meet the requirements for benefits as of January 2020. That will be based on the hours in the 2019-2020 school year, which is September 1 through August 31. The hours anticipated to be worked or actually worked in September will be part of the consideration of the eligibility determinations for the benefits that become effective in January.

Wayne Leonard: Okay. And severing the employment relationship with a substitute employee, one of the difficulties, I guess for the business offices is that if a substitute becomes eligible and then they no longer accept open days where they could sub, there's no paycheck to deduct their portion of the health insurance premium. My understanding is that the employer is still responsible for making that payment. Whereas if a person is on COBRA and they don't make their payment, their insurance is canceled. Is that correct?

Dave Iseminger: Wayne, everything you said is correct.

Wayne Leonard: Then you can imagine there's some frustration if people are receiving benefits and not accepting substitute positions. There was some discussion about can the employer sever the relationship if they refuse to take substitute assignments?

Dave Iseminger: Katy, you were starting to find the termination resolution. Did you find it?

Wayne Leonard: Substitutes haven't typically been eligible for benefits, that issue has never come up. But if we're paying for medical benefits for someone then there's going to be more of that employer/employee relationship, more skin in the game, so to speak. There are a lot of questions about how much are we, as a school district, going to be on the hook for in terms of medical premiums. A lot of times there's substitute shortages and we can't get subs. There's a lot of questions I'm getting around that and I'll be honest, I don't know the answers to all of those things because I haven't delved into the details like some of the other WASBO members have. That's where the questions are evolving from. If they're benefits eligible, and particularly if their benefits go in July and August, then there's no work. We don't typically want to be the Health Care Authority's collection agency if these people move away and we don't know where they are and we're still paying their benefits.

Dave Iseminger: What I'm going to do, Wayne, because you've eluded that you have a variety of questions that have come your way, I'm going to make sure that Barb Scott and Rob Parkman reach out to you to make sure we know which questions, in case they are ones they haven't received yet through their various channels --

Wayne Leonard: They may have received them already. I don't know.

Dave Iseminger: We'll at least confirm that piece so we can make sure we're answering those different questions. I know there is certainly a lot of concern from districts about the fact that HCA will send our invoicing on a monthly basis that uses the $994 funding rate times the benefits eligible individuals and expect payment for them, both the employer and employee contribution, regardless of state and local funded status. Ultimately, the requirement to collect the employee premium will be on the districts to recoup from the employees. So definitely aware of that piece, understanding that it has even more intricacies when it comes to substitute teachers. I know we've answered a fair amount of questions about substitute teachers. I'm positive we haven't answered all of them but I'll make sure the team gets to you to make sure we at least have all the questions so we can be working through them. There'll be more iterative process with work on the Board on rules probably around substitute teachers as we move forward.

Wayne Leonard: And it's not just substitute teachers. It's all substitutes, right?

Dave Iseminger: Yes. I often say substitute teachers but I do mean generally substitutes.

Dave Iseminger shared potential agenda topics for the June 12, 2019 SEB Board Meeting.

Lou McDermott: Thank you, Dave, to you and your staff. Thank you Board Members. Thank you TVW and Mrs. Walker and her first grade class.

Next Meeting
June 12, 2019
10:00 a.m. – 2:00 p.m.

Meeting adjourned at 3:11 p.m.

Washington State Health Care Authority

D R A F T

School Employees Benefits Board
Meeting Minutes

June 12, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
10:00 p.m. – 2:00 p.m.

Members Present
Wayne Leonard
Terri House
Dan Gossett
Alison Poulsen
Pete Cutler
Patty Estes
Lou McDermott

Member via Phone
Katy Henry
Sean Corry joined after break and left after Executive Session

SEB Board Counsel
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 10:02 a.m. Sufficient members were present to allow a quorum. Board self-introductions followed.

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

May 16, 2019 Board Meeting Follow Up
Dave Iseminger, Director, ERB Division. At last month's Board Meeting there was action on the UMP value formulary. There were additional questions about getting a documented step-by-step process for the exception process.

Slides 3-5 – Uniform Medical Plan (UMP) Value Formulary Exception Process describes what the tier structure will look like. Drugs not on the formulary will be covered only when medically necessary and all formulary drugs were found to have been ineffective or are not clinically appropriate. This is language stemming from the resolution. It's a one-page slide summation on Slide 3. Slides 4 and 5 talk about the exception process.

I'm going go to Slide 5 for purposes of today, which goes through the step-by-step process.

If somebody wants an exception for a drug not covered under the value formulary, the member or the provider can request a formulary exception by contacting Washington Prescription Services. Prescription Services will contact the member's provider and put in motion the exchange with that provider about the clinical information needed in order to get an exception. The clinical team at Washington Prescription Services will review the submitted information and make its determination. If there's any consultation under the Uniform Medical Plan that's needed or questions, there's the ability for our clinical staff to communicate and work with Washington Prescription Services on any difficult cases. HCA will also have an audit review process over them if there are member concerns with a particular appeal. Ultimately, the decision will be by the clinical team for Washington Prescription Services. If all alternatives have not been tried, the member could continue taking the non-formulary drug by paying the full cost. If they are approved, they would get the non-formulary drug at the cost that is included within the tiering structure of the plan. This is the boiled down, step-by-step process we will be communicating out to members as they are transitioning into the UMP if that is their plan selection.

Pete Cutler: That last point is what I'm interested in. Will this be displayed prominently on the website? How accessible will this information be as we get beyond the first few months? How easy will it be for members who have a concern about this issue be able to find this exception process information?

Dave Iseminger: There's a lot of information, Pete, people are going to be receiving this fall. There's going to probably be a saturation point where there are so many important things to communicate. But once we're up and running and we don't have to generally communicate the core eligibility rules to everybody in the system, that real estate will not be as prominent or needed from the school employees' perspective. We will be focusing even more on highlighting and raising the awareness of things like this.

I'm anticipating as we go forward and have our standard communications and newsletters with individuals, we'll make sure we are highlighting pieces that indicate where to find this information. It is important to note that as of plan year 2021, under one of the bills whose number I already forget that passed this last legislative session, there are rules and requirements about communicating clear exception processes to enrollees. We'll also be making sure that we're complying with those pieces. After we get through this saturation of launch information that individuals need, we will make sure this type of information is prominent and easier to find for members and highlighted in communications.

Pete Cutler: Great, thank you.

Lou McDermott: Dave, I know with our newsletter, I'm assuming we're going to be doing a SEBB newsletter as well. It's an opportunity to highlight different facets of the benefit. It goes on an annual basis.

Dave Iseminger: We're anticipating we'll have a newsletter at least three, sometimes four times a year. The first newsletter is at the printers and will be mailed towards the

end of next week. I think it's 12 pages plus four pages of nondiscrimination notices. There is a lot of content to help orient people to what's coming and how they're going to be getting new information. Once we get through the core information, we will have a standard communication cadence with the school employees directly. We take the opportunity to highlight things like this on an annual cadence.

Slide 6 – Cafeteria Plan Benefit Follow Ups. There were questions at the last meeting about HRAs, Medical FSAs, DCAPs.

Sllide 7 – HRAs – Health Reimbursement Accounts. This is not a particular benefit design that fits within any of the benefits in the SEBB Program portfolio suite, nor the PEBB Program portfolio suite. But it is something that many people have heard about and they try to understand if it relates. So this isn't something that is necessarily a benefit design within the SEBB portfolio. But it is to juxtapose because people often hear some parts of IRS code and lump them all together. I want to provide a bit of education about HRAs even though it's not directly applicable to the portfolio that school employees would access.

These are tax reimbursement accounts that employees don't contribute to. They're contributions the employer makes available. Typically a common cadence is an employer might make a wellness benefit and if you do three of the following eight activities, we'll put X number of dollars in an HRA and then as you have claims that come in, the first amount that would normally be charged to the member is deducted from the HRA. It's treated almost as first dollar coverage to cover the member's out-of-pocket expenses. Because it's employer-owned, the employer owns the funds themselves. They set the rules for when they can be used and when the use expires. Typically, an employer will set it on the plan year. If it's unused at the end of the plan year, it reverts back to the employer. It's not like an HSA that is employee-owned and rolls over year over year, or Medical FSA, which many people think of as a short term employer loan that is repaid via employee contributions.

That's where this is fundamentally different. All of it is employer contributions. The employer owns it so if it's unused, it reverts back to the employer. Generally, the rules for expenditures are very similar to a Medical FSA. There are qualified expenses but most of the time what people are using it for is that out-of-pocket copayment or other out-of-pocket expenses, or even prescription drug expenses. It's based on the claims experience of the enrollee. They are compatible with many other health plans. They don't have specific enrollment requirements, unlike an HSA where you have to be enrolled on a high deductible health plan that meets IRS requirements in order for the contributions.

There's nothing that overlays HRAs. It's purely a separate revolving account that an employer can set up within many different plan structures. We already talked a little bit about the bottom pieces. The reason so many people hear components about HRAs is they know they are tax-free contributions and there are tax advantages to the employer. And so that's why people hear different tax advantage pieces with Medical FSAs, HRAs, HSAs. They put the alphabet soup together and start to get confused.

Slide 8 – Medical FSAs: Split Accounts. There was a separate question about Medical FSAs and the concept of split accounts. If you have two employees eligible for benefits

in two completely unrelated employers, what are the rules for an individual to be able to elect funds? Can they elect the full IRS or employer allowed maximum at both employers, or is it a single contribution coordinated between the employers? If you have that type of situation, you are allowed to elect the maximum your employer allows you to elect. It's important from a Medical FSA standpoint to remember that the IRS sets the ceiling, but the employer can set a number that's lower than that ceiling. Whatever the employer allows, if you have eligibility in separate areas, you would be able to elect multiple Medical FSAs at the end of the day. Where that difference breaks down is if you work for multiple employers that ultimately are in these same employer control and they bubble up to the same parent company. That employer could have limitations within its subsidiaries.

Slide 9 – HSAs, Medical FSAs, and Medicare. The last question was related to HSAs and Medical FSAs and their interaction with Medicare. An individual can't be enrolled in Medicare and have access to making contributions to an HSA account because you have to be in an IRS qualified health plan and Medicare plans don't meet those qualifications. There is no way enroll in Medicare and have access to the health savings account aspect. For Medical FSAs, there is no such linkage. The Medical FSA eligibility is rooted solely on your employment relationship and whether the employer or plan sponsor has eligibility requirements that allow you to access it. HSA is completely incompatible with Medicare. Medical FSAs could exist for an individual who enrolls in Medicare.

Pete Cutler: Regarding Medical FSAs, am I correct the Health Care Authority will be providing the Medical FSA option to school employees and school districts are prohibited from offering their own parallel or alternative Medical FSA program?

Dave Iseminger: That is correct. There are multiple types of flexible spending arrangements. There's what people call a full Medical FSA and a limited Medical FSA used primarily for dental or vision. We are working to communicate to everyone the fact that the Cafeteria Plan authority with the agency is for all types of Medical FSAs. The authority for a district to offer benefits doesn't include any form of a Medical FSA, DCAP, disability, life insurance, dental, vision, or medical. We are working on being able to clarify that for folks.

Pete Cutler: I would follow then that for school employees, even though they worked a couple different school districts that had no interaction with each other and could be considered separate employers, they're not going to be able to double up in terms of Medical FSA coverage because they are going to be in the one Medical FSA plan. It doesn't matter which school district they're in.

Dave Iseminger: Correct, Pete, because the state is putting forth the Cafeteria Plan benefit on Medical FSA. We are, as a single program, offering that benefit fitting that common control language on the prior slide. There won't be a way for somebody to double dip into the program because it's all bubbling up through the SEBB Program.

Pete Cutler: Right, unless they had a job with a completely different employer that was not included under SEBB coverage.

Dave Iseminger: Correct.

Patty Estes: I wanted to point out that you said people that are enrolled in Medicare can't contribute to an HSA but they can still use their HSA if they're --

Dave Iseminger: Yes, that's correct. A lot of nuances are, if you have an HSA and you previously put contributions in that met all IRS requirements, you can spend them whenever you want. But you only get the tax advantage if it's for qualified expenses.

Patty Estes: Perfect, thank you.

Dave Iseminger: There was another follow-up question not in the slide materials. It was about utilization management criteria requirements under House Bill 1879 that was part of Cade's legislative update. The piece I have to bring back to the Board is that the bill doesn't address a requirement for carriers to specifically post their utilization management criteria. That was the crux of the question, do UM requirements have to be posted or what is the notice for requirements? They are required to provide it but that doesn't necessarily mean an affirmative posting of it.

Pete Cutler: Following that up, that's implying the member would have to know to ask and figure out how to appropriately ask for any given health plan?

Dave Iseminger: At this point, yes.

Pete Cutler: Would it be possible for the agency to send us an email, somehow post information on the exact sections of the budget that have an impact on the SEBB Program? We're told subsections five and section nine. But I realize it's a big document. It would certainly be a lot easier if you could hone us in on the exact sections.

Dave Iseminger: Yes, we can definitely provide that information. It is scattered throughout the budget. There's many different components to it. That would make sense that we can work on providing a roadmap.

Rate Development Process

Megan Atkinson, Chief Financial Officer. This presentation is to prepare you for the July meetings where we will present final rates, final employer and employee contributions and asking you to take action. That's a huge milestone in this journey that we've been on for the last couple of years. We'll walk through where we are on our rate development and our negotiations with plans. We'll give you a little bit of an update and then I'm going to walk you through the sample spreadsheets.

Slide 3 – Medical Rate Development and Negotiations. With the fully insured carriers, we have gone through two or three rounds of bid rates with them. We've sent out the benefit package and had the carriers propose in different plan designs. We've had a multitude of conversations with them, both on the financial side and the program side. Service area, benefits, deductibles, etc. Where we're getting close to being to conclusion is doing our own UMP self-insured bid rates. It's a self-insured product, it's not really a bid rate, but we still call them that. It allows us to talk about apples to apples comparison. We most recently had an additional year of claims experience for the K-12 population that we were able to bring in and update our data book. That was the 2018 year. That was released to the plans. We have the same data book. The

data book we use for our self-insured product is the same data book we have available for the plans. Everyone has the same information. With that, we're updating our self-insured rates. And then we show to the plans our self-insured rates. We don't share rates across the plans because those are propriety when we're in negotiations. But we do let them see our self-insured product rates. That helps our managed care partners understand where we're positioning our products and it allows them to make a more informed decision about how they want to position their own portfolios.

In addition, it can drive an interesting conversation about what our actuaries are seeing in the experience and what the plans' actuaries are seeing in the experience. That's where we are now, getting to the final round of rates.

Slide 4 – Next Steps: July SEB Board Meetings. On July 18 we'll be bringing you the numbers and the proposed resolutions. On July 25 we'll ask you to take action on the resolutions.

Dave Iseminger: Typically we introduce resolutions and then ask you to take action after a 30-day period between one meeting to the next. As we get into the rate setting process, year over year, there's often this crunch that happens in July. At the end of the day, when it gets to July 25, it's an up or down vote. At that point, it's too late to go back and tweak further. That's why we use Executive Sessions in May, the one we'll have today, and the ones we've been having all along to get your insight as we're going through the negotiation process. We know when it comes to July, there will be this point where we say publicly where we are. It's up to you to say yes or no at that point.

You'll note on the calendar we have an August 1 meeting on the books. When we created the schedule for the SEB Board back in October 2017, we had no idea exactly what the legislative process would look like. Our experience over the last decade is that we've often had a lot to do in July because the information that is critical for us to complete the work isn't available until late May or late June. We always plan accordingly.

This year the Legislature got out early. We're anticipating you will take action at the July 25 meeting. It's going to be important, especially in this launch year. If all goes well, the August 1 meeting would get canceled. We're only 66 days away from open enrollment. An extra six or seven days is critical to be able to get information into the materials, do quality checks, finish the rate books, push everything into the system, and do the final IT checks as we march towards that October 1 open enrollment date.

Megan Atkinson: That's another reason why we wanted to walk you through this presentation today, to get you familiar with the structure of what we will be presenting so you'll be comfortable and ready to take action on July 25.

Slide 5 – Rates Update. You'll get final proposed service area maps. I'll be coordinating with Lauren on the program side to give you that comprehensive look across the portfolio with the different carriers, different plans, different offerings, what is the value assessment for the member. Hopefully, that will help you make your decisions. If there are concerns, the Board can take action to remove a carrier or a plan from the portfolio. Premiums will be an up vote for yes or a down vote for no. You wouldn't be in a position to do additional negotiations at that point.

Slide 6 – Employee Premium Contributions: Sample Spreadsheets (Medical). I'll walk you through what the sample spreadsheets would look like for medical.

Slide 7 – Employee/Employer Premium Contributions. These numbers are for illustration purposes. These are not the final numbers. We'll be showing you, for the medical premiums, the employee and employer contributions. Again, for the SEBB Program, the employer contributions on the medical side are the employer medical contribution. That is detailed in the Collective Bargaining Agreement and it is 85% of the 88% AV self-insured plan. It'll be 85% of the UMP Achieve 2 bid rate. Once you do that, it's really just math, but I'm going to walk you through the spreadsheet because the spreadsheet goes from right to left.

The proposed 2020 bid rates are in the far right column. The employer medical contribution, again, spring boarding off the Achieve 2 bid rate. Moving left, the gray column, the proposed 2020 employee contribution is just the math. We populated this with sample numbers so you can see how it works. We will be showing you the four UMP offerings and the full set of fully insured plans by carrier and plan.

Dave Iseminger: Although they're sample numbers, these is the most recent not-to-exceed (NTE) UMP bid rate information that we've presented to you in prior meetings. The tables were goldenrod with green rows that indicate the employer contribution. These are the most recent NTE rates for UMP.

Megan Atkinson: But these are not the final rates. They are the most recent ones you have seen, but they are not the final. They do not reflect the updated 2018 experience. These don't reflect the last round of data book that we updated and shared with the plans and that we used with our actuaries for our own rate development.

Slide 8 – Employee Contribution by Tier. We've taken off the employer side and building out the employee contribution by tier. We did a tier ratio conversation earlier in our journey together, talked you through the proposed tier ratios, and took action. We have a statutory direction around the spread of the tier ratios. The top gray row is subscribers of 1.0, subscriber and spouse 2.0, subscriber and children 1.75. Regardless of whether you have one child or ten, it is 1.75. The far row on the right is the subscriber, spouse or partner, and child or children. The rows moving down are the self-insured and fully insured offerings.

Again, numbers are for illustration purposes but the math works where you take the single subscriber amount and multiply it by the tier ratio and that gives you the amount. Taking the first row down to the UMP Achieve 1, under single subscriber, the employee contribution would be $34. When you move to the subscriber and spouse or partner tier where the tier ratio is 2.0, you take the 34 times 2.0, you get $68 and then etc. as you go across.

Below the bottom gray line there are two surcharges we are directed to assess. One is the tobacco surcharge and one is the spousal surcharge. You can see in the tier ratios how those work. You only have the spousal surcharge on the two tiers where you would have a spouse or partner enrolled as a dependent. This is the format we will use when we walk you through this next Board Meeting.

Slide 9 – Employer Contributions: Sample Spreadsheets. Now we'll discuss employer contributions for the additional benefit offerings, dental, vision, etc. This is slightly different in that there is not an employee contribution on these benefits. The employer contribution is 100% of the premium and is a result of our procurement at this stage of the game. Depending on how successful we've been with our procurement drives how the rates come out.

Slide 10 – Dental Premiums. We'll have our self-insured Uniform Dental Plan and then our fully insured offerings.

Slide 11 – Vision Premiums. We don't have a self-insured vision offering so we'll be showing you our contracted plans. In the SEBB Program offering, we have vision carved out of medical and it is 100% employer paid.

Slide 12 – Basic Life/LTD and Basic Long-Term Disability. We'll have subscriber rates. We don't self-insure for that.

Slide 13 – Supplemental Benefits. These are the benefit offerings the employee can choose to add on to their own portfolio of benefits that they're carrying. Because these are the supplemental benefits, what we'll be showing you is the cost to the employee. There is not an employer contribution on these.

Supplemental Life/AD&D will be the result of how successful we'll have been on our procurement so you'll have rates there. There's supplemental life smoker and nonsmoker rates. On the far right is Supplemental AD&D for the employee, spouse, and child. There are footnotes of how to calculate member premiums.

Slide 15 – Supplemental Long-Term Disability. These rates change by age. People move through the rate brackets as time marches on. Again, it'll be the result of how successful we are with our procurement.

Slide 16 – Sample Proposed Resolution. This is a sample of a proposed resolution. "The SEB Board endorses the [carrier name] employee premiums." You can vote yes or no.

Dave Iseminger: As an additional piece of context, the resolutions only relate to the medical plans because your authority includes the setting of the employee premiums. For the employer-paid benefits, we provide you the information, but there's no action for you to take.

Megan Atkinson: Pete, you asked for a follow-up on the budget. We do have a listing of all the places in the budget where we have pulled out directions specifically to SEBB. We'll get those put together and get that to you.

Pete Cutler: That'd be great. Thank you very much. And just for the record, I want you to know I think the very last stage when you have actuaries discussing the nuances of the different items, that's the crème de la crème. And exciting portion of the process.

Megan Atkinson: It is pretty interesting.

SEBB Program Stakeholder Activities

John Bowden, Manager, School Employees Benefits Section, ERB Division. I'm setting up future presentations, two today, one on stakeholder communications and one on SEBB My Account.

Slide 2 – SEBB Program Stakeholder Engagement. We have a lot going on but it's a coordinated effort that we have underway. We did presentations to public school employees, the Washington Education Association (WEA), and benefit advisory committees. The employee newsletter and the enrollment benefit guide will be coming out in September. For SEBB Organizations, there have been lots of regional meetings at Educational Service Districts (ESDs) with superintendents, finance officers, HR folks. We've presented at WASBO, School Personnel Association. We have some coming up at WASA with school principals. We've done several WSIPC pieces and some Business Plus conferences.

We have lots of resources we'll provide to the benefits administrators in the SEBB Organizations to help them assist their employees in making benefit selections and managing the selections they've made. One of the areas where it overlaps is we have some onsite benefits fairs coming up. The agency is creating a virtual benefits fair because we can't get to everywhere in the state.

We have a pilot project, ALEX, a benefit selection support tool. I've heard a lot from the SEBB Organizations benefits administrators about how excited they are about the availability of ALEX. Later today, Chatrina Pitsch will present to you where we are with SEBB My Account. In developing SEBB My Account, we have done a lot of work with the SEBB Organizations and involved them, as well as the end users, in doing beta testing. We have user acceptance testing going on within the agency. There is a lot going on to make sure SEBB My Account will be ready.

We have an IT Support Contact Center we're developing so if there are problems, people will be able to call in, send emails in, and get assistance. One of the areas they may need assistance is creating accounts and getting secure access, Washington login or confidentiality security

SEBB My Account videos are being developed. You can find information on questions you may have. You can say you want to know how to enter my dependents and there'll be a little video clip on that. Maybe you want to know more about making a benefit selection or how to take somebody off of SEBB My Account, or how to make changes. There will be video clips to offer guidance.

Slide 3 – SEBB Program Stakeholder Timeline. This timeline shows some of the things we have going on, starting with the SEBB My Account piece and the beta testing I talked about. We're getting information from the SEBB Organizations about who within their organization should have access in SEBB My Account to add employees, make employee changes. Those are authorized by superintendents and that's going on now. We have training materials being produced. We will probably have a webinar coming up in a couple of weeks to talk with SEBB Organizations about submitting eligibility files so we can have all of the eligible employees. It's actually not going to be all of them. People get hired, even after the start of the school year. But we'll have as many of the

eligible employees in as we can so they can find themselves in the system and start making benefit selections. The two-day training coming up is August 1 through nearly the end of September. The SEBB Organization benefits administrators will know how to help people with the SEBB My Account, how to work it themselves, as well as all of the eligibility and enrollment types of rules this Board has passed. The virtual benefits fair goes live October 1. The enrollment guide will be going out mid-September. After they have the enrollment guides, we'll provide them with the virtual benefits fair and the ALEX tool.

Pete Cutler: Just to be clear, I think we had clear instructions. We should have them finished before August 1.

John Bowden: Yes. The first open enrollment starts October 1 and goes through November 15. We have a lot going on in a short amount of time.

Dave Iseminger: Before we move off this slide, I want to highlight one piece. The green bar, the SEBB My Account final eligibility file uploads, is a key piece. SEBB Organizations putting that information in SEBB My Account is what will enable us to push the data through the system so an individual can access the system when they go in on October 1 at 12:01 a.m. And there will be someone who does that on 11:59 p.m. on November 15.

We are working on getting to districts file specifications as early as we can. This summer we're trying to target the end of this month so districts are aware of the eligibility rules. They may be able to start to pre-load into the specifications and the file itself the information needed to be put into that file so they can upload it in September. We're anticipating districts will be able to at least start core eligibility determinations in July. There'll be many people they know are coming back that clearly meets 630 hours. They can put them in the file, so to speak.

As they're working through those eligibility requirements, they'll start to see employees where they're not quite understanding what the eligibility requirements are and how it works. Those are great questions to bring to the training in August and September. Once they've answered and gotten information about that you can go back, finish the files, and upload things in early September. That way there's as much time to populate and push the data through the system. Although the file eligibility upload is really what that green bar is about, there is work that we're anticipating SEBB Organizations will be able to do this summer once we get the file specifications out later this month.

John Bowden: For the districts, ESDs, and charter schools in the Washington School Information Processing Cooperative (WSIPC), we are working with WSIPC to get those eligibility files.

Slide 4 – SEBB Stakeholder Presentations. This list is some of the presentations made in the past month and then a few that we have going forward. Some additional presentations have been added.

Alison Poulsen: I had one comment and it may be more appropriate for the next section. I am a mom so my kids go to the Freeman School District and I've been

intrigued and slightly disappointed, I will be honest, at some of the communication about budget cuts coming to the district, being very specifically tied in their communication about SEBB. And it peaked for me the missing point, which is all these people who are going to get health insurance now that haven't had it in a much more equitable way. I wondered if the agency had been thinking about some op-eds around sort of the more productive message. I can appreciate the effect this is having on the school district. I'm not sure this is the only thing that is putting financial pressure, considering we just had a huge legislative action with McCleary and so forth. It feels a little convenient and yet sort of missing out on, I think, one of the intents behind the Legislature of having such a low threshold for people being able to access health benefits.

Dave Iseminger: Thanks, Alison, for that question. At the beginning of the legislative session, before the final answer came from the Legislature, there had been efforts to do some op-eds since there were some initial questions around what this whole cost would be and the impact it would have on the budgetary process. We had done a bit at the beginning of the session. What we have been doing is we have a robust pressroom. Our central communications team has information they periodically update for news organizations. We've been responding to various reporter questions.

I've done several interviews with a couple of newspapers in the state to get out different key messages. A lot of the questions I've been directly asked in those news conversations have been about explaining why an employer has to pay when somebody doesn't want benefits. We talk about how the funding rate's an average. And I always bring it back to the 3:1 ratio. We are going to have roughly 40,000 people between that 630 hour and 720 hour threshold who have access to more coverage than they've ever had before. Our anecdotes, through the studies year over year with the Health Care Authority, are there will be people who get family coverage and have more they take home out of their paychecks versus writing their employer a paycheck to have health care. We've brought that up as a talking point because that's something both Patty and Terri have prominently mentioned many times in prior Board Meetings.

We do have different pieces of the puzzle in place. I'll talk with our communications team and Director Birch about other things we can do to help combat that perception. We have a keen insight and tracking of where the different news stories are and how the SEBB Program is talked about in the media. And so far, there are some ties. It hasn't felt, from our perspective, that it's been overly targeted towards the SEBB Program. It's acknowledging the SEBB Program is a piece of the puzzle. I'd be interested if there are pieces you're seeing that you think are more targeted that we can work on responses to. We haven't felt that there's been such a pervasive negative connotation solely focused on the SEBB Program that we've done a pure proactive campaign at this point. We've discussed it a couple of different times.

Alison Poulsen: That's great. Ours was actually direct communication from the district to parents saying, "These are the cuts we are expecting because of SEBB."

Patty Estes: I did have a member reach out to me last week saying the exact same thing that she's a leader for classified employees saying the rates were going to kill the employees. I said, "How is that possible? We haven't set rates yet." She said the districts are telling them that same exact message that these people are getting laid off

because of SEBB. I think that message needs to be put out there that it's not necessarily true.

Dave Iseminger: There's one fortunate thing, we do have direct access to communicate with the school employees themselves and there are key things that we have to communicate as an agency and as a program. A good one is the newsletter that is going out and hitting mailboxes starting late next week. I can't remember all the articles in it but we do have the venue to be able to make sure we're pushing things out. And believe me when I say that everybody who reads those has different views of every sentence in them. Some people love every sentence and some people hate every sentence.

This agency's responsible for the messaging of the core foundational aspects of this program and ensuring that notice of various requirements, of various benefits, the changes to those benefits on an annual basis are communicated to school employees. We take that responsibility very seriously because at the end of the day, the Legislature has given you the authority to set the eligibility framework. This agency's administering it. We sub-delegate a lot of that authority to the employer but as issues come up in appeals, it bubbles back up to this agency. We make a decision because we have that authority and then we defend that decision.

Pete Cutler: By way of comparison, working with Insurance Commissioner's Office, when the Affordable Care Act went into place, we had carriers who I will choose not to name, when some of the Affordable Care Act provisions went into place, their yearly increases in the individual market came up. They were going for 15%, 20%, 25% increases and they blamed it on the Affordable Care Act. Even their actuaries admitted about 2% or 3%, maybe 4% of the 15% to 25% increase was Affordable Care Act. It was a part but it was not the only part. In fact, it was not even the driving factor.

My guess is with school districts it varies among the 200, almost 300 school districts quite a bit in that for some, maybe they do have a large number of non-state funded positions and maybe for them, it's a huge factor. But my guess is a little bit of a dynamic is that the SEBB Program is a lot easier for people to conceptualize than a lot of the other more complex factors that would drive budget finance challenges. In whatever case, I'm glad to know that the agency will be communicating with the districts trying to encourage them at least not to deny that there is an impact but trying to have a fair presentation of the relative impact. So thank you.

Katy Henry: To follow up with what Pete said, I think that every message to districts should be clear that every district has a different situation. Like Pete referenced, in Spokane we have a much higher number of unfunded positions. Your district has to go out and they're much more cautious and careful about how many part-time positions they are rolling out because it does have a significant impact when they are paying full medical benefits for, what used to be, a large number of part-time employees. That has impacted where we fit in terms of layoffs and with the budget going forward. While it's not the biggest piece of where we are, it is a factor in how they're looking at everything. I think there's not one size that fits all in terms of messaging but I would hope you keep that in mind in whatever you message out.

Dave Iseminger: We know that in the PEBB Program, the variety of employers and their financial situations is very different than in the SEBB Program. We are very keen to try to thread that needle. Like I said, every sentence we write we've realized there's going to be at least 295 different perspectives. We try to balance each communication saying this is a foundational piece that everybody needs to know. Ultimately, we make those judgment calls about exactly what we communicate about the Program directly to school employees. But we do have a keen awareness and regularly are talking about how one message does not fit all. There are 317 SEBB Organizations. Charter schools are different than ESDs, which are different than districts. A common thing we say is, does that happen in K-12 land? The answer is somewhere yes, undoubtedly it does. We know there is not a one size fits all approach when it comes to communication.

Alison Poulsen: I want to make sure my point was clearly articulated. I have zero doubt that there is actual financial impact on our school district. Part of what I feel like is missing out of the message though is all of the people who are going to get access to health care at an affordable price. And yes, that costs the whole system and the collective, but it's actually a much fairer way when the collective is paying for it than asking bus drivers to just pay for it. That's the part that feels like it's missing. There is absolutely no doubt that education is a very complex financial equation. I think what felt sad to me was sort of penalizing folks who have just story after story that we had heard like, "You're the reason somebody else is losing their job," or "We're not doing this," versus, "This is how we start to build a healthier community."

[break]

Benefits Administrator Communications

Rochelle Andrake, SEBB Program Communications Supervisor. Jesse and I are here to talk about employer communications for SEBB Organizations. We'll be back next month to talk about open enrollment communications specific to school employees.

Slide 2 – Communications to SEBB Organizations. We've been communicating with SEBB Organizations for over a year now preparing them for the transition to SEB Board benefits. As enrollment has grown closer, communications to benefits administrators in particular have increased. Since November, we've been sharing information with benefits administrators regularly, providing them with resources about the SEBB Program to share with employees. These materials are like posters and flyers they can display and distribute, as well as articles they can post in employee newsletters or in email communications.

In addition, we reached out to SEBB Organizations to request contact information so we could send direct mail communications to employees. There have been several messages recently regarding the implementation of SEBB My Account as the online enrollment system, particularly to provide an opportunity to participate in testing and also to authorize administrator access, which is crucial so that SEBB Organizations can authorize their employees to use SEBB My Account to enroll this fall. We've also been working with benefits administrators to implement payroll processes between the SEBB Organizations, HCA, and our insurance carriers.

Dave Iseminger: We've been communicating for over a year. We started last November. That doesn't mean that communication was a predominant two-way street.

It was primarily a one-way street for the most part at the beginning. We were able to see evidence that some school districts, even before the legislative session, were beginning to communicate things to their school employees. Other school districts had a "wait-and-see" approach, wondering what the Legislature would do. But since April, that communication street has become much more robust in a two-way communication. We have many questions. I alluded to this before the break that every sentence the Health Care Authority writes has questions about it from somebody. We're always talking about ways to improve those communications. We definitely take feedback.

Ultimately, we have a responsibility as the administrators for the program with the authority given by the Legislature to make the final decisions about the pieces we directly communicate to school employees. We do, after we've completed communications, send copies of things in advance to school districts to show what we're sending to their employees. For example, I believe in the last day or two, we've sent a copy of the newsletter that will be hitting school employees' mailboxes next week so they have a good five-day period to be able to have a sense as to the types of questions that might come towards them.

We anticipate that even though we're directly communicating, there will be questions from those that are directed to the school districts. Over time, we have definitely seen an uptick in questions, comments, and suggestions on all the communications we're providing. We take very seriously the fact there is a foundational level of information we want to make sure that gets out. We rely on the employer's to do additional communications. We give them many prepackaged tools they can use. We have noticed they have been using them more and more.

Pete Cutler: I'm curious, do you feel like you have at least one good definite contact source for each school district? Do you feel like those contacts, in terms of when I want to get ahold of a school district, I know exactly who it is and it's actually a successful connection?

Rochelle Andrake: Yes, I believe so. Jesse will tell you a little bit more about responses that we've been getting regarding when we actually need them to take action on things. We're getting more of a response than we anticipated.

Pete Cutler: I was going to say when I was with the Insurance Commissioner's Office and we were trying to collect data, that was a huge hurdle for us. You would get a name, an email address, or phone number, and weeks later when you tried to make contact, that person had nothing to do with that. Pinning down the right person for each district is a huge step.

Rochelle Andrake: I wanted to add on to what Dave was saying. As much as it is a one-way street, whenever we do receive feedback through whatever channel it may be, we tie it into our communications. We try to send out and run key messages by some stakeholders to ensure we're actually sending messages that resonate with the employees and the employers, giving them answers to their questions. As we hear things, we update our FAQs to stay on top of what it is they really want to know.

Slide 3 – Benefits Administrator's Role. These communications to SEBB Organizations, and particularly the benefits administrator, are vital because of the key role the benefits

administrator plays in their organization. They are the conduit between the SEBB Organization and HCA. They're the main point of contact for employees who have questions about their eligibility or enrollment in SEBB Program benefits. As mentioned earlier, the benefits administrator is often the primary SEBB My Account administrator for their organization, assigning system access and user roles. Because their role in administering SEB Board benefits to their organization is so important to the success of the program, we've been communicating with them often to prepare them for what lies ahead. Recently, we provided benefits administrators with even more information about their integral role and how we're going to get them trained and prepared for open enrollment.

Jesse Paulsboe, Outreach and Training Manager, ERB Division. On the previous slides, Rochelle outlined the role of the SEBB benefits administrator and now I will provide you with an overview of our strategy for training and communicating with benefits administrators as we progress through the months prior to, and then eventually into, SEBB's first annual open enrollment.

Slide 4 - Benefits Administrator Communication Timeline. This timeline is for communicating with benefits administrators. It stretches from early May and goes into mid-November. The two-day benefits administrator trainings followed by the benefits fairs, nests within the initial enrollment window. Although the training doesn't really ever end for benefits administrators, for the purposes of this presentation, we just stopped at the end of the first annual open enrollment.

Slide 5 – WASBO Spring Conference. The WASBO conference served as a milestone and catalyst for launching the two-way benefits administrator communication plan. We chose the WASBO spring conference as our communications' stepping off point because the event was ideally positioned both in location and timing. We had enough details about the upcoming training events solidified we could present it to large audiences and conveniently, a significant population of benefits administrators were at this event. They were able to learn firsthand from us about the upcoming training, the strategy, and the plan we have for them in the following months. We conducted five hours of presentations and introduced them to the training objectives. We told them about the locations and the resources that we have available.

We had ten staff at a booth for three days to sit and talk with them one-on-one and answer questions and alleviate concerns we were hearing. It was really beneficial and it prepped them for what was to come in the following weeks.

Dave Iseminger: It ended up being fortunate good timing. The Legislature had just adjourned roughly two weeks beforehand. The question of "is this going to happen" was not at all pervasive during the WASBO conference, whereas if the Legislature had not adjourned, that would have added another dynamic to the WASBO presentations. I keep saying, as I look back on the last two years, this is supposed to happen because there's a lot of things that could make things more difficult along the way. This was another shining example. The Legislature had adjourned, there was funding, this is happening. Let's talk about the nuts and bolts of it. It really helped be a very good launching point for working with the benefits administrators.

Jesse Paulsboe: Slide 6 – Benefits Administrator Training Registration. We're actually in the training registration window now. On Monday, an invitation was sent to the SEBB Organization benefits administrators. As of now, which is less than 48 hours after the invitation was sent, 189 out of the 317 SEBB Organizations have representation at our training. We're already at 60% representation for SEBB Organizations for our trainings.

As we move further into the registration, we can identify which Organizations have not registered yet. We can proactively engage them with these training opportunities as we move along. This registration is important because it serves a dual purpose. Upon registration, benefits administrators actually receive a link to a page that provides them a series of follow-up instructions that will assist them in preparing their organizations for initial open enrollment and beyond. We definitively have 60% of the SEBB Organization population who has proactively signed up. We're also averaging about two representatives per district.

Slide 7 – Benefits Administrator Resources. The screenshot on this slide is the SEBB initial enrollment webpage. As soon as they enroll, they get a chance to go here. This takes them through a series of three steps they need to prepare ahead of initial enrollment. The first is establish communication with HCA. We've provided them a link to FUZE, which is a secure email correspondence we use. It's is the primary way people can communicate with the Outreach and Training staff to get their questions or issues answered. GovDelivery is for alerts and bulletins. It's our fastest way of communicating. They have the link to sign up for that. They are also provided a dedicated 1-800 number that goes directly to the Outreach and Training team. So benefits administrators have a direct line to a human being that will answer questions for them. In addition, the initial enrollment page serves as a placeholder to get them started. It will be replaced by a SEBB benefits administrator website, which is going to be much more comprehensive and will be a permanent resource for reference and educational information for years to come, like it is with the PEBB Program now.

Slide 8 – Benefits Administrator Training. These are the main training events for benefits administrators. We have 19 events across August and September to educate SEBB benefits administrators on eligibility, enrollment, and the benefits administration through SEBB My Account. It's a two-day training event.

Pete Cutler: How many trainings are there going to be and what locations are being used?

Jesse Paulsboe: There are 19 trainings. Each region has at least one training in August and September. Spokane has a third training because it's such a large area.

Pete Cutler: Okay and Seattle even being bigger didn't rate a third?

Jesse Paulsboe: The actual area is broken apart a little better so we were able to distribute more evenly across the ESDs. Bremerton and Tumwater took some of that share where you have almost the whole eastern side of the state –

Pete Cutler: That's true. That's spread a lot of area. Are the trainings primarily being done at the ESD offices?

Jesse Paulsboe: Primarily, there are some exceptions where I know Wenatchee had some remodeling going on and we were unable to host there. Some of the other ones were unable to host as well. We've found areas that are very close to those areas. For instance, in Tumwater, we're hosting it at Labor and Industries.

Pete Cutler: The initial choice would've been the ESD location if they had one? But when that wasn't feasible then something in the general vicinity?

Jesse Paulsboe: That's correct.

Dave Iseminger: Although these trainings are in August and September, we're wanting districts to make decisions as early as possible. You might be trying to reconcile how are there trainings in September if Dave just said we want uploads at the beginning of September. These trainings are geared towards August. If you need a second stab at it, if you want to send additional staff to get training, send them in September. We're trying to get as many people in August as possible.

The other thing I'm personally excited about, mostly because it shows that my third grade teacher had an impact on my life, is that we have a pre-homework assignment for benefits administrators as they come to their first class. When I was entering third grade, three weeks before class I got a coin from Czechoslovakia and was told to bring a two-page report, it will be graded. Everybody in my class had a European coin and we had to educate each other about their countries. I said we have a lot of people to train so let's give them some pre-homework assignments, give them a difficult eligibility question or two. Make them work through a worksheet. So there is homework, even for the benefits administrators on the first day of school, so to speak.

Jesse Paulsboe: Slide 9 – SEBB Program Benefits Fairs. We are hosting 20 employee benefits fairs across the state. Slide 10 is a map. In addition to the benefits fairs, SEBB Organizations also have the freedom to host their own benefits fairs. Some have expressed a desire to do so when we were at the conference. Not everybody has the opportunity to travel to a centralized location and attend an in-person benefits fair. To supplement those fairs and provide an additional option, we're creating a virtual benefits fair, which serves the same purpose as an in-person benefits fair in terms of putting employees in touch with plans and information required to make an informed decision. It's online and open 24 hours a day. It's going to be a one-stop shop for information, the ALEX tool, and some of the additional resources - videos and training guides that we have prepared for both the benefits administrator and the employees.

Slide 10 - SEBB Benefits Fair Map. I've overlaid all of the benefits fairs on top of a map showing the main population centers. We're pretty well represented. For Moses Lake, we'll be at Moses Lake High School. It's a pretty aggressive schedule.

Dan Gossett: Just a question about the times not the date that these benefit fairs will happen.

Jesse Paulsboe: That was a consideration, understanding that this particular demographic is much different than PEBB Program members. Teachers can't get away from their classroom so we're hosting these in the evening and we're doubling the time.

Most benefits fairs are two and a half hours. Ours are now four hours for SEBB Program members. About four to eight in each location.

Pete Cutler: I'm very impressed with the breadth and intensity of the outreach to all the different SEBB Organizations. That's a very, very hopeful sign.

SEBB My Account Demo

Chatrina Pitsch, Business Analyst, Enterprise Technology Services. Today I will give you an overview of where we came from, where we're at, and present a recorded demonstration so you can get the latest look and feel for the online enrollment. SEBB My Account is the online enrollment platform. We have the two pieces, the front online enrollment and Pay1, our back end accounting system.

Slide 2 – Information Systems. SEBB My Account was custom done in-house. We're able to use agile methodology for development, which means we develop in small chunks, present that to the group, get feedback, and make adjustments along the way. That has proved to be helpful in the short compressed timeframe we had. We are finishing up our beta testing which involved SEBB Organization staff. They're using SEBB My Account in a test environment, operating both as subscribers and benefits administrators and providing feedback. For Pay1, we modified a copy of our existing PEBB Program application and added some functionality for the SEBB Program.

Slide 3. Currently, we have the major functionality done and ready for go live on September 3 for benefits administrators. We're focusing on completing minor bug fixes and language enhancements. We are doing user acceptance testing for internal HCA staff. We're about 100% complete on that. Pay1 work is ahead of schedule, over 90% complete. We've been fixing bugs as we go along.

Dave Iseminger: The SEBB My Account piece is key for the open enrollment functions of October 1. Pay1 is more critical for the administrative go live, which is no later than January 1. They are decoupled and on slightly different timelines. We will go through additional testing during open enrollment for the Pay1 aspects. I want to delink those in your minds.

Pete Cutler: My understanding is Pay1 is a very old programming language. I want to say COBOL, Fortran, or something like that.

Chatrina Pitsch: COBOL.

Pete Cutler: Do I understand that what you have for the SEBB Program is an equivalent of a copy of Pay1, the process as PEBB, or is it one system where you're running some risk of your work on the SEBB Program piece somehow inadvertently impacting the PEBB Program accounting? Is that question clear?

Dave Iseminger: Yes, your question is clear and you're correct. We took a separate copy. That way what's done in the SEBB Program can't mess up the PEBB Program. Any future changes for the PEBB Program can't mess up the SEBB Program. They're separate systems. If one breaks, the other one isn't inherently broken.

Pete Cutler: Right and you're not at risk of inadvertently making changes to the other because of linkages. From my understanding, it's very old, very complex.

Dave Iseminger: 1977, Gerald Ford was president. I have a whole slew of facts of what Pay1 is older than. But they're in separate rooms.

Pete Cutler: I came on when the original budget proposals to replace when Pay1 came in. That was 2002. I know it's been identified as needing upgrading for a long time. Thank you.

Wayne Leonard: You said these were two separate systems, but is the SEBB My Account really just a graphical interface for inputting data into Pay1? Or is it really a separate system?

Chatrina Pitsch: It's truly a separate system. At the end of each day, it's basically a batch process that sends updates from SEBB My Account into Pay1. Rochelle and Jesse touched on a number of different stakeholdering efforts we've been making. We have definitely received great feedback from school districts, both from our beta testing and from the additional events we've been attending. We have recorded some of their enhancement requests and overall suggestions.

One enhancement we were excited to implement was the application programming interface, which is an automated way for data to come from a payroll system into SEBB My Account without having to manually enter the information. This takes some of the burden off the school districts to have to do double entry. They were very happy about that. We will continue to engage with SEBB Organizations as we move forward, even past go live so we can continue to log enhancements and suggestions and make sure it's the most user friendly application it possibly can be.

Lou McDermott: I don't think most people understand, even in the PEBB Program, the front end, what the administrators use and what the members use is still pretty antiquated. The SEBB Program front end is on a modern platform and is state of the art.

Dave Iseminger: And was created since September 2018.

Chatrina Pitsch: Yes. The main difference is the benefits administrators for the PEBB Program are currently working in that old antiquated system, in Pay1. In this case, they'll be able to work in SEBB My Account with the modern front end. We'll demonstrate that shortly.

Dave Iseminger: A PEBB Program employer now signs into a black and green flashing screen, doing command entry to find the screen. They have to know, type in A.43 to get to the screen to type in the information. They are truly keying into an Atari gaming system, actually Pay1 predates Atari. They're in a Pong system. Whereas, in SEBB My Account, you're going to see what their experience is from a benefit administrator standpoint.

Lou McDermott: The PEBB Program has been around a long time and that's what they get to do. The SEBB Program is brand new, 2020, and they get the cool new toy.

Dave Iseminger: We will be leveraging our experience here to improve things for state agencies and higher education.

Chatrina Pitsch: Can we queue up the video?

Dave Iseminger: As we go through the demonstration, can I ask you to feel free to jot your questions down and we'll come back to then. I'd like to get through the whole video. It's about 11 minutes long.

[video plays]

Dave Iseminger: That was the quick demonstration. It's come a long way since the first demo we provided to you in January. There have been a lot of questions: how many times can a district or SEBB Organization upload an eligibility file? What's the turnaround time? Is this real time? The answer is it is real time. If you have a school district that has 6,000 employees, it takes three or four minutes for it to run all its checks and show the number of errors. Basically, every five minutes that school district could upload a file. The amount of time it takes to process is pretty much real time.

You also have the scenario of an individual employee struggling for whatever reason to get their verification document in person. You saw how easy it would be for a school district administrator to verify the documentation. That can also work in person. I could walk up to my benefits administrator and provide a hard copy of the birth certificate. They can log into the account, click that they saw it, hand back the birth certificate and it's done.

As new state systems are brought online, and SEBB My Account is one of them, there's a push at the state to have a secure system access portal where you can eventually add state services that you are trying to access through one portal. We need to overlay the SecureAccess Washington® (SAW) account feature for school employees who have not yet created a SAW account elsewhere. It's requiring an extra login feature before you can get to SEBB My Account. We are working on building up our tech call center and they will be able to help people through that process. We're also working with WATECH to make sure there are additional self-service question and answers and troubleshooting that people can access.

If you haven't heard about SAW, you're going to be hearing about SAW a lot more coming from the state as more and more systems are built. It's envisioned that it would be something you would be able to access Department of Licensing and your driver's records, or your TANF benefits through DSHS, or your employer benefits from the PEBB and SEBB Programs. It's a new piece being rolled out across many state systems.

Pete Cutler: I'm curious, in terms of the infrastructure especially of the front end program, what kind of magnitude of business or volume can it handle? I'm thinking you're going to have a period with this initial enrollment where you may have thousands of people wanting to come on roughly at the same time. How is it being designed in order to deal with those workload stresses?

Chatrina Pitsch: Ideally, we've developed it to handle 150,000 users at once but we know not everybody's going to hit the system at the same time. We've looked at PEBB Program data and know their peak times. We're also doing performance and load balance testing to make sure we are adequately set up and tested when we do have those peak times, we don't have any blips or issues.

Pete Cutler: Great. When the Health Benefit Exchange went live, both in this state and at the federal level, it was frustrating and embarrassing that both systems were swamped. I'm glad you're looking ahead and I sure hope it doesn't suffer similar starting hiccups.

Dave Iseminger: There's still a lot of polishing to do. We have a lot of copy edit, text edits to go. That wasn't the final version of all the words that will literally be on the page. We're working through that process now. I want to assure you if there were terms that were confusing, as part of our beta testing we're getting feedback about language and going through a separate language review to make the language as clear as possible. And consistent.

Lou McDermott: The Board will meet in Executive Session during the lunch period, pursuant to RCW 42.30.110(1)(d), to review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs; and pursuant to RCW 42.30.110(1)(l), to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session will conclude no later than 1:15 p.m. The public portion of the meeting will resume no earlier than 1:15 p.m.

Executive Session and Lunch

Dave Iseminger: Chair McDermott, I want to acknowledge that we were in Executive Session an extra 15 minutes. The Chair came back and announced we would be in Executive Session longer. Some people were on the phone and we weren't unmuted so they were wondering why we were late. I wanted to make sure people knew we followed the Open Public Meetings Act. Apologies for those on the phone who didn't get that information.

Lou McDermott: Thank you, Dave.

SEBB Program Medical Plan Update

Lauren Johnston, Contracts Manager, **Leanna Olive**, UMP Account Manager, and **Patty Conway**, Contractor.

Lauren Johnston. Slide 3 – Plan Update. I am happy to announce that we have one of the medical fully insured contracts out for signature. The others are very close. Approximately 98% of school employees will have access to at least two carriers and at least four to five plans. Of those 98%, approximately 79% of school employees will have access to three or more carriers and 8 to 13 plans.

Dave Iseminger: The slide says five plans, but it was supposed to say four to five. We'll get that corrected in the record.

Lauren Johnston: Slide 4 – Plan Names. The column on the left is the original HCA draft plan name. The column on the right are the updated plan names. One of the major changes is that the Kaiser Permanente Washington Plan 4 is now Kaiser Permanente WA SoundChoice.

Slide 5 – Plan Names (*cont.*). Slide 5 shows the Premera plan names. The Premera High PPO and the Peak Care EPO are the same benefit design when it comes to the plan. The only difference is they are offered in different service areas.

We received word from Providence that they have decided to pull out of contract negotiations.

Dave Iseminger: That information came from Providence late last week after we finished the slides. We will remove their information from these slides, as well as the summary documents similar to when Aetna ended negotiations. That means the only high deductible health plan offering within the portfolio is the UMP High Deductible plan, which is statewide.

Lauren Johnston: The total joint replacement bundle through the Centers of Excellence Program will not be part of the SEBB Program Premera plans. It was originally on their bid template in error and has been removed.

Dave Iseminger: Working with Premera to see about possibilities of including it in future iterations of the plan designs.

Lauren Johnston: Slide 6 – Rates Update. Rates will be presented in July along with the final proposed service area maps. At that time, if there are concerns, the Board could take action to remove a plan, plans, or carrier from the portfolio. Keep in mind that if the Board chooses not to endorse a premium, it would remove that plan from all of the service areas that pertained to that plan.

Slides 7-8 – Contractual Obligations. We've been through some of these in the past. All contracts are performance-based and include performance guarantees. The medical contracts include value-based purchasing models as well as quality measures. The contractors must comply with all OIC regulations. We developed office visit access standards within Premera. They agreed to some excellent office visit access standards.

All carriers must have a SEBB Program-specific microsite. A member, a member of the public, or a SEBB Program eligible member not enrolled in a Premera plan, could look at the provider's search tools. They could review the certificates of coverage, the summary of benefits and coverage, and put information into a cost calculator to get information around costs for different services or procedures. Their customer service has extended hours for school employees to be able to access either earlier in the morning or later in the evening.

Pete Cutler: When developing office visit access standards, I assume that would include if somebody wants to see a behavioral health, mental health provider or visit mental health services? Can you provide, at some point, the specifics of what those standards are for the behavior health access? In my own mind, delays that may be

acceptable for a routine office visit may not be acceptable for somebody in need of more immediate behavioral health services.

Lauren Johnston: I have one example. I would have to go back to them and ask if this would meet the behavioral health, but they committed to a member who experienced acute and non-urgent symptomatic office visits that they'd be available to see a primary care or alternate provider within seven calendar days.

Pete Cutler: Seven calendar days is not a good performance standard for behavioral health. At least I'm glad to know that's the standard; but I have to admit, I'm disappointed that's the best they apparently are willing to commit to. Thank you.

Lauren Johnston: Slide 9 - House Bill 1099. This ties into the public comment you heard in April. Effect January 1, 2020, all carrier provider directories must include mental health or substance abuse providers that are not accepting new patients. They are required to provide enhanced information on their websites regarding notification and access standards for mental health and substance abuse providers, treatment, and services. If you want to read more on that bill, we've provided the link.

Slide 10 – Implementation is underway for all of our plans, not just medical. We continue to take an active role in implementation, as well as monitoring the implementation, to be prepared for go live.

Dave Iseminger: We have a variety of different resources. It depends on the different product line, but we have hired project managers to help shepherd implementation and identify risks. For example, the payroll processes, life insurance, and with Navia for Medical FSA. We have a project manager related to the implementation of the self-insured plan, both the reboot we were already planning to do on the PEBB Program side and incorporating the SEBB Program into it.

We have contract managers who will do implementation benchmarking. The carriers have been working on implementation the entire time they've been negotiating contracts with us.

Leanna Olive: Slide 11 – UMP TPA Request for Proposal (RFP) Implementation. The Health Care Authority released a Request for Proposal in November 2016 for a third party administrator (TPA) for the Uniform Medical Plan. The new TPA contract with Regence Blue Shield of Washington was signed early 2018. After the contract was signed, we began implementation with the go live date of January 1, 2020.

Dave Iseminger: Just as a general reminder, obviously those dates precede the legislation for the very program we're in, but we talked through this with the Board last spring and summer when you authorized including the self-insured plans. We crafted that contract in a way that it could be leveraged and gave you that option. Leanna will go through the status of the implementation since the contract was executed.

Leanna Olive: Slide 12 – UMP TPA RFP Implementation. There are four stages of implementation. The first stage, alignment, took quite a bit of time because we baselined the scope to ensure both HCA and Regence understood what we were implementing. From there, we developed the initial implementation plan.

The second definition stage is where we turned the contract language into deliverables, developed the resource plan, and completed the implementation plan with baseline milestones.

Stage three, the stage we're in now, is the delivery stage where Regence is providing completed deliverables to HCA for final approval and sign off.

Stage four, the transition stage will occur post live date, January 1, 2020 and includes oversight and maintenance of the contract.

Pete Cutler: Can you give an example of a couple deliverables?

Leanna Olive: During the implementation plan, we developed milestones we need to reach to ensure everything is done on time. For example, we are developing an operations manual for the basic operations and the procedures in which we will conduct regular daily business. They have to deliver a sample manual. What does it look like? Does the flow work well? We have the Table of Contents. That's an example of a deliverable. It's a lot more involved with a lot more documents.

Pete Cutler: I imagine that's a lot of details. That's a good example. Thank you.

Leanna Olive: Slide 13 – Work Streams. There are several work streams involved in this implementation process. The first work stream is the Account Team Infrastructure, which includes creation of the operations manual for procedures and process documents in greater detail than in the contract. It includes setting up oversight and maintenance of the contract. The Accountable Care Program (ACP) Reporting work stream has about 70 reports on a monthly basis that go over to UMP Plus partners and documentation of layout, contents, and fields.

Dave Iseminger: When people hear there are 70 reports, I don't want people to get the wrong impression. These aren't reports that sit on a shelf and collect dust. They're reports given to those provider networks for the purposes of being able to have real time or responsive clinical intervention with members to improve the quality of care they're receiving. These are data feeds leveraged and used by provider networks to help facilitate and coordinate care for members.

Pete Cutler: Do I infer the data collected by the TPA Regence flows directly or through HCA to the clinics or other providers to give them feedback? Or does it come to the Health Care Authority?

Dave Iseminger: It flows through a data intermediary, Milliman, and blinded when necessary. They're doing some of the analytics and giving the provider networks information.

Pete Cutler: Does the information go back to the providers or does it go back to Regence, the TPA?

Dave Iseminger: It goes to the networks, the providers. The network is the provider in the lingo I've been using.

Leanna Olive: The Clinical Management work stream includes new clinical programs, customized clinical items such as the Health Technology Clinical Committee (HTCC) mandates and transgender benefits.

Dave Iseminger: The HTCC is a legislative body established to do coverage determinations of whether state purchased health plans, of which the SEBB Program is included, are allowed to, or prohibited from, covering certain things. Those will result in either coverage parameters or exclusions within the Uniform Medical Plan.

Leanna Olive: The Medical Pharmacy Management work stream includes new rebates for clinical drugs administered through a provider office or facility. The OCIO Design Review work stream ensures security of data across all systems.

The Operations - High Priority work streams and the Operations - Other Functional Areas work streams include customer service, claims, explanation of benefits, and coordination of benefits. The Communications work stream includes new public websites, Regence.com for members, certificates of coverage, welcome packets, and other member-facing documents.

Lou McDermott: I think something to point out is we've worked with Regence for many years before this new contract was signed. It seems a little odd that we have all these work streams with someone we've worked with for years. But there were things about the previous contract we wanted to change. We couldn't change those things while the contract was in place because we needed to reach a mutual agreement, come up with additional dollars the Legislature has to appropriate. So when we did the RFP, we threw the kitchen sink at it and we thought of all the things we would want. By implementing this new contract, there are tons of work streams. I think Regence's project team is over 100 people.

Patty Conway: 300 people. And there are 1,000 new requirements in the new contract.

Lou McDermott: I'm not going to say this is harder than if we were starting from scratch, but it is difficult because we're going from a process that's been in place a long time to a new process. We're having to project manage each one of those work streams. This is a huge lift for the agency and for Regence, obviously, 300 people! A lot of time and effort has gone into this effort. This is an overview, but it's an understatement of the work associated with it. The good news is the SEBB Program benefits from this work right out the gate.

Dave Iseminger: When we implemented the original Regence contract, it went live on January 1, 2011. We were negotiating the contract prior to 2011. A lot has happened, even on the PEBB Program side. The High Deductible Health Plan was established, the UMP Plus was added, the data streams and organizations needed for those ACP plans, our wellness plan was added. As you build different pieces, you think you're building it as efficient as possible, but you look back and see things you would have done differently. This is that opportunity to make the operations and administration more efficient for all the changes that have happened in the last decade.

Leanna Olive: The Provider Management work stream includes provider access and adequacy requirements. Provider search includes upgrades such as primary care provider search for UMP Plus plans as those have different cost sharing. Reporting and Benchmarking includes the creation of a reporting manual for all reports delivered to HCA and vendors to include the layout, owner, data source, frequency, fields, and samples of the report templates. The Value-based Programs include payments in line with Medicare, local area network, definition, and measurements thereof in performance guarantees on an ongoing collaborative effort.

Slides 14-15 – New UMP Clinical Programs Implemented. Although we had clinical programs prior to procuring the new TPA, we have expanded some of the existing programs and added new clinical programs to this new contract. We will be participating in the Radiology Full Utilization Management (UM) / Advanced Imaging Authorization (AIM). This is a vendor called AIM and it includes AIM reviewing all prior authorizations related to advanced imaging.

We will use the Sleep Medicine Program, managed through AIM. We will review the Pre-authorizations for Testing, equipment, and supplies. They will monitor compliance with CPAP machines for the first 90 days of use.

Physical Medicine will be managed through EviCore. They will also review pre-authorizations through Evicore for pain management, joint and back pain, and any type of back services. As a side note, we still have the Centers of Excellence Program for joint replacements and spine care. That's not included in this Physical Medicine Program. It's a separate program. This will be for members who go directly through their normal benefits and don't use the Centers of Excellence Program for any type of joint or spine care.

Dave Iseminger: You'll remember the Centers of Excellence Program. We've provided you a lot of information about its value. But for whatever reason, there will be members who don't want a free knee. If they don't, this is the kind of thing that goes along with those that don't want their free knee or don't qualify for their free knee.

Leanna Olive: We will have a 24-hour Nurse Advice line that includes a toll free number 24/7. It includes additional support from dieticians, diabetic educators, pharmacists, social workers, and respiratory therapists. The ACPs have chosen to use their own nurse line number so anybody enrolled in the UMP Plus plans will use their specific number. It won't be through this Program.

BabyWise is a program for pregnant members ages 18 and over. It's for maternity management, maternity support and education, and a phone application called Due Date Plus.

Dave Iseminger: We have had a lot of questions about BabyWise, This means there could be proactive reaching out by the plan for people who are 18 and over. But if there's an individual who's under 18, if they reach out to the plan, they can find out about the service but the plan would not be proactive to anybody under age 18. It's the difference in the advertising. But individuals under 18 could access these benefits if they initiate the request.

We wanted to give you an update on how implementation is going on the Uniform Medical Plan aspects. I want to thank Leanna and Patty for stepping in at the last minute to present. We will give you implementation updates at future meetings after contracts are signed.

In your Appendix in this tab is the SEBB Program Benefits: A high-level overview. It's six pages that we keep refreshing and it's already out of date from last Friday. We will be updating it. The primary thing that is different from last time is the overlay of the new plans, more official names. Obviously, with the announcement that Lauren made a few minutes ago about Providence withdrawing from contract negotiations, we will remove those plans from the summary sheet. We also have some updating to do in the UMP Achieve 2 column because it still references Tier 4 drugs, which after the UMP formulary vote last month, doesn't exist. There are a couple of things to update in those areas. It is in a constant improvement stage.

Next Meeting
July 18, 2019
9:00 a.m. – 1:15 p.m.

Preview of July 18, 2019 Meeting
Dave Iseminger shared potential agenda topics for the July 18, 2019 SEB Board Meeting.

Meeting adjourned at 2:03 p.m.

Washington State Health Care Authority

D R A F T

School Employees Benefits Board
Meeting Minutes

July 18, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 1:30 p.m.

Members Present
Pete Cutler
Terri House
Dan Gossett
Sean Corry
Patty Estes
Katy Henry
Wayne Leonard
Lou McDermott

Member on the Phone
Alison Poulsen (Joined around 10:15 a.m.)

SEB Board Counsel
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 9:02 a.m. Sufficient members present to allow a quorum. Board self-introductions followed.

Agenda Overview
Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda. The schedule for the 2020 SEB Board Meetings are behind Tab 1 in your Briefing Books.

January 24, 2019 Meeting Minutes
Pete Cutler moved and Katy Henry seconded a motion to approve the January 24, 2019 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

June 12, 2019 Board Meeting Follow Up
Dave Iseminger, Director, ERB Division. Slide 2. There is one follow-up question from the June meeting. The question was about current enrollment and plan design for school employees in KP Washington plans.

Slide 3 is about the PPO product line. The top blue bar graph is a group count. You can think of that as synonymous with SEBB Organizations. That is the total number of SEBB Organizations in the KP WA PPO product lines within the portfolios they're offering to school employees. The bottom green bar graph is enrollment and the X-axis is showing the various deductible levels.

The question asked was about PPO, but we have HMO data, too. Slide 4 is the same information but from the HMO product line perspective. I believe there is some overlap between these charts. Some districts offer both PPO and HMO product lines. We did not de-duplicate the information, but purely putting on the lens of each plan type, we wanted to provide the requested information about the number of districts that have these types of plans at various levels and the current number of employees enrolled in them.

Sean Corry: Dave, could you repeat what you just said about the overlap? Seattle popped into my head because they're all Kaiser.

Dave Iseminger: I was saying these two charts are not de-duplicated. I believe that Seattle Public Schools offers both products for the PPO and HMO product line. In that case, Seattle would appear on both charts, if we were to list each of the districts. They could be counted in the blue parts of the graph multiple times, but the employee enrollment would not have any duplicate counts. It's just the blue bars might have a duplicate count of a SEBB Organization's offerings.

Uniform Medical Plan (UMP) Plus

Ryan Ramsdell, UMP Plus Account Manager
Emily Transue, MD, ERB Associate Medical Director

Ryan Ramsdell: Slide 2 – UMP Plus. Dr. Transue and I are here to introduce the Uniform Medical Plan Plus Program, also known as "UMP Plus." A resolution passed in June 2018 to establish a Plus plan for the SEBB Program population. The expectation was it would carry similar services, exclusions, and networks, deductibles, out of pocket, coinsurance, etc. as the Plus plan in the PEBB Program. Like many of the UMP Plus programs, the purpose is to achieve the triple aim of looking at better health, better care, and lower costs. UMP Plus places much of the responsibility in this case on the providers. UMP Plus also works to effect change through a unique partnership with providers and the Health Care Authority (HCA). We're in constant contact with the people in the facilities on a daily and weekly basis.

Slide 3 – Value-Based Purchasing. UMP Plus is part of accountable care, which is a group of networks and providers that work together to provide care and attempt to manage costs. One of the ways we try to establish accountability through the contract is through financial and quality guarantees the networks must achieve through a combination of effective care, delivery models, health system reimbursement, and financial incentives. In terms of the PEBB Program product, and now for 2020 the SEBB Program, there will be two UMP Plus networks: Puget Sound High Value Network (PSHVN) and UW Medicine Accountable Care Network (UW Medicine (ACN).

Slide 4 – UMP Plus Benefits. UMP Plus comes with a competitive premium. Members have the flexibility to choose a primary care provider, a hospital, and other health

providers, but it's in that network. It has the lowest deductible of the UMP plans. Primary care office visits are free. There's no prescription drug deductible. The care is coordinated, which is important, and there's no referral required for specialists.

Slide 5 – UMP Plus Network Design. This illustration we call the donut. There's the core network where the providers are contracted with Puget Sound High Value Network and UW Medicine to provide care to subscribers and members. Within that core are primary care providers, your family doctors and pediatricians. They are typically at no cost. Specialty providers are specialists, like the cardiologists, allergists, rheumatologists, etc. And finally, there are the core providers within the ancillary that are contracted with the networks. These include mental health, acupuncturists, speech, occupational, physical therapists, etc.

In order to establish a more robust network, in addition to that within the service area, any provider contracted with Regence in the ancillary network would also be accessible to the members at the same cost. There is the core network, which are contracted with the networks and the support network on the outside, which is Regence-contracted individuals within that service area.

Dave Iseminger: I want to make sure Ryan's statement is clear for everybody. The deductible for UMP Plus is the lowest among them, but it's not the lowest premium. The lowest premium is the high deductible health plan. I was reading "deductible" I think I might have heard Ryan say "premium." The lowest deductible is in Uniform Medical Plan. The premium that's lowest is actually the high deductible plan.

Pete Cutler: On that support network where it says, "Regence Ancillary Providers," is that to say that's only for the types of ancillary providers listed in the core network? The mental health, acupuncturist, etc.? Or is that a much broader --

Ryan Ramsdell: Both ancillary networks are quite broad. I didn't list them out because the list is extensive and I certainly could go through some of those items at the end if you'd like.

Pete Cutler: I mean by definition, it's not the primary care provider.

Ryan Ramsdell: Correct.

Emily Transue: I am going to talk at a high level about accountable care. Slide 6 – UMP Plus: Clinical Elements. As you look at the 30,000-foot level on accountable care, this is taking some of the things that traditionally insurers do, and shifting them to the providers. In a traditional system, the doctor orders and the insurer has its "yes" or "no" stamp. This is moving some of that so the provider has reason to think about "if I could look at this problem with a $300 ultrasound, or I could look at it equally as well with a $3,000 MRI." This whole movement came out of providers reaching out and saying we could do this better in some ways, some pieces of it, than insurers can, and also, having responsibility for quality. That's the philosophy of this work, building that into the contracts.

We have a number of clinical requirements in the contracts that include accountability for quality. The outcomes - are patients getting better based on the care they're given?

And also, care transformation, which is looking at the way care is delivered and making that better.

Slide 7 – Quality Improvement Score (QIS) Measures. Quality measure is the simpler side. We have 15 quality metrics in this contract for 2020 and they're pretty varied. We have measures for diabetics, depression, immunization, four around different kinds of cancer screenings plus chlamydia, C-section rates, and then four about member experience.

For member experience, we want to know if care was timely, did providers communicate well, and overall rating of a provider. There's always a concern when you look at quality measures of are you asking people to teach to the test, essentially. There's some interesting research around that. If you pick a couple measures, people really do tend to focus on those. If you make them broader across the population, that's much less of an issue. Each of these requires certain capabilities for a provider system to develop. If you're going to improve diabetes, you need to know who has a certain disease in order to reach out and track them.

Slide 8 – Care Transformation – Improving the way care is delivered. Care transformation we require in a number of ways. Part of that is participation in a number of programs and projects that are both local to Washington and national. One of those is the Bree Collaborative. If that sounds familiar, it might be because Dan Lessler, our former Chief Medical Officer, spoke to you at one of the earliest Board meetings around Bree. This is a group funded by the Legislature, but consists of independent medical experts across Washington who discuss areas where there's variation or uncertainty around care and create best practices for how people should be handling those. Our networks are required to implement those guidelines and tell us how they're doing that.

Dave Iseminger: Another reason you might remember the Bree Collaborative is those standards and guidelines created by the Bree Collaborative are the underpinnings of the Centers of Excellence Program. The total joint, hip, and knee replacement, as well as the spine care bundle. The Board authorized that Program, which is rooted in criteria established by the Bree Collaborative.

Emily Transue: Another area of participation is the Foundation for Health Care Quality, which is a Washington-based group that has the Clinical Outcome Assessment Programs (COAP). These programs collect detailed clinical data around certain areas of care and use that to drive improvement. An example of that would be one around obstetrics, and the ability to determine if a woman is given Pitocin to drive labor, at this point in labor, she's much more likely to have a C-section. If you delay a couple of hours and give it at a later stage, there are much better outcomes. That kind of thing you would never be able to see unless somebody was really looking at that detailed data across a big group. That's the kind of work COAPs do. We require them to participate in those.

Another is Primary Care Medical Home (PCMH). This is a national set of standards. I think of these as being what primary care should be. Certainly, I as a primary care doctor, do. This includes making sure the primary care office is functioning well as a team. Making sure they're coordinating all of the patients' care and making sure that

different specialists aren't contradicting each other or failing to communicate, doing outreach to people who need care but aren't coming in.

Slide 9 – Care Transformation – UMP Plus Quality Improvement. This list of projects are what we have them working on. Things like care coordination, preventing re-admissions, total knee, hip, and spinal fusion, a new project around opioids and addiction, which hadn't been part of the PEBB ACP Program, but will be going forward. Each of these has a number of components they're working with us on. The knee and hip replacement and spinal fusion will seem familiar from the Centers of Excellence (COE) Program.

The financial model in COE is different from the financial model of accountable care, but the clinical standards are the same. The care somebody would be getting would be the same within this program. Many of these projects have a requirement for shared decision making, which is a structured process for making sure somebody making a complex medical decision is getting information about all the options, all the pros and cons, and what about their values and goals would make them pick one choice versus the other?

Ryan Ramsdell: Slide 10 – Financial Arrangement. We talk a lot about accountability. In this particular arrangement, there's a combination of cost and care. UMP Plus incentivizes the networks to provide more efficient care than other plans, while being held to quality and care transformation standards, many of which Dr. Transue mentioned. It's a lot about sharing. If the networks save the program money, they share in those savings. However, if the networks overspend or underperform in care delivery, they share in some of those deficits. Quality results determine the percentage of savings and deficits shared, and this is what enables the plan to have a higher actuarial value, with the lower premium and deductible.

Slide 11 – Contracts and Negotiations Update. Negotiations wrapped up mid-June and we have two UMP Plus networks starting January 1, 2020: Puget Sound High Value Network and UW Medicine Accountable Care Network. Both networks contracted to participate through 2021, with an option to extend through 2024. Negotiations for strictly financial terms will begin late 2020 through early 2021. In terms of the contract related to operations and clinical expectations, those remain the same during that time frame, depending on outcome.

Pete Cutler: Ryan, are the networks for both identical between the SEBB and PEBB Programs?

Ryan Ramsdell: They are, in terms of the partner providers within the networks. I'll talk about the counties they serve at the end.

Dave Iseminger: It was important not to have opportunities between the two programs for people to stumble on similar, yet different, information.

Pete Cutler: Great strategy.

Lou McDermott: I want to make sure people understand. For us who work on this all the time, we understand it deeply! But when we try and explain it, we're utilizing our

third party administrator's network. We're utilizing Regence as the network, but we're subcontracting. We are making a direct contract with the networks. We're still using Regence, payments are still being made, but then we take a look at the data and the separate quality measures and separate financial terms. It's a contract on a contract. It's a bit cumbersome to explain, but we're still using Regence. There are more expectations on top of it.

Ryan Ramsdell: Slide 12 – Network Partners – PSHVN. For 2020, there is the Puget Sound High Value Network. The partners in that group are Virginia Mason; Rainier Health Network, better known by its individual parts: CHI Franciscan, City MD, Northwest Physicians Network, The Doctors Clinic, Pediatrics Northwest, and Highline Medical; the Physicians Care Alliance, better known as The Polyclinic; Seattle Children's Hospital; and Signal Health, which serves mainly in Yakima.

Slide 13 – Network Partners – UW Medicine. For the UW Medicine Accountable Care Network, there is UW Medicine, Multicare, Cascade Valley Hospitals and Clinics, Seattle Cancer Care Alliance, Seattle Children's Hospital, and Skagit Regional Health.

Slide 14 – UMP Plus – 2020 Counties Served. In terms of the actual counties served by both of these networks, there is a group of roughly five core counties in the center in yellow that serve both Puget Sound High Value Network and UW Medicine. In addition, UW Medicine will be serving Skagit County and Spokane County, and Puget Sound High Value Network will be serving Yakima County. This is a mirror of the PEBB UMP Plus.

Lou McDermott: I'd like to thank you for all the work on the contracts. It was an extremely difficult negotiation with a lot of moving parts and many unknowns, especially with the SEBB Program. Nice work.

Pete Cutler: I want to second those congratulations. As a Board member, waiting for this status report, I was getting a tad nervous, as the months went by. I'm very excited about what the HCA is doing here.

Lou McDermott: We were all getting nervous, Pete.

Dave Iseminger: This was one of the longest contract negotiations. We initiated contract negotiations for the PEBB Program extension. It was a very complicated, four-phased negotiation that lasted somewhere between 16 to 18 months. It's been a very long journey to get to this point.

Lou McDermott: We had some complexities refreshing our contract with Regence starting in January 1, 2020. That added a layer of complexity. The SEBB Program coming online added a layer of complexity. The negotiations were taking hit after hit, but they managed to get it done. So, really nice job.

Medical Plan Service Areas

Lauren Johnston, SEBB Senior Account Manager, Employees and Retirees Benefits (ERB) Division. First, I want to provide a procurement update since the last time we met. The Kaiser, Premera, and MetLife contracts are signed.

Dave Iseminger: Again, an understatement to the amount of work required for this. In total, about 24 contracts have been executive or amended since the beginning of the launch of the SEBB Program. It has been a very long journey. Lauren's lived with the medical piece from the inception of the procurement to the execution of the contracts, and she's done a fabulous job for getting choices for school employees.

Lauren Johnston: The presentation has been updated since its original release. We received a number of similar questions. When people were looking at the service areas based on the county in which a member lives, and then looking at their school district, there was confusion between seeing a bunch of plan options based on the counties in which they lived, going down to the employer level, and only seeing the three UMP plans. We have gone through and updated this presentation to eliminate some of that confusion.

Dave Iseminger: When you see "primarily based on the county in which a school employee lives," that approximately applies to well over 95% of the population. That is the rule. The exception addresses about 5,000 school employees. A lot of people are used to looking at things from the lens of their district offering and not where they live; but we need to help people understand the rule is where you live. The additional options are based on where you work.

Lauren Johnston: Over the next 20 pages, there is a lot of information that's going to be layered on top of itself, which ultimately will lead to the end result of what plan options are available to school employees.

Slide 3 – County-Based Service Area Maps. This is in contrast to current K-12 offerings. The vast majority of the school employees' options for SEBB medical plans are based on the county where the employee lives. When the fully insured plans file with the Office of the Insurance Commissioner, they do so based on county. There's no more granular level, not zip code, not by school district. It's based on county lines. The following maps reflect the county-based medical options.

Slide 4 – Kaiser Permanente Service Areas. This map shows service areas for all of the Kaiser Permanente plans, which includes Kaiser Northwest, Kaiser Washington, and Kaiser Washington Options. The purple is Kaiser Northwest with three plans offered in both Cowlitz and Clark Counties. The Kaiser Washington Core 1, 2, and 3 are in the green counties. Kaiser Washington 1, 2, 3, and the Kaiser Washington Options Access PPO 1, 2, and 3 are in the light blue. Kaiser Washington 1, 2, and SoundChoice, and the Kaiser Options Access PPO 1, 2, and 3 are in the dark blue. The only difference between the light blue and the dark blue is that the light blue offers the KP WA Core 3 Plan, and the dark blue is where KP WA SoundChoice is offered.

Dave Iseminger: This map represents the full county footprint that each of these carriers serves in the individual market and their other filings.

Lauren Johnston: Slide 5 – Premera Service Area. Premera is offering three plans: a high PPO, a Peak Care EPO, and their standard PPO 33 counties across Washington, only six counties they are not in. In November 2018, you originally saw a Premera Plan 1, later named Value PPO, which was withdrawn recently during negotiations. That

plan was at a higher prescription drug deductible. It had a $500 prescription drug deductible for a single subscriber and a $1,250 prescription drug deductible for two or more enrollees. During the November 8, 2018 Board Meeting, you asked Premera to price this plan and another plan that met, or was lower, than the UMP Achieve 1 prescription drug deductible at $250 for a single subscriber, and $750 for two or more enrollees. Since that time, and after rate development, Premera has decided to remove their Value PPO at the higher prescription drug deductible and keep the Standard PPO at the lower prescription drug deductible.

Dave Iseminger: The rates ultimately were so similar that to add the extra complexity of such a nuanced difference within the portfolio did not make sense. Premera consistently asked the Board to consider the Value PPO plan. You offered to entertain that in rate negotiations, but when the rates came in, they decided it was no longer necessary to continue to request that plan.

Lou McDermott: Lauren, the counties that Premera is not in, are those related to blues rules?

Lauren Johnston: Only Clark County.

Dave Iseminger: Building on the statement I made on Slide 4, Premera filed service areas within the individual market in 38 of 39 counties. They cannot file in Clark County for blues rules, but the package they presented includes 33 counties. They are serving the individual market in the other five counties. We are hopeful that in future years there will be opportunities for expansion to encompass their entire footprint in the state.

Lauren Johnston: Slide 6 – Uniform Medical Plan (UMP) Coverage, administered by Regence and Washington Prescription Drug Services. This is their coverage map for the state of Washington. Because UMP is a self-insured plan, they do not need to file service areas with the Office of the Insurance Commissioner (OIC). Regardless of where a member lives, even if they live outside of the state, or they have dependents outside of the state, they could enroll in the Uniform Medical Plan.

Slide 7 – UMP Plus Network Coverage. We included this slide so you would have the whole portfolio of service and coverage areas for the SEBB Program.

Slide 8 – Combined Medical Plan Service Areas. This is a tile map to give you an idea of the carriers and the number of plans each carrier has in every county in Washington State. There are only three counties that are UMP only, San Juan, Douglas, and Klickitat County. The two counties with the most plans are Thurston and Pierce Counties at 14 plans. The counties after that are Kitsap, Skagit, Snohomish, King, and Spokane. They all have at least 12 or more plans.

Sean Corry: What plan is missing from King County, relative to others?

Lauren Johnston: One of the Premera plans.

Dave Iseminger: Sean, to be more specific, it's the Peak Care EPO plan. It's similar to UMP Plus, in the sense that it's a smaller partner provider network and it's an

agreement that Premera has with Multicare, so Multicare servicing Pierce, Thurston, and Spokane counties. That network is an option within those areas that Multicare specifically serves.

Lauren Johnston: Slide 9 – Plan Availability Considerations. Carriers must file their service areas based on county lines. 71 school districts cross county lines. Going through this process, we were looking at what constraints our IT system might have and what the carriers' preferences were. There were a number of different considerations, as well as the complexities that each of the considerations involved. Something to note is that well over half of those 71 school districts that crossed county lines have different plans in the two counties served. We decided the easiest way to present this to school employees who work in a school district that crosses county lines, was to give them the maximum number of options available that were in one of the counties. If you had one county that had three plans and one county that had five plans, and the school district crossed both of those counties, the employees that worked for that school district would have five plans available to them instead of just the three.

Dave Iseminger: There's always an exception to the exception. Lauren's statement is generally true. There are a couple of instances where it is not the full package of the most generous plans, if you lined up both counties. The specific example is UMP Plus as Ryan highlighted. The network contract itself requires a residency requirement. If a school district straddles into and out of the UMP Plus network, that plan would not be available based on the work location. You have to live in the county that fits the UMP Plus service area. There are a couple of nuances, but we were working with the carriers to have the most generous offering for a school district that straddled both county lines and service areas.

Lauren Johnston: Also considered, we found there were a little over 1,700 employees that would only have access to UMP. We were able to bring that number down to just under 1,500. The other consideration was there are over 1,500 school employees that live outside of Washington State.

Slide 10 – SEBB Program Medical Plan Offerings. All school employees may select from plans based on the county they live. An exception to this is additional plan options may be available if an employee works in a district that straddles county lines, or is in a county that borders Idaho or Oregon. We gained an appreciation of the plans that were going to be available to members who lived in rural communities and worked for rural school districts. We tried to prioritize to get them as many plan options as possible.

Slide 11 – Medical Plan Offerings Based on Where a School Employee Lives. All school employees, regardless of the county in which they live, may select a plan based on the county they live in. As you go down the county lines and across the columns, school employees will be able to see the options available to them.

Slides 12 – 20. These slides are the medical plan offerings based on an employee's employer. For example, if I work for Aberdeen School District, I have to select my plan based on the county in which I live. So if I live in Aberdeen, and I live in Grays Harbor County, I would have the plans available to me that are offered in Grays Harbor County. If I live in Mason County and I work for Aberdeen School District, I would have the plans available to me offered in Mason County.

Dave Iseminger: Because Aberdeen School District is wholly within Grays Harbor County, and Grays Harbor County does not touch the state of Oregon. Line-by-line, everywhere you see employer medical plans are based on the county in which they live, it's because that district does not meet one of the two exception criteria.

Lauren Johnston: Almira School District crosses county lines of Grant and Lincoln Counties. If I live in Grant or Lincoln County, I could choose one of the plans offered in those counties. It just so happens in Almira's example the plans offered in both counties are the same, two Premera plans and three UMP plans available to me.

Slide 21 – Examples Applying Exception Criteria. These are examples applying the exception criteria of crossing county lines, or border Idaho or Oregon. A school employee lives in Grays Harbor County and works in the Mary M. Knight School District, which crosses Grays Harbor and Mason Counties. The employee can select from one of the following plans: KP WA Core 1, 2, 3; KP WA Options Access PPO 1, 2, 3; Premera High PPO and Standard PPO; UMP Achieve 1, 2; and the Uniform Medical Plan High Deductible. This affects approximately 15-20 members who have additional plan options after applying this criteria.

Dave Iseminger: Lauren, can you explain why some plans are underlined on Slide 21 and others aren't?

Lauren Johnston: The underlining indicates the additional plan choices based on the Slide 8 employer criteria, crossing county lines or bordering Idaho or Oregon.

Dave Iseminger: I just realized, when we updated the slide deck, we didn't update the slide reference at the bottom. It should "Slide 10 employer criteria."

Lauren Johnston: The second example is a school employee who lives in Stevens County and works in the Nine Mile Falls School District, which crosses over Stevens and Spokane Counties. They can select from one of the following plans: KP WA Core 1, 2 and SoundChoice; KP WA Options Access PPO 1, 2, 3; Premera High PPO, Standard PPO, and Peak Care PPO; and the UMP Achieve 1, 2, and the Uniform Medical High Deductible Plan.

The final example is a school employee who lives in Portland, Oregon and works in the Washougal School District, which crosses over Clark and Skamania Counties. They can select from one of the following plans: KP Northwest 1, 2, 3; Premera High PPO or Standard PPO; UMP Achieve 1, 2, and the Uniform Medical High Deductible Plan.

Dave Iseminger: I'm going to describe a couple of other high-level numbers. Lauren described the first example on Slide 21 would impact about 15-20 school employees. The second example would impact about 120 employees. The third example would impact approximately 15-20 employees. As you add up the individual scenarios across the state, it ends up being about five thousand school employees.

I want to highlight a couple of large examples. For example, about 780 school employees work in a school district in Clark County, but live in Portland, Oregon. All of those individuals, without the exception criteria, would only be able to elect Uniform

Medical Plan options. They have additional options because of the exception criteria. In Southeast Washington, about 90 individuals who work in the Pomeroy School District would have additional plan options because of the exception criteria. In Clarkston, which straddles Asotin, Whitman, and Garfield Counties, about 300 school employees who have additional plan options because of the exception criteria. An additional 120 who commute from Idaho would have additional plan options.

About 200 people commute to Spokane and Mead Public Schools and some of the sister school districts in Spokane that have additional options. About 90 people that work in either White Salmon Valley or Bickleton in Klickitat County will have additional plan choices because of the exception criteria. About 200 people who live in Island County but work in the Standwood Camano School District will have additional plan options. Approximately 1,300 school employees who work in the Northshore School District will have additional plan options because of the Premera option that exists in King County, which is not in Snohomish County.

There are lots of examples of the exception criteria, giving real additional options to about 5,000 school employees in the state. Our ultimate goal is to work with carriers in future iterations to see if we can continue to expand and push the envelope on work options and have a full live or work ability for plan selection. We wanted to make strides on out of state and rural access choices to be able to present as much of a robust offering and opportunities for school employees for this program launch.

Lauren Johnston: The Appendix has a high-level look at available benefits. There are a couple changes since the last time you saw this.

Dave Iseminger: There are two items in the Appendix. The first one is a six-page document. The second document, Board Members have a blown up version in the pocket of your binders.

Lauren Johnston: The first change I want to note is that Premera had previously presented, in their rate development for the Standard PPO, the lower deductible at the Achieve 1. They also wanted to lower the deductible for their high PPO and their Peak Care PPO. They essentially cut the prescription drug deductible in half, so now it's $125 and $312.

Dave Iseminger: We presented that and had it as a footnote in this chart in several of the iterations we've been bringing back to the Board since January or March. We're embodying that in the final chart here. Your interest was in having no drug deductible if possible, but certainly not a drug deductible higher than Uniform Medical Plan Achieve 1 when Premera came forward several months ago. We added this as a footnote to the chart. When you ultimately vote on resolutions, it would be ratifying that change from the November benefits that you authorized into the rate development process.

Lauren Johnston: The next change is in the Uniform Medical Plan. The prescription drug out-of-pocket maximum limit used to say" $2,000 per member" for the UMP Achieve 1, UMP Achieve 2, and UMP Plus. It now says, "$2,000 per member; $4,000 family maximum."

On the Dental Benefits slide, the change is under the high-level overview for the dental benefits. Originally, there was a mixture of what the member would pay and what the plan would pay. It now shows only the member's cost share. For example, the routine emergency exams used to say "100%" because the plan covered at 100%. It now says, "$0" to indicate the member will pay $0. Another change under the dental benefit is under fillings. It used to say under the Uniform Dental Plan, "80%," which is what the plan covers. It now says, "20%," which is the member share.

Dave Iseminger: In the Uniform Dental Plan if you go back to prior iterations, there was one line for fillings and crowns, when actually the coinsurance is different for those. We broke out those two lines.

Lauren Johnston: There were a couple changes to the larger chart, too, the SEBB Program Medical Benefits Comparison Chart. Under Kaiser Washington Options Access PPO Plan 1, the diagnostic tests, labs, and x-rays row, it used to say "20%" and now it says "20% over $500." The plan pays the first $500 and the member share is 20% over that amount. It matches the column for the Access PPO 2 Plan.

Looking at the back side of the chart, for Premera's High PPO and Peak Care PPO plans, the prescription drug deductible is now $125 for a single subscriber and $312 for two or more enrollees.

The Uniform Medical Plan out-of-pocket limit for prescription drugs changed from "$2,000 per member" to "$2,000 per member; $4,000 family maximum" for UMP Achieve 1, UMP Achieve 2, and Uniform Medical Plus.

Dave Iseminger: The vast majority of these changes are clarifications of how it was supposed to be written. They're not fundamental changes, with the exception of the prescription drug deductible being cut in half for Premera's High PPO and Peak Care PPO, which was highlighted as a footnote on these charts, and verbally whenever we were presenting them in the past couple of Board Meetings.

Terri House: I'd like to say thank you to Lauren, because over the last year I know we, as Board Members, have come to her on different things to ask the insurance companies on our behalf. She's followed through every single time with everything we've asked her to do so I really, really appreciate that. Thank you.

Lauren Johnston: You're welcome.

2020 Rates Overview

Megan Atkinson, Chief Financial Officer, Financial Services Division. Today we are getting to a culminating point of our journey. We are at the last stage of rate development. We can see the results of your hard work in setting up the program, the partnerships we established with our managed care partners, and our own rate development for the self-insured plans. You've had the slides for a few days and many of you had an opportunity to talk with Dave in advance of the meeting. Similar to what Lauren experienced, after these slides were posted, we received questions that led us to the conclusion that it's not clear to a lot of people exactly how the tier ratios work. I'm going to spend time on these slides. I know the Board gets it, but others might be listening that need clarification on understanding how the tier ratios work.

Dave Iseminger: We're also taking that feedback and refining our final member communications. The Board is one audience and the record for what you built. That is a different audience than the individual school employees. We expect the school employees in districts are paying attention. We were fast to incorporate feedback on Lauren's presentation in the last 48 hours. We will take that feedback and work on ways to minimize the chance for confusion, especially when it comes to the tier ratio. For example, in the final member communications, we won't show the multiplier. We'll just do the multiplication.

Megan Atkinson: Slide 4 - Determining Employee Premiums – Sample Illustration. We have a bid rate and premium mechanism in the SEBB Program where we hinge off what our Employer Medical Contribution (EMC) is. In this illustration, we receive plan bid rates, Plan A is a bid rate of $700 per member per month (PMPM). In Plan B it's $650 and Plan C it's $600. The Employer Medical Contribution (EMC) calculation is based on the bid rate of our self-insured Achieve 2 Plan, which is our self-insured plan with an 88% actuarial value (AV). When you do the math you get the employee contribution. Plan bid rates – EMC = Employee contribution.

Staying with the green bar, sample Plan A had a bid rate of $700. The EMC is $500. You subtract and end up with an employee contribution of $200. That's how the math works in all of the examples.

Slide 5 – Determining Employee Premiums by Tier – Sample Illustration shows how the tier ratios work. This is where the multipliers come into account, and where we're getting feedback that it's confusing to folks. Tier 1 is our single subscriber tier because there is only one subscriber in that tier. As you move down the tiers is where the subscribers can add their dependents to coverage. Tier 2 is two adults, the subscriber plus his or her spouse or partner.

Then we get into iterations of the family tiers. Tier 3 is a single adult and a child or children. The tier ratio is 1.75. Here's where I want to pause because this is where some of the confusion come in. Tier 3 is one adult, and it's always one adult, but it can be any number of children. It can be a single dependent child, it can be two, it can be twelve, however many. The tier ratio remains the same at 1.75.

It's a similar construct on Tier 4, which is sometimes referred to as the Full Family Tier. It's the subscriber plus an additional adult (their partner or spouse) and any number of children in their family unit. It can be two adults and one child, two adults two children, two adults 25 children. That tier ratio of three remains the same, regardless of how many are on that subscriber's account.

The math for the tiers is Employee Contribution x Tier = Employee Premium. Staying with the green bar:

- Plan A – $200 x 1 (Tier 1) = $200 per month for the single subscriber
- Plan A – $200 x 2 (Tier 2) = $400 per month for two adults.
- Plan A – $200 x 1.75 (Tier 3) = $350 per month for one adult and child(ren).

This is where confusion is happening. It is just $350 per subscriber's account per month. It is not $350 times the tier ratio. It is $200 times the 1.75 tier ratio. That is what gets to the $350. No additional multiplication needed.

- Plan A - $200 x 3 (Tier 4) = $600 per month for two adults and child(ren).

Slides 6-7 – Employee / Employer Premium Contributions. Because we have a large number of carrier and plan offerings, this table is split across two slides. These slides show the results of procurement, our final rates, and showing you for each carrier and plan offering how the total composite rate, the employer medical contribution, and the single subscriber employee contributions, come out mathematically. I have additional slides that will show you how the employee contributions across the tiers work out mathematically.

Slides 6-7. These two slides show the entirety of the offerings. The table is read from right to left. On the far right are the proposed 2020 total composite rates. The middle column is the employer medical contribution (EMC). That number is the same for every plan because we pivot off the 85% of UMP Achieve 2. Based on our final bid for Achieve 2, the final rate build for Achieve 2 is $555. For every subscriber in the SEBB Program, the employer contribution is calculated for purposes of calculating employee premiums at $555.

The green column is the math. Composite Rate – EMC = Employee Contribution. For Kaiser Permanente NW 1, the total composite rate (rounded to the nearest dollar) was $583. Subtract $555 and you get $28, the single subscriber employee contribution. That's how the table on Slide 6 works and it continues on Slide 7.

Sean Corry: On the first example, I was figuring out the percentages that employees pay, percentage of the total premium, and the percentages themselves vary widely. On top, if the employee contribution for Kaiser Permanente NW 1 is $28 over $583, it's 4.8%. I've come up with 2% at another place, 13% at another place, 17% of the premium that the employee pays? Could you explain why there is that percentage variation? Why employees pay a bigger share, or a lesser share of a premium?

Megan Atkinson: The Collective Bargaining Agreement dictates how we set employee contributions for the SEBB Program. In terms of the Collective Bargaining Agreement on the SEBB Program, we're benchmarking off of the UMP Achieve 2 self-insured plan. The Collective Bargaining Agreement says the employer contribution shall be 85% of the state self-insured 88% AV plan. That's our Achieve 2 Plan. If you look at that row on Slide 7, third from the bottom, the UMP Achieve 2 Plan is $555 is 85% of the $653, and the $98 is 15% of the $653. As employees make their plan choice, their percentage will vary. You're correct, the percentage of the total they are paying will vary because that $555 is locked in as a raw number, a nominal number, and doesn't float as a percentage. Does that answer your question?

Sean Corry: It does, although I raise the thought that it changes the selection process. In terms of the rating of a plan, there's an expectation that a certain number of people will come in either of the vendors, it doesn't really matter. The point is that there's an expectation for a plan, certain type of people coming in, family sizes, all of that, and if

the premium sharing arrangement is set up based on a fixed contract number that skews the selection process. How did the carriers take that in?

Megan Atkinson: I think it definitely changes the dynamics. I don't want to speak for the carriers. I would imagine it would change the dynamics by which they think about selection, because you are correct. Again, depending on each individual's selection and the utility they're trying to drive from their plan selection. We had an interesting conversation at our HCA Coordination Team meeting yesterday talking about what drives people's selection. For me, and I'm decently good at numbers and decently understand health care selection, I am going to select the plan where I can get to my pediatrician. It doesn't matter, anything else. If my pediatrician changes networks, I'm changing plans. When I was single, I had a very different utility equation. I selected on very different criteria.

To your point, Sean, the amount of the premium, the financial consideration, will most likely play into the decision-making. If people are making decisions based on minimizing their employee premium, then yes that can skew the way they select. I don't know exactly how each carrier took that into consideration. What we did, from managing the portfolio from our perspective, we made certain the carriers understood the way the SEBB Program employee and employer premiums were calculated. That was a topic of conversation in many of our carrier meetings. In addition, we made sure they knew how the UMP bid rates were coming out as we were developing those, and gave them an opportunity to adjust their bid rates, based on the UMP bids. and then based on the final EMC, $555. That allowed them to position themselves competitively in the market based on what the carriers and the plans are trying to maximize for themselves, either in terms of positioning or maximizing revenue. There's a variety of things I would imagine they take into consideration, just like we do.

That's how we address that. I understand the point you're making. It is a different dynamic in the SEBB Program than what we have for the PEBB Program. It's one of the things we've worked on trying to communicate, especially with Kaiser Permanente, because they partner with us already in the PEBB Program. Premera, it's a little bit different. We are starting from ground zero with them on explaining how it works. Does that help at all?

Sean Corry: It did, thank you.

Pete Cutler: Megan, part of the context for this, if nothing else, is I want to get confirmation as I understand the change was made with the most recent Collective Bargaining Agreement. My understanding is that prior to this Collective Bargaining Agreement, all the prior ones had the employer commitment to be funding an average of 85% of the overall average premium cost. On average, regardless of which plan people picked, the rates were calculated to come up with, for the total premium costs, 85% would be employer money, 15% would be employee contributions.

Megan Atkinson: I want to clarify, Pete. We are in a situation where the PEBB Program health care benefits are calculated per that methodology. The PEBB Program Collective Bargaining Agreement, of course, is separate from the SEBB Program Collective Bargaining Agreement. The way the employer and the employee premiums are split are different in the two programs.

Pete Cutler: That's very helpful because I actually had not tracked that the two Collective Bargaining Agreements for the two different groups this year had varied in terms of that point. With the SEBB Program, instead of the commitment from the state being for the employer to contribute 85% of the overall average, we have a commitment of a funding level for 85% of the Achieve 2, which is more expensive than the average, I believe. But the bottom line is it appears to drive much lower percentage employee contributions, as a total, than would be the case in a PEBB Program. I haven't done all the numbers, but from just going through all the examples, it seems to me that's a major win for school employees compared to state employees. Am I reading that correctly?

Megan Atkinson: I haven't done the math on if we used the PEBB Program methodology on the SEBB Program rates, how it would pan out. One of the things we faced working with our labor relations partners and supporting collective bargaining last summer, is the PEBB Program methodology uses what you were describing, a weighted average methodology. But with the SEBB Program, we don't have any enrollment yet. There's no way for us to do a weighted average methodology. When we were working through collective bargaining last summer, one of the things from the HCA perspective was we went through collective bargaining after the Board voted to have the self-insured products. There were so many unknowns when working through collective bargaining. That was something we could use as a known. We are familiar with the UMP product, obviously. We know our TPA. The Board supported having that as one of the offerings, and it gave us something we could benchmark off and model.

Lou McDermott: Pete, I did play with the numbers a bit. The answer is, it depends. It is possible, theoretically, for members to sign up and depending on the tier they sign up for, it could be at 15%. But that’s not going to happen. It's going to be over/under depending on what plans they select and doing the PEBB Program weighted average calculation, we'll know at the end what the actual number is.

Pete Cutler: Thanks. I understand that's theoretically possible. And I sure hope that the Health Care Authority will, when we get through with open enrollment sometime in January, provide us with what the actual average employee contribution is, as a percent, because I think inquiring minds would be very interested in knowing how that has evolved. Thank you.

Megan Atkinson: I want to say absolutely we'll provide you with any statistic you would like to have. I would encourage us to not go too far down the path of "what if the SEBB modeling were on the PEBB population, what if the PEBB modeling were on the SEBB population." They are different programs with different carrier offerings. We'll see how much the populations mirror/don't mirror each other. There's geographical distribution differences. It'll be interesting to see as the SEBB Program matures.

Pete Cutler: This Board won't have any decisions in front of it or adjustments that will be needed that we expect to make between now and the next plan year cycle. I think it's more a matter of going into the rate setting for 2021. It probably will not affect there because we have the Collective Bargaining Agreement just down the road. Just being aware, are there differences? Is it shaking out differently between the two populations? I think a question for a lot of us will be, “Is that result what policy makers want?”

Megan Atkinson: Definitely.

Sean Corry: Maybe in summary, if one were able to toggle back and forth to compare like plans between SEBB and PEBB and look at the premium sharing arrangements for those plans. They would see differences that may be remarkable differences in employee share of the premium for a plan similar in the other population because the premium share for employees differs between the two programs. Finding an HMO from Kaiser Permanente, for example, premium shares for employees would be different in the SEBB Program and in the PEBB Program, and sometimes, rather large differences, I would guess, for employee share of the premium because of the differing methodologies.

Megan Atkinson: I have not done a comparison of the two to see where they are similar or identical other than when working with Milliman on developing our own self-insured bids and building those. For our own self-insured products, we utilized a lot of similar assumptions that we know about the PEBB Program population as we built out the SEBB Program rates. Again, I can't speak to the other carriers and what we did. There are general similarities and I believe our UMP High Deductible, at $25 on the single subscriber tier for the SEBB Program is similar if not exactly the same as the PEBB Program?

Dave Iseminger: I can't speak to the bid rate, whether it's the same, but the employee premium contribution is identical.

Megan Atkinson: I think the Achieve 2 at $98 is about the same.

Dave Iseminger: The PEBB Program single subscriber UMP Classic rate for 2020 is $104. So it's $6 less, but I can't speak to the relativity of the bid rates.

Megan Atkinson: I think to your point, Sean, if they are not exactly the same, for those families that may have dual eligibility, it plays into some of their decision making. I think what you'll see as we move forward into year two and three, is how the demographics, the riskiness, the health status, and the utilization of the populations is able to come in and inform subsequent rates and subsequent bid rates.

Dave Iseminger: Another piece to think about is the part-time eligibility rules between the PEBB and SEBB Programs are very different, which led to us bringing to this Board the possibility, and you ultimately approved it, of including the UMP Achieve 1 Plan, which is an actuarial value of 82%. That entire plan, within the self-insured portfolio, does not exist in the PEBB Program. That's another dynamic. The underlying eligibility framework does have some key differences between the two programs that could be playing into the demographics as Megan's referencing.

Megan Atkinson: To tie up Slides 6 and 7, they are showing the same information for different plans, sorted by carrier, by plan. Slide 6 are the KP offerings. Slide 7 shows the Premera and the UMP offerings. I want to point out at the single subscriber tier, the lowest single subscriber contribution is $13 with Kaiser Permanente WA Core 1. On Slide 6, that's the fourth row down. The most expensive is also on Slide 6, last row, Kaiser Permanente WA Options Access PPO 3 at $116 single subscriber employee contribution. In our communication materials, we will help educate members look at both the premium contributions and the benefit offerings of each plan. Everybody's

decision-making is unique. There are network considerations, deductible considerations, all of those things people will take into consideration as they make their selection.

On Slide 7 for the Uniform Medical Plan, I want to highlight the last four rows. The UMP single subscriber contributions vary from a low of $25 on the high deductible, which includes a health savings account (HSA) identified in the second bullet below the chart. The HSA contribution on Tier 1 is $375 per year. For Tiers 2, 3, and 4, it's $750.

Dave Iseminger: Up until now, the only "not to exceed" rate numbers you've seen from the portfolio are the Achieve 1, Achieve 2, and High Deductible rows. If you were remembering something cost over $100, you're correct. In the "not to exceed" rates from a couple of months ago, UMP Achieve 2 was looking like it was hitting a target of $101. In these final rates, all three of these plans came in under $100 at the single subscriber level. I believe High Deductible did not change. The not to exceed rate was $25 before. The Achieve 1 not to exceed was $34, so that ended up being a dollar lower. UMP Achieve 2 dropped from the $101 not to exceed to a $98.

Lou McDermott: Dave, what's the most expensive plan for two adults and 25 kids?

Dave Iseminger: That was a great transition, Chair McDermott, because Megan was about to go to Slide 8.

Megan Atkinson: Slides 8 and 9 can be used together because it's showing all of the plan offerings sorted by carrier and plan. They show how the employee contribution varies by tier. If you refer back to the Lego person slide from the beginning of the conversation, these tiering factors are shown at the top in the grey bar, and it's one of the things we're going to remove when we share materials. We think it’s leading to confusion where people are thinking they're supposed to take the number in the column and multiply it by that tier ratio, not understanding the multiplication has already been done.

Looking at these slides from left to right is the single subscriber tier, the subscriber and spouse or partner tier, the subscriber and child or any number of children tier, and the last tier, subscriber, spouse or partner, and child or children tier. The last tier has the highest tier ratio, and ultimately, we would expect it to have the highest average number of people per account.

I will walk through a couple examples. If you go down about midway, let’s look at Kaiser Permanente WA SoundChoice that has a single subscriber employee contribution of $49 per month. Moving to the right, if the subscriber and spouse or partner enroll, they pay $98 per month. The subscriber and child(ren) pay $86 per month, a little lower because the tier factor is 1.75. The previous tier factor for two adults is 2.0. And finally, moving to the far right, subscriber, spouse or partner, and child(ren) is $147 per month.

Our most expensive plan for 2020 is the Kaiser Permanente WA Options Access PPO 3, towards the bottom of the page above the second gray line. If you look at the tier furthest right, they pay $348 per month. There is no maximum to the number of dependents the subscriber may enroll. The tobacco and the spousal surcharges can come into play for additional charges on the subscriber's account.

Slide 9 is the rest of our offerings, the Premera products and the self-insured offerings. The math works the same.

Dave Iseminger: I alluded at the very beginning we're describing and presenting this, showing those tier ratios at the top. That's proven to be a very confusing point for school employees in districts, understandably from the existing world they're coming from. When we sent out our June newsletter, we had a mockup describing the tier ratios and we used a $300 example, because at the time, with UMP Achieve 2 had a not to exceed $100, we wanted a round number for the purposes of examples. What we found after that newsletter went out, and after these slides went out on Monday, is we started getting phone calls saying, "I pay $2,200 a month now for my family coverage. When I look at this, I see $300. I have four people I'm covering, I must have to take $300 times four. I'm going to pay $1,200. Thank you, you're saving me $1,000! Am I reading that right?" Staff responded that, "No, you'll pay $300. You're going to save $1,900 a month."

This gets back to something Patty said a couple months ago. When the Eatonville School District transitioned to PEBB Program benefits, everyone kept saying the math is so simple, what am I missing? As we go forward, we're not going to describe the tier ratios, we're not going to call it Tier 1, Tier 2, Tier 3, Tier 4, because if you call it Tier 4 people think they have to take that 4 and do something with it. We're going to say subscriber, subscriber and spouse/state-registered domestic partner, this is what you pay. We'll do some illustrative examples like Dave is a school employee and is going to enroll himself and his two children. Next year Dave has three kids. The next year Dave has four kids and Dave still pays $300 a month. We want to help drive home that point.

Those are the calls we're getting. That's the point we're driving home and we wanted to assure you as we move forward with member communications, we're going to do everything we can to help people understand there's no extra multiplication. We'll have as few numbers on the page that might lead someone to believe they have to do multiplication, to avoid some of that confusion. The people who have called and asked these questions have been quite shocked at the final numbers. Especially for the family coverage because it's very different. It's one of those pieces, when the legislation set in the maximum tier ratio of three to one, we knew this was coming. But here we are today with the numbers, and people are digging into them and realizing what's about to happen.

Patty Estes: Looking at this, I'm getting emotional because this is what we've been building and this is what classified school employees have been working towards, because that $2,200 a month is an employee I know. She had to write a check to the district at the end of every month above and beyond her paycheck to pay for her insurance. And now she won't have to do that anymore. So thank you, guys, this is great.

Dave Iseminger: Patty, it's -- now you're making me tear up! We've been working on the program for two years. And we're here two years after the legislation was signed. To realize the number of people who will, for the first time, have take home pay. That's a profound difference. It's what this whole thing is about.

Patty Estes: And to point out, that's the maximum they're going to pay. That's like the Cadillac version, not everybody's going to pick that one. But that's the maximum they could have to pay, and that's amazing.

Dave Iseminger: We should have brought tissues.

[laughter]

Megan Atkinson: I will say I have been pleased with how the procurement has come in. I was optimistic all along, but I've been really excited and really happy to see how the procurement is coming.

Slides 10-17 have the additional suite of benefits that are 100% employer paid. This presentation is a bit different because I don't need to break it out between employee and employer.

Slide 11 – Dental Premiums. These are the per subscriber rates for the three dental offerings. Again, the premiums are 100% paid by the employer. The rates vary from $41.43 up to $49.90. We do have tier ratios on dental, but I didn't show it because it's 100% employer paid.

Slide 12 – Vision Premiums. There are three vision care offerings. A difference between the PEBB Program and the SEBB Program is the PEBB Program vision coverage is is part of the medical offering and is subject to employee and employer contributions. In the SEBB Program, we have vision carved out as a stand-alone vision benefit, 100% paid by the employer. The monthly premiums range from $4.36 to $6.66 per month.

Slide 13 – Basic Life / AD&D and Basic Long-Term Disability (LTD). These are employer paid. The rates are $3.96 per month for Life and AD&D and $2.10 per month for LTD.

Slide 14 – Supplemental Benefits, which are optional benefits that an employee may choose to enroll in. They are employee paid should they choose to enroll. We do leverage our contracts, however.

Slide 15 – Supplemental Life. Rates are based on age bands at the rate per $1,000 of coverage the individual selects. There's a sample formula on the right of the slide.

Slide 16 - Supplemental AD&D. The rate is not age-banded, but a rate times the amount of coverage selected gets you the monthly premium. An example is shown on the slide.

Dave Iseminger: The last bullet says "Based on age as of December 31 prior year." That was a vestige from the prior slide with a copy and paste. As Megan just said, there's no age banding. You can't underwrite for an accident. It doesn't matter how young or old you are.

Megan Atkinson: Slide 17 – Supplemental Long-Term Disability. These rates are age banded. The formula is there and it's a simple rate times the insured monthly earnings equals the employee's monthly premium.

Slides 18-23 are proposed resolutions.

Dave Iseminger: As we look at the proposed resolutions, I'll give you context as to why you see resolutions the way you do and why you don't see other resolutions. I'll identify changes. We renumbered the resolutions in the updated Board packet. We had skipped a few numbers by accident. These resolutions are by carrier, a resolution that says the Board endorses the employee premiums for said carrier. There's one for each carrier.

You're not voting plan by plan. As we go through the rate development process, it's a bundle of sticks of those plans. That bundle, by passing the employee premium, is the ratification of the underlying benefit design, as well as the service area. Since they're all intricately linked, we just tee up premiums for you to vote on. In future years, we would tee up for you employee premium changes. We would educate you and bring you along the journey, during Executive Session, about what different benefit impacts are. We'd work through Executive Session and get insight for us to go back during the procurement negotiations cycle. Ultimately, the action that you take as a Board is setting the employee premiums and that's also how your authority is described in statute. It is specific to employee premiums. And that's why you only have medical premiums in front of you. There's no employee premium to set when it comes to dental, basic life, and basic AD&D.

When it comes to supplemental benefits, there are no resolutions for supplemental life and supplemental LTD. You already ratified and passed a specific complex benefit design resolution on life insurance and LTD. At that point, it's plug that benefit design into the actuarial formula. Specific numbers come out with very little manipulation. So by passing the benefit design on the supplemental life and LTD, that was the precursor to setting of the rates. On life insurance and basic LTD, you passed the benefit design, which comes with rates. Here you pass the rates, which comes with benefits designs. That's why you see the resolutions the way you do, each one successive.

We do things in alphabetical order:
SEBB 2019-12 – KP Northwest
SEBB 2019-13 – KP Washington
SEBB 2019-14 – KP Washington Options, Inc.
SEBB 2019-15 – Premera
SEBB 2019-16 – Uniform Medical Plan

Those are the resolutions.

[break]

Lou McDermott: Alison, did you join us on the phone?

Dave Iseminger: She might be on mute. She was texting me a while ago. She knew we were breaking. I have proof she was on the call!

Lou McDermott: We'll let it go at that.

SEBB Program Default Plans

Marcia Peterson, Manager, Benefit Strategy and Design Section, ERB Division. I am going to present the intended plan default selections for the SEBB Program for 2020 and why they were selected.

Slides 2-3 – Background. In December the Board passed the resolution establishing a default plan selection for school employees who don't make a plan selection. I'm going to bring forward the intended HCA default plans and to get your feedback. We said during the final rate setting, HCA would identify default plans with the final rate information in July for discussion. We would formalize those plans once the Board endorses rates.

Slide 4 – Default Considerations. First we said we'd look at the monthly employee premium, or in the case where the plan is 100% employer paid, we'd look at the overall plan rates. We would take into consideration the actuarial value of the plan. Second, we said we would look at the extent of the service area of each of the plans. And finally, we said we'd take into consideration the provider network availability and access.

Slide 5 – Intended Default Plans. Listed are the intended default plans for dental, vision, basic life and AD&D, and basic LTD. As you can see, all of these plans are 100% employer paid. If the member doesn't sign up, they still have the benefit and are not penalized for not signing up. In both dental and vision, these were selected because they have the most robust provider network covering the most counties.

Dave Iseminger: For dental, in the SEBB Program, the benefits are a carbon copy of the PEBB Program. Both carriers were very familiar with the process and the rate assumptions, and from the beginning assumed that the Uniform Dental Plan would be the default dental plan, which was accounted for in the entire rate development. For dental we had a lot of understanding from the carrier perspective.

Marcia Peterson: Slide 6 – Default Plan Considerations – Medical. There were more choices and considerations for medical. The first criteria considered was the default plan must be available statewide in order to facilitate administration and limit member confusion. The UMP plans, with the exception of UMP Plus being only offered in certain counties, but the UMP plans in general are the only ones fully offered statewide to all SEBB Program members, regardless of where they live or work.

We then considered the richness of the benefit. What percentage of plan costs would the employee be responsible for? The premiums and deductible rates for the two UMP Achieve Plans are on Slide 6. Achieve 2 has a higher actuarial value than Achieve 1.

Slide 7. The other plan considered for the default was UMP High Deductible. It fits the criteria of offering statewide coverage and it has the lowest monthly premium cost. By definition, it has the highest deductible. There were a couple concerns with this option. If a member is defaulted into UMP High Deductible and they don't sign up for an Health Savings Account (HSA), they'd be paying for a more expensive plan by the end of the year because they'll be paying for the high deductible directly out of their pocket. We

also worried about a member signing up for the HSA but then don't sign up for a SEBB Program plan because they think they are going to be covered, or perhaps they are going to get coverage through their spouse or their state-registered domestic partner. There could be tax consequences for that member because you cannot contribute to an HSA if you have any other health insurance other than a high deductible plan. We didn't want to put our members in that situation.

Slide 8 – Intended Default Plan – Medical. The Health Care Authority believes UMP Achieve 1 would be the best option to put forward as the default plan for SEBB Program members. Mainly because we heard from stakeholders that affordability is a real concern for SEBB Program members, especially those members who are part time. We are concerned that committing those members to a higher monthly cost could cause them financial harm. About half of K-12 employees make less than $50,000 annually and about one third make less than $31,000 annually. Affordability is a real issue when you start talking about a default plan, something that someone didn't know they were going to end up paying for.

We know people will often choose a plan with a lower monthly premium. The annual Achieve 1 premium would be $396. It does have a higher deductible cost. They often choose a lower monthly premium even though there's a higher deductible. Particularly if they think they don't use health care all that much. The annual premium for Achieve 2 is $1,176. So $396 versus $1,176 is a significant difference. Even if you run the risk of having to pay out that higher deductible of $750, before your deductible kicks in, for people who haven't placed a value on medical insurance, the certainty of that lower cost premium they have to pay monthly beats out the potential for a future cost savings.

We were also concerned about the impact on appeals, which is something we look at on the PEBB Program side. Appeals for people who didn't know they were being defaulted into a plan. We want people defaulted into a lower cost plan, in that event. We felt there would be fewer appeals.

We also heard from Washington Association of School Business Officials (WASBO) representatives. They thought there would be less risk to the SEBB Organizations if the default were the lower cost plan. If an employee loses employment without paying their contribution, or the amount of pay the employee earned prior to their departure wasn’t sufficient to cover the contribution, the SEBB Organizations would rather be on the hook for the lower premium.

Dave Iseminger: At the same time, you might have thought why not the high deductible health plan? We also heard a strong commitment from WASBO officials who provided feedback that the Achieve 1 would be a good, appropriate balance of all of those interests. They want their employees to have a high quality plan and they felt Achieve 1 balanced those pieces. It wasn’t just a cost analysis from that stakeholder.

Marcia Peterson: To summarize, we selected the UMP Achieve 1 Plan for the intended default plan for SEBB Program members. It is available statewide; provides full coverage for members who fail to enroll, but commits then to a lower out of pocket cost; may avoid appeals; and has a lower financial risk to SEBB Organizations if the employee were to leave service.

Slide 9 – Communications Plan. We will communicate the default plans in the fall enrollment guide and throughout our member communications.

We would love to hear your feedback.

Pete Cutler: I would defer to the employee and school folks on the appropriateness, but to me it sounds like a good decision based on good logic. The one question I have is I don't see a resolution or motion. Is it the belief of the Health Care Authority that it's a decision that doesn't require Board action?

Dave Iseminger: I think when we first started talking about the default plans, even with the original resolution about defaulting into or out of coverage, we believed it is part of the administrative aspects of being able to manage this part of the portfolio. The administrative function is with the Health Care Authority. But I did make the commitment that we would bring to you and get your insights as we move forward on this decision. You're not seeing a resolution, because we believe it's in the agency's purview, but we certainly know that it's a key piece that school employees and the Board are heavily interested in. We wanted to make sure we shared it with the Board before a final decision was made.

Pete Cutler: I appreciate that. Thank you very much. I will note that interpretation is something upon which reasonable people can have different outcomes, but I'm happy with moving ahead. Thank you.

Wayne Leonard: I think these look like logical default plans. Last month we talked about the smoker surcharge being a default, right? I'm appreciating your communication plan. It's an incentive to save money because to positively affirm to go in and enroll so people say, "these were the plans I'm going to choose anyway, I just won't enroll and I'll be defaulted in." They will be paying the smoker surcharge.

Dave Iseminger: Thank you for raising that, Wayne. I believe even in some of the FAQs right now we describe you would be defaulted into medical at a subscriber only level, into dental, and it highlights the tobacco surcharge piece. We'll make sure we communicate that, along with the other parts of what happens if you don't engage in the system.

Another piece I'll highlight for the Board is once open enrollment starts on October 1, we're going to be heavily watching the uptake in utilization of SEBB My Account. If we are seeing low enrollment in the first week or two, we'll ramp up additional communications. We all want the default rate to be as low as possible. We want people to engage, make affirmative choices. There will always be individuals who just let the default happen. We're talking about 150,000 people. We'll have some people, just like in the PEBB Program, who just don't like to give the state of Washington anything with their signature on it.

There are many reasons someone might not engage in the system. As we go through the first couple of weeks of open enrollment, if we see the chance for a high default rate, we may send a postcard to everybody who hasn't done something in the first two weeks to let them know there are four weeks left. If you don't, you will be enrolled in medical

insurance, your paycheck will be deducted $33 per month, plus $25 for a smoker surcharge. We have an interest just as you in school employees keeping that default rate as low as possible.

Lou McDermott: I always find it interesting when an item's brought before the Board and I know the background on how much time and effort the agency has spent. This topic has been many meetings. Many differing opinions. Pete, to your point, reasonable people can come to different conclusions. This issue's no different. There were varied opinions within the agency. I think Dave and his staff did a good job of trying to collate that. There is no right answer. There is just answers that have different pros and cons and I think they landed on a good ground, despite all the various input they received from everyone who had an opinion, which is just about everyone in the agency, and people outside the agency. So, Dave, good job. That was a tough call.

Next on the agenda is Executive Session. We are early. Are we going to start early?

Dave Iseminger: Chair McDermott, I can bring you up to date. We can certainly start Executive Session early. We don't anticipate Executive Session will take the full time allotted. We are likely to start early and end early. Katy Hatfield is nodding her head all of those things are okay.

Public Comment

Fred Yancey, Washington Association of School Administrators. Like many, thank you all and the Health Care Authority staff for the tremendously hard work to get to this point. It's nice to see fruition. The only remark I would make, I've sent a few emails on some follow-up questions, but the only remark I would make is I was very impressed with the UMP Plus presentation. I would hope the Health Care Authority and the SEB and PEB Boards work to increase the number of counties that provide that level, let's call it coordinated outcome-based care which saddens me if I think that my care currently doesn't fit that definition. [laughter] But that's really all I have to say. I would really like to see that model expand across the state. Any effort you and/or the PEB Board and Health Care Authority to advance that would be appreciated. Thank you very much.

Katy Hatfield: We're going to break for Executive Session. The meeting will adjourn after Executive Session, but there won't be a public portion of the meeting after Executive Session.

Next Meeting

July 25, 2019
9:00 a.m. – 12:00 p.m.

Preview of July 25, 2019 SEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the July 25, 2019 Board Meeting.

Lou McDermott: The Board will meet in Executive Session during lunch period, pursuant to RCW 42.30.110(1)(l) to consider proprietary or confidential nonpublished

information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session will conclude no later than 1:30 p.m. The public portion of the meeting will resume right after the Executive Session concludes, and then the public meeting will immediately adjourn.

Meeting adjourned at 12:28 p.m.

Washington State Health Care Authority

D R A F T

School Employees Benefits Board
Meeting Minutes

July 25, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 p.m. – 12:00 p.m.

Members Present

Sean Corry
Alison Poulsen
Katy Henry
Pete Cutler
Dan Gossett
Lou McDermott

Member via Phone

Wayne Leonard
Patty Estes
Terri House

SEB Board Counsel

Angela Coats McCarthy

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. TV Washington (TVW) was in attendance live webcasting the meeting (www.tvw.org).

Meeting Overview

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

Approval of March 7, 2019 Meeting Minutes

Alison Poulsen moved and Pete Cutler seconded a motion to approve. Minutes approved as written by unanimous vote.

July 18, 2019 Board Meeting Follow Up,

Dave Iseminger, Director, ERB Division. Many of the questions asked were answered contemporaneously last week or were broader, long-term policy questions for discussion regarding the program launch. Today is an historic meeting. This is the Board's 21st meeting with two significant pieces of legislation and a funding bill enacted and signed by the Governor. The Board, HCA staff, and many stakeholders have been

working very hard for two years. Some stakeholders have been working for decades, or most of their careers, to bring about state consolidated, high quality, affordable benefits for school employees. I'm very proud of all the hard collaborative work you and so many other stakeholders have gone through that have brought us to this monumental point.

As you know from reviewing the Board materials for this meeting, Megan will be presenting additional updated rate information to you, specifically revised rates from Premera, when she presents shortly. I want to give the Board and public additional context about the last few days, Premera's newly proposed rates, and the resulting employee premium contributions.

Starting with the Board materials produced for the July 18 Board Meeting, they were published on HCA's website on Monday, July 15. As Board Members, you already had received an email copy before they were posted. Unsolicited, Premera emailed the agency and submitted revised, lower rates to the Health Care Authority on the afternoon of Wednesday, July 17. When Megan comes up, she'll be able to talk with you more about the rate setting process that occurred over the past several months.

At the Thursday, July 18 Board Meeting, HCA presented to the Board the rate information and employee premium contributions from the already publicly available Board materials. As is clear in the record, the Board did meet in Executive Session last Thursday. Although I cannot comment about the discussion that occurred during that Executive Session, I want the record to be clear about who attended the Executive Session because the agency has heard concerns about who was present during that Executive Session. The attendees included only SEB Board Members, HCA staff, and Assistant Attorney General Katy Hatfield from the AG's Office.

Between last Wednesday and last Friday, our HCA finance team had conversations with Premera and discussed the basis for their rate change. Again, when Megan comes up, she can provide more information during or after her presentation. Last Friday afternoon, we informed all potential SEBB Program fully insured medical carriers about Premera's recently submitted revised rates. Remember, until the Board takes action, no one is a carrier in the portfolio.

The agency stated an intent to present the revised Premera rates to you at this July 25 Board Meeting, and we initially gave Kaiser Northwest, Kaiser Washington, and Kaiser Washington Options until this past Monday morning to submit revised rates. The Board received, in your materials this week, a copy of a letter sent by Kaiser Washington and Kaiser Washington Options to the Health Care Authority. And after receiving that letter, HCA responded by offering additional time to provide updated rates and the ability to delay a vote on their premium resolutions until August 1. We did not receive updated rates or a request to delay action on the resolutions.

The agency had an obligation to present the Board with Premera's revised rates because only the Board has the authority to authorize employee premium contributions. Therefore, rates and premium contributions are not final until this Board acts. The additional rate information you received could have a significant impact, and as Megan will describe, millions of dollars each month on the monthly employee premium

contributions. For clarity, the materials you have before you today have all the rate information as it was presented last week and a version with Premera's revised rates. The Board has the authority to accept either of the proposed rates. I want to be clear the order of the resolutions before you is in alphabetical order. You've heard me say many times over the last two years that we try to alphabetize things here at the Health Care Authority. Again, the Board has the authority and the rates are not final until the Board has acted. Megan and I will answer your questions to the best of our abilities during the next part of the meeting during her presentation.

2020 Premium Resolutions

Megan Atkinson, Chief Financial Officer. Slide 2 – Overview. I have one follow-up item and then the voting on the premium resolutions. There's a bullet missing between the two bullets listed. I will be walking you through the latest rates.

Slide 3 – SEBB Funding Rate. We've walked through this slide several times. This is the conference budget funding rate updated with our procurement information. Starting at the top of the table is the $555 employer medical contribution (EMC) that is on a per adult unit per month (PAUPM) basis. That pivots off of our self-insured UMP Achieve 2 plan. We multiply that by an assumed ratio of adult units per employee. That ratio is calculated to take into account the enrollment of dependents, as well as an assumed amount of eligible subscribers who will waive their coverage.

We then get to the $869 medical premium contribution that is now on a per subscriber per month (PSPM) basis. Moving down the chart is the dental premium, vision, basic life, basic LTD, all of which are paid by the employer. There is a K-12 remittance also paid by the employer. The K-12 remittance is specified in the funding act, the budget bill. The administrative and other costs are next. And we end up with a surplus or deficit spend.

As you see in this scenario, we balance to the bottom line, which is the total cost of the funding rate that is assumed in the biennial appropriations act, which is per subscriber per month (PSPM). That funding rate for fiscal year 2020 is $994. We balance to that, which puts us projecting to be in a deficit situation of $81, again, on a per member per month basis. That's the update on how we look balanced against the funding rate.

Slide 4 – Employee Premium Contributions: Medical. Slide 5 – Employee / Employer Premium Contributions. This information is presented the same way as last week. It's helpful to look at Slide 5 and Slide 6 together because it takes the physical space of two slides to walk you through all the plan offerings. Slide 5 is the employee contributions for Kaiser Northwest, Kaiser WA, and Kaiser WA Options offerings. This slide is read from right to left. On the far right is the proposed 2020 total composite rate. The middle column is the employer medical contribution, which is the same number for all the offerings because it's based off of HCA's own self-insured UMP Achieve 2 plan. The green highlighted column is the proposed 2020 employee contribution at the single subscriber tier. Those get multiplied by the tier ratios. The breakdown isn't included in today's presentation but it is in the Appendix, which are the slides from last week.

Slide 6 has numbers that changed from last week. Slide 6 shows the other two offerings in the portfolio, the Premera and UMP offerings. The first three rows are the

three Premera offerings. You'll see an asterisk and a footnote. These values have been updated since the July 18 Board meeting. Dave was explaining in his introductory remarks, last week we received, unsolicited from Premera, an inquiry about their ability to submit revised rates. While we were through the phase of the process that is rate negotiation with the carriers, we were not through the rate development cycle. The rate development cycle comes to conclusion when the Board votes affirmatively on employee contributions. That authority for setting employee contributions and accepting rates rests with the Board. We could even today be sent back to the negotiating table based on your actions.

While rate negotiation with the carriers was complete, the rate development was not complete. Premera notified the agency and asked about submitting new rates. We communicated to them that while we would make no commitment about taking those rates forward, we were willing to accept their information so we could at least have a conversation with them. The subsequent rates that Premera submitted resulted, in our opinion, in significant reductions to the employee contributions. Therefore, we brought those rates forward to you for action today. Those rates are on Slide 6 in the first three rows. You can see the employee contribution. For comparison purposes, the prior Premera rates are in the Appendix and shown on Slide 21.

So everyone can have an understanding of the relative change, the lowered rates, updated rates showing here are: employee contributions of $70 for the Premera Blue Cross High PPO, $31 for the Peak Care EPO, and $22 for the Standard PPO. The prior rates resulted in employee contributions of $98, $80, and $48 respectively for reductions from $98 to $70, $80 to $31, $48 to $22.

Because of this significant change in the Premera rates and the significant impact on employee contributions, we felt an obligation from the agency's standpoint to bring those forward to you for consideration. I want to reiterate that the ultimate authority for improving the employee contributions rests with the Board. We have brought both sets of Premera rates forward for you and obviously we'll respect the decision and the action of the Board.

Pete Cutler: Megan, my first question is, in a 24-hour period, we had Premera come forward with significantly reduced rates. Those new rates presumably were based on new changes in their actuarial assumptions in terms of estimating their costs going forward. Did they explain the details of each element that went into the change of assumptions? Did they explain why they waited until after they had submitted their final bids before they suddenly came up with new assumptions and a new bid?

Megan Atkinson: Yes. We did enter into conversations with Premera about that because we had those same questions. Those are the obvious questions. In subsequent conversations that the Health Care Authority had with Premera, Premera indicated a couple of things. They indicated they had a misunderstanding of the process and thought there was one more round of rate negotiations still to occur, indicated they had those lower rates already prepared for a final round of rate negotiations. They indicated the rates still had space in them to be lowered because they made changes in their margin assumptions, as well as changes in their out-year trend assumptions.

Pete Cutler: Do we have this in writing? As a Board Member, I'm really uncomfortable relying on verbal assurances.

Megan Atkinson: The explanation about the lowered margin and lowered trend assumptions was in verbal conversation with them. The misunderstanding about the process was, I believe, included in one of their emails. I would need to double check, but that's my recollection.

Lou McDermott: Megan, what do you think the annual impact would be based on our modeling of how many people are going to go into those plans? What do you think that number would be from a member perspective?

Megan Atkinson: Obviously we've talked a lot about the enrollment modeling we've done to date and how that's come into play in various points along the process. While we don't have any type of stochastic decision modeling happening where we're trying to model actual employee decision making, we do have enrollment modeling both at the population level and then enrollment modeling where we've spread the population across the offered plans in the portfolio. Based on how we have the population spread currently, over a 12-month period, these reduced rates would result in member reduction and member cost for premiums cost of around $35 million a year. And again, I think for us, that underscores the significance of this rate change and the obligation we felt on the agency side of being able to bring those forward to you.

Pete Cutler: Megan, I'm really uncomfortable with that number without knowing the assumptions because clearly there are other plans that school employees could go to that would not require higher contributions. There are key assumptions, would people stay in and pay the higher premium or would they move to another plan offering that would allow them either same or lower premiums. Understanding more details about the assumptions that go into that, would be important. From my point of view, the integrity of the process is more critical anyway. But in addition to that, I'm really uncomfortable relying on a single number without knowing the details of the assumptions. Where would these people who you think would have gone into Premera, where would they have gone, and the basis behind that. I assume that's something the actuaries put together?

Megan Atkinson: No, we do not. Again, I want to emphasize, we do not have any type of stochastic decision model underlying our enrollment assumptions. The enrollment assumptions we have relied on our actuaries for have been at the population level. We have spread the population across the plans in the portfolio offerings for purposes other than rate setting like when we needed to have communication or conversations with the legislative staff during the state budget negotiations, when we have needed information to build into our admin assumptions, for example.

I understand the point you are making, Pete, that all of our modeling is based on a series of assumptions. For some of the modeling, we utilize our actuaries to support us in that. Other modeling, we do internally in HCA. The spreading of the population across the plans in the portfolio is modeling we did within the agency and you are correct. We could be, and in fact, I guarantee you we will be, wrong in how we have predicted people could spread or enroll across the plans. I don't share that $35 million

figure with you to in any way try to encourage you to use that as a single data point in your decision making. What we are trying to do from the agency perspective is bring forward to you the information we have, any contextual data points that we think might be helpful to you in making your decision.

Lou McDermott: Megan, I want to be clear on something. We had the internal modeling, which spread the population out among the plans that were available. Then this wrinkle comes into play where there is a significant rate reduction. You made no further adjustments to those models based on how people would respond to that rate reduction. You said this is where we think they're going to land and that $35 million is just a straight calculation off that from one rate to another with no additional populations moving around towards or away from the plan?

Megan Atkinson: That is exactly correct.

Pete Cutler: I appreciate that this was done under a tight timeframe. I have to admit, having worked with actuaries and knowing how important pricing is to predicting where people will move, I'm frankly uncomfortable being asked to make a decision without that kind of analysis. Based on actuarial analysis and what actuarial science says about how people move based on pricing options, this is our estimate of where we really think we'd end up, which I understand is a different kind of calculation than what you were able to pull together based on the data you have. I guess that's really not a question. I feel like that's a bit of data that would've been better for the Board to have.

Megan Atkinson: I want to remind everyone that the way we manage the bidding for the population is we ask all the plans to bid the entirety of the population. Then we use additional risk adjustment, as well as regional adjustment factors, to get to the plan's payment rate. The plans bid as if they receive the entire population. And then we use risk adjustment with the actuaries based on how people actually enroll to get to a payment rate for the plans.

Sean Corry: Megan, could you tell us please, what we know about the actuarial work that's been done on either Kaiser Permanente's reduced rates and Premera's reduced rates? Are these reductions fully supported by the actuaries who vet these kinds of things for us?

Megan Atkinson: I want to draw a couple of distinctions for some of us who are familiar and have worked in the Medicaid business. We have very strict guidelines from the federal government, from CMMS at the federal level, on having actuarial certification of our Medicaid rates. We don't have those same requirements for our employer sponsored offerings. The process that the carriers go through is they submit information on our bid rate forms. Those go to our actuaries. We also receive them here at the Health Care Authority. We do a review to make certain formulas are correct. It's not a cursory review, but a first tier review, making sure the forms are completed correctly, there are no formula errors, there are no omissions of the data.

In addition to that, we rely on our actuaries to go in and see the way the carriers built up their rates to see if the actuaries see anything that appears alarming, inconsistent, or unsupportable. We do not ask our Milliman actuaries to certify the carriers' rates. We

have our actuaries certify our UMP rates because they are responsible for building our UMP rates and they have to adhere to their standards of practice for that. Each carrier has their own actuary team and I assume each carrier is utilizing their internal actuaries to build up their rates and certify to the carrier's comfort level the rates they submitted to us. We do not have any way to validate or invalidate the different business decisions that each carrier is making about how they are trying to position their plans or their offerings across the portfolio.

When we get in conversations, and we've been in conversations with both of the carriers because both carriers had reductions to their rates late in the game. The Kaiser reductions to the rates occurred before the materials were submitted for the July 18 meeting. The Premera reductions occurred after. And that is what makes it unusual. Both carriers, though, lowered their rates late in the rate development process and we had similar conversations with both of them around how sustainable their rates are, why the late change, what has changed in your view of the data. Remember, we use the same data book they have. We had all of those conversations but there's not a step in the process, Sean, like we have in the Medicaid side where we actually get a firm certification of the rates. Does that help at all?

Sean Corry: It does. Thank you. It makes me wonder about the extremes though. If carriers have cut their rates in half and propose those, which, on its face, would be too low? Let's just presume. What's the mechanism for you then? What triggers would you have to declare that this is just over the line?

Lou McDermott: Can I get a point of clarification? When Sean said cutting the rates in half, they did not cut their bid rate in half. They cut the premium portion, which is a small -- I just want to make sure folks --

Megan Atkinson: The bid rate reduced such that --

Sean Corry: I understand. Thank you for that clarification.

Megan Atkinson: -- but the employee contributions went down, some of them by half, not all of them, yes.

Sean Corry: But back to my question. There seems to be an implied point at which you would step in and say these are unreal. Tell me, if you don't have a rigorous actuarial vetting of the proponent's numbers and the new numbers, how do we handle the smell test?

Megan Atkinson: I want to clarify, while we don't require an actuarial certification on our SEBB Program rates like CMMS requires on the Medicaid side, we do rely on our actuaries to do a vetting, a review of the rates. We have conversations with our actuaries about do we think these rates are too low? Do we think these rates are sustainable? Do we agree with the carrier's analysis of the trend assumptions? We have those conversations. If the rates were so low that we felt strongly they were dangerous in some way, jeopardizing the program, jeopardizing the offerings, that's information we would communicate with you now while you're getting ready to vote on the rate resolutions. Instead of just presenting the rates to you, we would have

additional commentary. I will say, when we had the conversations with Premera and they indicated they had lowered their margin and trend assumptions they conveyed to us, the trend assumptions they're carrying in their rate development are in line with the trend assumptions we're carrying in our own UMP rate development. They didn't seem out of line with what we're carrying ourselves.

Dave Iseminger: I want to make sure Board Members on the phone know that we had some background noise so we keep muting and unmuting. If you're trying to talk, we'll turn it back on for you periodically to get your talking points. Also, we described late in the process rates coming in. I wanted to be very clear that our documentation described a rate process that spanned multiple months, an April-June-ish range was anticipated for that rate negotiation process. June was when we received the most recent round of rates from KP Washington, KP Washington Options, and KP Northwest. Premera provided them on July 17. When we were describing things as coming in late in the process, I wanted to be very clear on the record that there is a difference between June and July and who was received in June and Premera's receipt in July. I did not want them to be lumped together in people's minds incorrectly.

Wayne Leonard: Pete mentioned the integrity of the rate negotiation process. I'm a little confused on that too. My experiences with these kinds of processes is that once that timeline is spelled out fairly clearly in the request for proposal or a bid document, at a certain point in time, no new information would be accepted. Hearing that Premera was confused about that timeline is a little concerning. But not having been involved in a rate negotiation process, or a rate development cycle, and not having seen the RFP, my question to the HCA staff, is this normal in this kind of process that information would come in this late from both carriers, especially when the Health Care Authority hasn't adjusted their rates this late in the process? They're sticking with their original rates. Is it normal to see this kind of activity this late in this process?

Megan Atkinson: I want to walk through the process for everyone. Last year the RFP was released and carriers responded. As part of that, we communicated with the carriers in the RFP that we would do a second phase, a request for completion (RFC), which is underneath that umbrella, when we finalize rates. Within the RFC is where we spelled out the timeline for rate negotiation and finalizing the rates with action from the Board. Because rate negotiations can be difficult to predict how many times you need to go back and forth, and because this was a new offering, we didn't spell out to the day or even the week the timeline. Instead, we had broad categories of months as Dave was explaining earlier. We spelled out, I think it was April to June would be rate negotiations between HCA and the carriers, and July through August would be finalization of the rates with action taken by the Board.

I want to clarify again because I might be creating the confusion. Dave clarified it, but I want to clarify it again. The final rates that we have from Kaiser came in June before we prepared and released the Board materials for the July meeting. It was in the last round of rate negotiations with Kaiser that they lowered their rates and then we had conversations with them of what caused this? This is after we've given you all the data. We had that conversation with Kaiser. Again, that was in June.

We had the notification from Premera in July, after we prepared and released the Board materials, and after we communicated the rates to both carriers. We asked if these

were their final rates for us to submit to the Board. I want to be clear we did communicate to the carriers these are your final rates to be submitted to the Board. Emphasizing again, the rate development process does not end until the Board takes action. Does that help at all, Wayne?

Wayne Leonard: But then they weren't final. Is that what I'm hearing? After you told them these were the final rates you submitted to the Board, they submitted lower rates?

Megan Atkinson: Yes. The electronic communication from us goes out to the carriers. In the message we includes their rates and ask them to validate those rates. These are your final rates for us to submit to the Board on July 18.

Katy Henry: Did they validate the rates at that time?

Megan Atkinson: Yes. Then Premera responded indicating they misunderstood the process, and upon further reflection, were able to lower their rates more. They asked if we would accept a late offering. We told them we couldn't promise that we would take the new rates to the Board, but they could submit in order for us to have a conversation about them. They submitted the lower rates, we had the conversation with them about what caused this change, what are you seeing in the data, how are you able to lower your rates at this point. And now we've brought them forward to you.

Terri House: If we were to move forward with accepting Premera's reduced rates, is Premera offering any greater coverage in the state of Washington, in areas they hadn't covered before?

Dave Iseminger: Terri, when we received the revised rates last week, there was nothing changed, or proposed as changes, to the service areas that were in the Board's materials last Thursday and publicly released. The revising downward of the rates did not impact positively or negatively service areas already locked in with a carrier.

Lou McDermott: Or benefit design? No changes to benefit design?

Dave Iseminger: Correct. There were no changes to benefit design. It was purely numbers.

Alison Poulsen: Going on a different line of thinking, can you talk through next year's rates and how this ties into future rate development and expectations members would have around, if I select a plan like this, do we cap how much growth there could be? Can you talk through that process for us?

Megan Atkinson: Definitely. Before I do that, I want to clarify one thing because I'm looking at the email chain now. On Thursday July 11, we communicated to Premera, "Good afternoon. Thank you for your most recent round of bids. We are considering these final and will be presenting the information below to the Board on July 18." The next communication we had from Premera was the communication asking to lower their rates. I mentioned a moment ago that Premera said, "Yes. These are our final rates." That is not what happened. We communicated, "Are these final?" It was a few days later that they communicated, "We'd like to revise our rates." I want to clarify that for the record.

Now I'll answer your question, Alison. One of the things we do immediately after this process is done is to start thinking about next year. We've already started strategizing. One is what data will we request back from the carriers as we enter into 2021 rate negotiations. What type of information will we want to be looking at? What type of analyses will we want the actuaries to undertake? For example, some of you are probably aware there's been some really interesting national research done around hospital prices, and especially around regionalization or regional differences in hospital prices. That's going on my list of what type of information will we want on that and what type of analyses will we want the actuaries to do. We do have the regionalization factors we've calculated for the SEBB Program, and we see differences across the state in cost. We have assumptions about how that is indicative or isn't indicative of provider and contract efficiency. We'll probably want to look at that.

How are the carriers' costs happening across the regions? As you also may recall, when we walked you through the PEBB Program contracts that we're leveraging for the SEBB Program, we have certain performance guarantees on our UMP side. Those performance guarantees are pegged in some instances off of a certain percent of Medicare. That is also a pricing mechanism you're seeing a lot of research around, a lot of focus on nationally, of using the Medicare pricing, which already includes some regionalization as a base when you compare your plan offerings to try to judge the cost effectiveness and efficiency of your plan.

Those types of things are what's already going on the drawing board as we think about the 2021 negotiations. For timing purposes, we will probably have the first communication with carriers for 2021 in November or December 2019. It's not that far into the future. In addition, I think it's fair to say we anticipate clarifying with more detail the rate development process and the timelines for rate negotiations. Does that help?

Alison Poulsen: I guess part of what I was curious about is rates that are set this year and how that would affect what a member would expect to see in increases next year. I understand the data analysis. I don't think I have enough context for where there are protections for members, or it's just a market force that if your rate went up that much, I might be looking at a different kind of plan.

Megan Atkinson: We don't have rate guarantees on any of our rates. We asked both carriers for rate guarantees. Kaiser did offer a rate guarantee that we ultimately did not accept because we felt it was too high. Accepting a rate guarantee signaled our willingness to negotiate up to that level. Premera did not offer a rate guarantee. There are a couple data points we look at for rate negotiations for subsequent years. A lot of focus ends up, especially when we're communicating, what percent increase are future rates? Your rate that you set, especially here at year one, is pretty important because we judge the "acceptableness" of future rates off of what percent increase are they from where you are right now. We benchmark against national data, which also will have percent increase information in it.

We will heavily leverage the information we have about our own self-insured offerings. Depending on how much population we get, it's very likely we could have enough of the population where it's statistically significant when we look at the experience of the carriers. What is their claims experience? We want a relationship with carriers where they stay in business and want to be in this space, but not so much that we're

overpaying. We also have the ability to leverage the federal calculations around medical loss ratio and administrative ratios. We will leverage that information as we work the carriers.

I can't say we will only allow 2% on in-patient and 3% on professional services, and, 7.5% on prescription drugs. I can't give you those types of firm benchmarks. I can describe the totality of the information we bring in. If we get into the 2021 rate negotiations with carriers and some of our partners come forward with rates we feel are not acceptable, the agency will communicate that to you and why we feel they're unacceptable. Does that help?

Alison Poulsen: That does. Thank you very much.

Pete Cutler: Two questions. In terms of the trend assumption, margin assumption changes, and whatever other actuarial assumption changes Premera made, would it be possible for HCA to do a comparison chart of what the Kaiser Permanente proposed rates, what their assumptions were for those factors versus Premera versus UMP?

Megan Atkinson: We definitely can pull together a comparison chart for you of the specific data points that we have for all of the carriers, of the crucial ones. The rate book is large. We'll distill some of those down. I'm not sitting here today without looking at it. I'm not confident that margin is a data point in the rate book. The trend information and those types of things, we can pull out.

Pete Cutler: What you're saying is somewhere Premera laid out that they reduced their margin, presumably they'd tell you how much. But you may not be able to compare that with Kaiser.

Megan Atkinson: I'm not certain that margin is a data point that we have across all plans.

Dave Iseminger: And Pete, we'd have to think carefully about whether this is proprietary and confidential information.

Pete Cutler: That's what I was trying to get at.

Dave Iseminger: Distinguish between the public and what the Board would have access to, so if that's something the Board wants to review, we'd have to think about that overlay as well, to lay that out for the record, too.

Pete Cutler: That was part of my question, whether this was even something you could share and it sounds from your comment, David, that it may be something you can share with the Board but not the public.

Dave Iseminger: Possibly. I just wanted to raise the yellow flag that this could be something considered to be proprietary. We would have to walk through that analysis. I'm not saying I know the answer to that question. We'd have to talk with the Attorney General's Office and the carriers because they also have a right to protect proprietary information.

Pete Cutler: Sure. I'm not asking to violate any contract terms, especially regarding proprietary things. There is an underlying question for the Board of this last minute change, which Premera claims they had been working on and had been planning to propose before. It's a red flag for me as a Board Member that a significant change would be made so late in the game, and especially knowing that they made that change after they knew what the Kaiser rates were. They obviously knew the UMP rates before that. I think part of my due diligence in terms of fiduciary duties is I want to know are those assumptions similar so that it seems reasonable? I've worked with actuaries for a long time. I know when you predict the future, there could be a wide range of assumptions that are considered professionally acceptable, albeit, not all equally strongly defensible. I would like that information if possible.

The second thing I just want a confirmation. Kaiser said an email went out May 11 saying send us your final rates and they did use the term final rates by a certain date. Then as you indicated, either a letter or an email was sent on July 11 was sent saying, "We have your final rates. We're sending them in." I guess what I don't understand is how could Premera possibly think after those two communications they had another opportunity to propose different rates. I guess that's really a question for Premera rather than for you. Thank you.

Lou McDermott: Megan, while you were talking, you did indicate when you reviewed the Premera out years, you reviewed their trend assumptions. They were in line with UMP. Is that correct? You did say that? Okay.

Sean Corry: Megan, I want to follow up with basically the same question Pete just asked. What I'm hearing from you folks, the Health Care Authority, is that this language about final rates was written in pencil and not in pen. Final doesn't really mean final. Give me please a clearer understanding of that term and how it's been used in the past as compared to how it's being used today.

Megan Atkinson: I appreciate that question, Sean, and that distinction because it is the crux of the conversations we've had internally and obviously the crux for a lot of you. I think it really rests on the understanding of the rate development process and the authority of the Board to approve employee contributions, and de facto approved bids. We consider the rate negotiations with the carriers to be a component of the rate development process. It's not the entirety of the rate development process.

When we use the term "final" with the carriers, we had been meaning we're through negotiating with you. It's final. The reason we felt the Premera rates needed to come before you is because you haven't taken action on the employee contributions. Therefore, we aren't finished with rate development until that action occurs. We can't presume the action you're going to take on the resolutions. All of the resolutions could fail and we would need to get information from you and go completely back to the table. Because of our clarity that final action from the Board has yet to occur, we felt these rates could come back to you. If, and at the point in time when that action has been taken by the Board, we wouldn't bring anything back. A carrier could come in after that asking to revise and we would say it's too late. Board has taken action and we're finished with 2020. Does distinguishing final in that context help?

Sean Corry: It helps a little. Thank you for that. The use of the word "final" is still bugging me because it's clearly not final. What we're hearing is there was a discussion and a decision at the Health Care Authority, that in this case, final is up until this hour. We could hear from Kaiser or Premera right now. Somebody could pop up and say they have better rates. Given that context, has this circumstance occurred in your many years of negotiations with the carriers now only one, I think, for the PEBB population where final didn't really mean final? Or is it more likely if you look back that when you said this is the final date, these are your final rates, you've rejected submissions after that in other circumstances like this? Is this unique? Have you never faced this circumstance? And if you have faced this circumstance, how did you handle it?

Megan Atkinson: I have not gone back and looked at all of the timelines for every PEBB rate development that's occurred over however many decades we've had the PEBB Program in place. It is somewhat of a different situation in this regard because the years that I have been involved on the PEBB side, we've only had a self-insured product and one plan offering, one carrier offering.

Dave Iseminger: Megan, just to correct, we've had two but they haven't had overlapping service areas.

Megan Atkinson: Correct. I think of them as one. They haven't had overlap in service areas. Again, I haven't gone back and looked at all the PEBB timelines to see if this has happened. I will say for the ones that I have been involved in, we haven't had this happen. Again, the communication from Premera was unsolicited by the agency and unexpected. But given the timing of where we were in the rate development process, we felt strongly that it needed to come forward to the Board.

Our understanding of the rate development process is an additional factor and the rates aren't final. The employee contributions have not had Board action yet. In addition, we look at the entirety of it. If we sat on this information and not brought it to the Board for your deliberation, that equally feels like we're holding information from the Board that you should have access to in your deliberations. It's trying to find the right balance in those situations. Yes, it is unusual and I feel strongly that this wasn't information for us to keep from you.

Sean Corry: Thank you. I appreciate that. But there's an in between. The in between would have been these came in late after the date we declared it final; and therefore, rejected. This seems unique unless there are other people from the Health Care Authority who can remember times before you were in your position where this has occurred where final did not mean final. Or it was squishier than what I would have expected. Is this a unique circumstance, Dave? Lou?

Lou McDermott: In 2012 when I ran the PEBB Program, there was one year in particular where there was significant rate increases by Kaiser Permanente, which was Group Health at the time. So Group Health had a significant increase. We worked back and forth, again, looking at their assumptions, the actuaries stating their cases. We got to a point where they were not willing to move any further. It was done. We looked at those rates. There was a lot going on with employees not getting raises, different things were going on. It was going to have a negative impact on our members. I went to

Group Health headquarters and made the plea that they help us out, that they help out our state employees, that they reduce their rates. They came back with lower rates.

So the negotiations were done. I made one last plea. It was very out of the ordinary and they did reduce their rates. I think one of the reasons why rate development isn't as prescripted in rules is because it's a very unusual process. You're trying to weigh many different variables that come into play: market share, location, where are the service areas, what is the other plan doing, what is the UMP or self-insured experience showing. If we are showing a dip in in-patient across the board and we're being told by the carrier they're seeing a massive increase in in-patient across the board, we have those discussions to understand why. What's going on with your contracting? Why is this happening? Every year is a different flavor. I haven't been in direct negotiations with the carriers in many years now. My experience showed that every year had its own flavor, its own cadence.

Sean Corry: Thank you, Lou. So one summary statement that's in my head is that this is the year in which it becomes clear to everyone that final really doesn't mean final. I haven't seen the language in the documents referred to in Kaiser Permanente's letter that Board Members at least received. It wasn't in the public packet. And I don't know why, but in any case, we're setting a precedent, I think, very clearly based on this conversation mostly, that final doesn't mean final, that the use of the word is squishy. It's really not final until we take the vote. So let's go at it until the last moment.

Dave Iseminger: Sean, I would say we have an opportunity in the next year to redefine words, be even clearer. And so whatever action is taken by the Board today can also be refined by how the agency communicates with carriers in the future.

Katy Henry: Have both of these carriers worked with the HCA in the PEBB Program and gone through those timelines with the PEBB Program in the past?

Dave Iseminger: KP Washington, and in its prior iteration Group Health, has been a longstanding, partner with the PEBB Program for many, many years. I'm trying to think, Premera has a supplemental Medicare plan in the Medicare population for the PEBB Program and has for as far back as I can remember reading the various enrollment documents. I'm not sure how far back, but at least not in the last roughly decade, they've not been on the employee side of the equation. They've only been on the retiree side of the equation. If you go back far enough in the early days of the PEBB Program, maybe 15 years ago, there were 10, 12, 15 carriers and Premera was among them at that time. They are a TPA for the Centers of Excellence Program, the bundled payment program. That's a very different kind of rate negotiation contract piece but I wanted to be clear about the other contractual relationship they have with the PEBB and SEBB Programs through the Centers of Excellence as the TPA, third party administrator.

Katy Henry: Two other questions. I'm going to get them in while I can before Sean and Pete have more questions. One relates to what Alison said earlier based on going into the next year and looking at rates and plans. Going into next year, the Board still has the authority to decide plans and rates in the following year. So just because we may vote on a plan this year, or carrier, does not mean that would still apply next year? We would still go through the voting process, correct?

Dave Iseminger: That's correct. We would talk with you during the rate development process about how it's going. If you are concerned about a plan, we would negotiate with the carrier a rate that would exclude or include a plan so you would have that option available to you to cut a plan out of the portfolio.

Katy Henry: Okay.

Lou McDermott: This may be jumping ahead, but we have other tools available to us. If we felt the rate changes that come in for next year were having a negative impact on our members, and with the nature of sticky insurance, a lot of times once people have insurance, they stay with it. There are opportunities to take other actions such as active enrollment. We could have an active enrollment every single year. That's not what we do in the PEBB Program. We haven't had the conversations on the SEBB Program side as to whether we're going to do that, but that is a conversation we could have to combat some of these forces at play. There are some things we can do on our side. Obviously, most of our attention has been around finalizing the negotiations, the SEB Board meetings, getting the rates in, communication, and updating the IT systems, doing all those things. But those conversations will kick in as we begin rate development for the next year.

Katy Henry: If the Board does not take action today, what is the drop dead date by which something has to happen in order to have plans ready for 2020?

Dave Iseminger: Katy, that would be next Thursday's August 1 Board Meeting. When we set the original Board timetable schedule and released it sometime in mid-2018, we had no foresight as to how long the legislative process would take during the 2019 legislative session. We prepared timetables as if the Legislature completed its work on June 30 of this year. As we all know, the Legislature got out earlier than June 30 but we had built and accommodated a system in which we could proceed with open enrollment with all the information locked in on August 1. Since the legislature adjourned in late April, we saw an opportunity to expedite getting more information out to school employees. We have a very tight timetable. Six business days is a long time when you're talking less than 50 business days to go. There is a real positive aspect if the Board were comfortable and took action today. But if you're asking what the drop dead date is, it is next Thursday. As we've gone through this past week, we've been very clear with the options that we presented to the letters that we received from carriers. If a carrier needed more time they could ask for a delay from their end for us to bring and host an August 1 meeting for you to act on them. Does that answer your question?

Katy Henry: Yes, thank you.

Sean Corry: The letter from Kaiser Permanente identifies specific parts of the RFP or other documents which we have not seen. And the argument that they make and we probably will hear them make is that the language referred to is clear enough that final should mean final. That's the essence of their argument, I think. It makes me wonder if a delay of a week might be important enough to do so we Board Members can see what the language is to get a sense of what we think was truly communicated to the carriers as opposed to what we're hearing now, which is final doesn't really mean final. Final isn't until the vote. I'm essentially asking this question of other Board Members whether

we think there's value to delaying a week on this particular vote so we can get clarity about what we have actually communicated in the RFP process.

Dave Iseminger: We can make the documentation available to the Board. There are extra things that we add onto your Board emails, like we always batch the stakeholder feedback. There was a request in January as we were going through the eligibility resolutions to see the raw feedback HCA receives in addition to the presentation that happens at the Board meeting. We've always added supplemental materials. We did provide you copies of the various letters we received from Kaiser Washington/Washington Options and Kaiser Northwest. There are those references to the RFP document and a contract provision. We haven't included them but we can certainly provide them to you.

I will say the RFP itself has been on the HCA website since last August and is still there to this day. We've known that's a very active, high interest, RFP and it sat there along with the disability procurement. Basically, every procurement we've done in the PEBB and SEBB Programs in the last year and a half has been maintained on that website, partly because we anticipated we would get multiple public records requests. The answer when we receive such requests is to go to the website. That's not trying to say the Board should go look. I'm just saying that piece has been publicly available.

Megan and I both described the nature of the description in the RFP and the contract had very broad anticipated phases. It described the legislature will do this in these months and then we'll all get together and work on these activities in this range of months. It did not get to a granular level of a week by week, hour by hour, five pm close of business on this day deadline. The contract RFP provisions cited, the RFC, which is a subset of documents within the RFP, they do not get into that granular level. We'll certainly provide them to the Board if you want them.

Lou McDermott: Angela, I'm correct in assuming that the protest component for the RFP has already been adjudicated.

Angela Coats McCarthy: Yes, it was dismissed as untimely.

Sean Corry: Can you explain that because I didn't understand.

Dave Iseminger: The letter you received invoked two potentially different processes. One was a protest of the procurement and the other was invoking the dispute resolution process under the contract. The agency has already communicated back in writing that a protest of the procurement is untimely. Under procurement rules of the state, a bidder during a procurement has five business days after the protest period after they've received a debriefing to submit a protest. That debriefing has to occur within a set number of days of the announcement of the apparently successful bidders, which as I'm sure you remember occurred last fall, approximately in September. So after we announced ASBs, there's a period in which a debriefing can happen for any carrier. From that debriefing opportunity, there's a timetable to submit a protest. Under those rules, a protest of the procurement itself is approximately ten months late at this point.

Sean Corry: Thank you, Dave. So in this case, final means final?

Dave Iseminger: I'm not sure I understand your question, Sean.

Sean Corry: Well, they have a particular number of days to act and they did not act within that period of time. There's a final date on that.

Dave Iseminger: Sean, if you're looking for how these are reconcilable, both of them are how the law is described. The procurement laws describe a specific period for a protest period and the laws of the state of Washington give this Board the authority for the final rate setting in employee premium contributions. So the law speaks as to where the various authorities are and that's how, if you're struggling with how to reconcile final may mean or appear to mean different things in different settings, it's the legal framework from which each is presented.

Pete Cutler: Dave, if I understand correctly, the essence of the situation as the HCA looks at it is to the extent Kaiser Permanente wanted to challenge or protest the RFP that the assumption is the law provides when the RFP goes out and the apparently successful bidders are selected, there's a very short period. That's for challenges of the very basis of the RFP, just the structure, whatever is wrong, it somehow doesn't comply with law. Whereas there's a separate question of when you have a challenge of is RFP being followed. Is the contract, the initiation of a contract, I'm not sure what the status is. And that seems to me is really what KP is getting at, not that the underlying RFP was fundamentally flawed from a legal point of view. From their point of view, they don't think the RFP provisions are being followed. And that kind of challenge, I assume, can be made by them now. It's not challenging the RFP per se. It's challenging whether the Health Care Authority is following the RFP.

Dave Iseminger: Pete, I'll tread lightly here. I discussed how we have communicated the untimeliness of a protest of the RFP. We have engaged in the contract dispute resolution process. There are timetables within the contract for the dispute resolution process and we have not issued, under that timetable, our next stage in that process. So we are engaged in the contract dispute resolution process but the challenge to the underlying RFP and the process that it is invoking a protest as it's defined for procurement purposes, has been denied as untimely.

Pete Cutler: I appreciate the clarification because I think that was the important difference. Thank you.

Lou McDermott: And Sean, I have a follow-up question for you. When you talked about delaying the vote, are you talking about delaying the specific vote for the Premera rates? Is that what you're interested in?

Sean Corry: You're making me commit. The answer is when I was speaking before, that's what I was talking about. That's what I meant. That's what I did not articulate.

Lou McDermott: Understand. And I think we have, as we go through our procedure, an opportunity as the resolution is introduced to move the date of the resolution, to move it to next meeting.

Megan Atkinson: If there are no other questions on the slides, the next thing in the slide deck are the resolutions. Slides 6-8 show how the single subscriber employee

contributions multiply across the tiers. We spent a lot of time on that last week. I think you are familiar with how that multiplication works.

Dave Iseminger: There are five separate resolutions before you. With one exception that I'll speak to in a moment, they are the same as presented last Thursday. The structure of them is carrier by carrier. The question before you is about the acceptance of the suite of plans and the employee premiums associated with those plans. I want to remind you as I did last week that the passing of an employee resolution inherently ratifies the underlying benefit design, as well as the service areas as we presented them at the last meeting. Your authority is related to setting the employee premiums. That's why these are structured this way. It's an up or down vote on the entire suite for that carrier.

The difference you will see is in Slide 12 – SEBB 2019-15 Premera Medical Premiums, because we have presented you numbers for rates that are different for that carrier on two different dates. We wanted a resolution that was very clear. I believe when we get to that resolution, Chair McDermott will specifically ask if there's an amendment to strike and put a different date in the resolution, if the Board wants to, for example, insert July 18, 2019 and adopt the rates that were presented last Thursday instead of this Thursday. We wanted to at least present the syntax of it and the parliamentary process will exist to be able to go through amendments, motions, and changes.

Sean Corry: Dave, thank you for that. A question for clarification. At that point, I'm asking for a suggestion, actually if we were to agree to wait for one week on the particular issue we've been talking at great length about, the Premera submission, would it be at that point that we would move, second, and vote on the delay of that particular item?

Lou McDermott: Yes. I will read the resolution, ask for a motion to adopt, and a second. I'll ask for public comment, comments from the Board until we're prepared to vote, and then we'll vote.

Premium Resolution SEBB 2019-12 - KPNW Medical Premiums

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

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

Susan Mullaney: Mr. McDermott, I respectfully request to be recognized by the Chair to address the Board on the 2020 premium resolutions and process. Thank you. Mr. McDermott and members of the School Employees Benefit Board, I'm Susan Mullaney. I serve as President of Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Incorporated. That's a mouthful. Both carriers are honored to provide care and coverage for over 62,000 teachers, administrators, and staff, as well as their families in public schools around Washington State. And we are committed to continuing to serve as their trusted provider and partner for many, many more years to come in the SEBB Program.

Why I'm here today, I wanted to be here personally, it's a simple one. I'm here to express Kaiser Permanente Washington's deep and significant concern with and objection to an eleventh hour radical departure from the established process to which all bidders were obligated to follow. That process aberration allowed Premera to submit rates after the deadline established by the Health Care Authority procedures. I can tell by now, I think everybody's read the letter that I submitted so thank you very much for taking the time to do that.

Briefly, in extensive materials, I want to talk about process. In extensive materials and communications from the Health Care Authority, each bidder was directed to submit the most favorable terms it was capable of providing for the benefit of school employees and their families. The HCA and the successful bidders -- so we submitted our final rates June 19. Not July 17, June 19. And bidders entered into contracts on or by July 3. Final rates were confirmed on July 11 by the Health Care Authority to Kaiser Permanente Washington, and to the best of our knowledge, and I think it's been confirmed here this morning, to the other successful bidder. That was July 11. We submitted our final rates June 19.

In the SEBB Briefing Book published on Monday, July 15, those previously private rates were made public in preparation for the July 18 SEB Board meeting. That was proper procedure as it gave the public, including teachers and other school employees via the SEBB website, the fully vetted and HCA analyzed rates and enabling public awareness and comment. Presenting the rates to the public on July 15 also informed the contracting plans for the very first time of other plans' best and final rates. So this is the first time that any health plan saw another health plan's rates. And if we understand it correctly, only after Kaiser Permanente's rates were made public, did Premera then quietly communicate to the Health Care Authority on Wednesday, July 17 that it wished to revise its final rates. Nevertheless, at the July 18 SEB Board meeting, we were all told that the rates that were presented in the July 15 SEBB Briefing Book would be voted upon by the SEB Board at today's Board meeting.

Unfortunately, in what we believe is a plain violation of contract and the basic notions of fairness and integrity in the public contracting process. Outside of public view, Premera's late altered rates were presented to this Board behind closed doors. As you might imagine, when we learned about this after the fact, we objected to this subversion of the contracting and public review process. Let me paint this in simple terms: despite clear protocols that guarantee that all bidders would have equal opportunity to develop and submit their best and final offers without knowledge of their competitors' bids, Premera was permitted to see our rates and then submit changes that would be to its advantage. I think it's curious that their rates came down so much and they are within a dollar, if you look closely, they are within a dollar of our rates. I've heard an assertion that the late submitted Premera rates would also provide savings to the state and school employees that would've been unavailable had Premera not been permitted to submit late rates.

So the process is one thing and I've covered that. But then there's also, it sounds like, the question of, "wow, this is worth so much money. How can we not look at it?" There are no savings to the state. I want to be really clear about that. Why is that? The state is using a defined contribution approach that was walked through earlier this morning

based on the UMP benchmark plans. The defined contribution means that the state is fixing what it will pay at a maximum dollar amount on the basis of a formula. Prior to Premera's amended rates, that defined contribution was $555 for a single employee per month for all plans. With Premera's amended late rates, none of their rates come in low enough to affect that $555 contribution on the state's part. So therefore, the state would still pay the same amount per employee, that $555 rate, regardless of the amended rates. That's true for all employee coverage tiers. So I want to be crystal clear, the state does not save any money.

As for school employees, real people who need access to affordable, high-quality health care, the bidding process already produced a number of affordable health care options available to school employees and their families at similar benefits. Here's an example: if I'm a single school employee, the original rate submissions included seven plan options for me priced at $50 or less a month. Of those seven, three plan options are actually priced at $25 or less. If I'm married with a family, there are also seven health care options priced at $150 or less per month. None of Premera's proposed new rates would offer a less expensive choice to me than what's already available in a UMP or Kaiser Permanente plan. And because the large provider networks offered under the states in Kaiser Permanente's PPO plans, with most of those options, it's very unlikely an employee would need to change providers, which I think is also another important consideration when selecting a lower cost plan other than Premera's.

These are massively important technical details. That's why I'm taking the time today to walk you through this. But I'll take a step back, though. What matters as much, so there's the money issue, all right? So the state doesn't save money. A real person already has really good options. Premera's new rates don't change that and they are also enough options out there with a broad enough network that a real person wouldn't have to change providers to gain access to those lower rated plans. But what matters as much as that is the integrity of the process and you've all discussed that at great length this morning. So you, this Board of directors and the Health Care Authority are leading a brand new process. You know, it is a momentous occasion. And with that, you carry such a significant burden and responsibility to make sure that this process is airtight. And I agree with the comment said earlier that you're setting a precedent. You are setting a really important precedent with following a process that from our perspective was really well laid out. We know that a lack of process integrity could undermine the trust in the entire program, in this entire new program. Process matters.

If the SEB Board were to endorse this radical departure from the established process, I'm really concerned that future bidders would be deterred from entering the process, diminishing competition, and driving up costs. You know, to some of the points made earlier, where does the process begin and end? Is it actuarially sound? Could I show up today and say, "Hey, I've got a lower rate." You know, we put our best foot forward. We submitted rates in mid-June. We did a lot of work on that. And that will stand up to actuarial test for sure. Me, personally, I don't think I'd feel comfortable with a 24-hour turn cycle changing rates so dramatically. So that process really matters. Does final mean final? In our eyes, final meant final when we were notified these were final rates. And now they're coming to you.

Public scrutiny of the bids and rates will diminish if the process is not adhered to. Undermining the benefit of a largely transparent process, I think that matters a lot. A

transparent process where members of the public and affected employees can have a meaningful say in its outcome, meaningful access to transparent, vetted rates, and a meaningful say in its outcome. Kaiser Permanente, we have served school employees as our valued customers, patients, and partners in this state over many years and in Oregon, over many, many years. We would not engage in -- I want to be really clear about this -- we would not engage in or ask SEBB to countenance or support this kind of gamesmanship, which ultimately hurts a thoughtful and deliberate process designed to get the best and most effective health care services for school employees. We would not ask that of you.

The good news is that there is a way to correct the procedural problems and reestablish fairness into this process. The SEB Board, you as this Board, have the ability to approve the rates originally and timely submitted with the July 15 SEB Board Briefing Book. Those were the rates that followed the prescribed process that was really well laid out by this very hardworking HCA team. You guys have worked night and day to bring this to life. That was really well laid out. Those rates have been reviewed for actuarial soundness and they offer to the employees of our schools a wide variety of affordable options for excellent care and coverage. So we respectfully request that this Board take that action today clearly and decisively. My team has prepared, and I will now provide you with a motion to accomplish that outcome. I'll give this to you David since you're running the show here. So there you go.

I trust, especially after hearing this really thoughtful discussion, and after seeing the incredible hard work that was put in by this great HCA team, this Board will take the necessary actions to guarantee that procedural integrity is assured in the SEBB Program so teachers, administrators, and staff of our public schools can have confidence and trust in the system that provides their health care and coverage.

Mr. McDermott, I really want to thank you for you giving me this opportunity today and for the thoughtful discussions that we've had. I really appreciate that and for all the work that your team has put into this process. It's been a lot. And I want to thank this entire Board for all the work you've put into this process and for setting up SEBB. That's huge. And I really want to thank you for listening to me this morning and thoughtfully hearing Kaiser Permanente's point of view. And I'll conclude there.

Lou McDermott: Thank you, Susan. Are there more comments from the public?

Doug Nelson: On behalf of Public School Employees of Washington and our 30,000 members, several thousand of who are on Premera currently and will be on Premera, we're looking for the lowest premiums possible for quality health insurance. It is absurd to me that process issues are getting in the way of providing the lowest cost insurance to my members. I urge you to approve the Premera updated rate. If Kaiser needs more time to come up with another competitive offer, they should. I have negotiated with school districts for decades who told me this is their last, best, and final offer and I think that's interesting, but we think you can do better. All that is happening here is a very competitive market with a strong interest in providing quality health care at the lowest cost. I urge you to approve updated Premera rates. Thank you.

Lou McDermott: Any comments from the Board?

Pete Cutler: I just want to confirm, we're on Premium Resolution 2019-12. Will we have a chance to make comments specifically on the Premera resolution later?

Lou McDermott: We are going to follow the same exact procedure for each resolution: public, Board, opportunities to amend or modify the resolution.

Pete Cutler: Okay, because I will have comments at that point but I have no comments related to the Kaiser Permanente Northwest medical premium motion.

Voting to Approve: 9
Voting No: 0

Lou McDermott: **Premium Resolution SEBB 2019-12 passes.**

Dave Iseminger: I just want to pause for this historic moment. You now have medical plans in your SEBB Program!

Lou McDermott: **Premium Resolution SEBB 2019-13 - KPWA Medical Premiums.**

Resolved that, the SEB Board endorses the Kaiser Foundation Health Plan of Washington employee premiums. Is there a motion to adopt?

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: **Premium Resolution SEBB 2019-13 passes.**

Premium Resolution SEBB 2019-14 – KPWAO Medical Premiums

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

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: **Premium Resolution SEBB 2019-14 passes.**

Premium Resolution SEBB 2019-15 – Premera Medical Premiums

Resolved that, the SEB Board endorses the Premera employee premiums as presented at the July 25, 2019 Board Meeting.

We're at the Premera resolution. Do any Board Members want to make a motion? I think the options before us are we can vote on the former premiums, we can vote on the new premiums, we can vote to delay the vote until August 1. I think those are the three permutations.

Sean Corry: I would like to propose a motion that on this particular resolution SEBB 2019-15 we delay consideration and voting on this resolution until next week's meeting.

Lou McDermott: There's a motion to move the vote not specifically to which rate set but to move the vote to next Thursday.

Sean Corry: Yes, thank you.

Pete Cutler moved and Terri House seconded a motion to delay the vote on Premium Resolution SEBB 2019-15 until the August 1, 2019 SEB Board Meeting.

Julie Salvi: Good morning. This is Julie Salvi with the Washington Education Association and I was holding my comments until you got to Premera. I want to start by recognizing the work of the Board that you've done over these many months and clearly you are taking your jobs very seriously and I appreciate the due diligence that you have. I don't have an objection to delaying the vote but I did want to share our perspective on some of the things we've heard today, and the rate considerations going forward.

I certainly recognize why Kaiser Permanente would feel the way they do. In the end, I represent members who work in K-12 education and who are going to want to see the best deal possible on every plan. We have members who are loyal to Premera. We have members who are loyal to Kaiser. This is a new system for them. There is a lot of skepticism out there among many members that this may not be the best deal for them. And to see a Board pass on an ability to get lower rates would not be well received by my membership and would add to that skepticism.

Things that I heard today include, this was within the scope of a fluid process. Maybe it is not the norm. It is highly unusual. It is unfortunate that it happened that way but that it was within the bounds of what could happen because you had not formally adopted rates yet. I also heard from HCA -- or I did not hear -- any alarm bells being raised. I heard that they asked questions about the rates. They did their investigation. They are not bringing forward to you any major concerns at this point. It was not an ideal process point but it is something within the scope of what can be done, and within the bounds of what might be considered reasonable in terms of rates.

You are standing up a new and very large system. It's gone pretty flawlessly over time. This is the first bump in the road. I appreciate that you've asked serious questions and taken time to consider this; but in the end, I would recommend that you accept the rates that Premera has put in for the July 25 Board Meeting. Thank you.

Wayne Leonard: I just want to understand, or be clear what we hope to find out in the next week by August 1, if we delay the vote.

Lou McDermott: Well, Wayne, I think you're asking a good question. I wondered myself the same thing. I do not believe the dispute portion of the contract, which is being invoked, will be resolved and remedied by August 1. We have already adjudicated the protest. That has been denied so additional information would be, if the Board Members want additional information that they want to study and evaluate and review to make their decision by next week, or further contemplation from the agency's perspective. I don't know what other work we're going to do between now and then.

We would not have brought the rates from a finance perspective until those conversations with the carriers happened, questions were asked. It was pressure tested. So I don't know the answer to your question. I believe others do though. Others have feelings about that.

Dave Iseminger: I always struggle with whether I should say something in public or Board comment, but it's a point of clarification inquiry. If the Board feels it wants to see the contract, the phrases, parts of the contract in RFP, we could recess, pull that together, give it to you, put copies on the table outside. I can move the member experience presentation to your August 29 meeting. I am presenting that as an opportunity, if you wanted to exercise it and felt that would give you the information you're looking for. I'm not positive it would or wouldn't, but we could push that item to the next agenda and give you space within the confines of this meeting as well, to review it and we could put copies on the table for the public as well, and email it to the Board Members on the phone. So just a point of clarification inquiry.

Lou McDermott: We were finishing up the public. Wayne chimed in. So now we're on Board discussion. Unless there was somebody from the public on the phone who didn't have an opportunity to speak up, feel free to do that. But we're now at Board discussion. So folks are free to make comments or ask questions.

Doug Nelson: This is Doug Nelson from Public School Employees. So we just want to go on the record of opposing a delay for the very reason that Wayne was bringing up. What is it you need to make the final decision? I agree it's a tough decision for you. However, you're talking about $35 million in premium decreases that you're possibly going to turn down. If you're going to possibly turn that down, you better have a very good reason. And if you don't have a strong direction why you don't vote for it today, I'd like to know what it is. What is it you need to make that tough, final decision? Your Attorney General has said it is approved for you to make this decision today on the updated Premera rates. Your Attorney General says it's okay. So we urge you to do it today, get it done so we can build SEBB for 2020. Thank you.

Terri House: Okay. So my seconding Sean's motion, I'm wondering if giving the additional time, would that allow Kaiser to revise rates?

Lou McDermott: It is my understanding, we have given Kaiser the opportunity to take this additional time to revise the rates and Kaiser is standing on their current rates. They did not invoke that request and ask for additional time. So I don't know if the answer would change if we didn't vote today and we went back to Kaiser and asked if they were really sure. I don't think it would change.

Terri House: Can I piggyback onto my question? If we vote no on the motion that's on the floor right now, then we just turn around and vote on the resolution today, correct?

Lou McDermott: That is correct. And there would be another opportunity, just to be clear, to vote on either rate set. We could vote on the old rate set or the new set. That's a change that can be made as well. So this vote right now, we're at the Board discussion component. The next will be a roll call vote. If you vote yes and we have five votes then we will delay the Premera vote until August 1. If we have less than five then we will not.

Terri House: Thank you.

Pete Cutler: In terms of what information would be useful, as I pointed out earlier, we do not have specific information about the actuarial assumptions that Premera changed and I come back to the fact they made those changes under very short notice. They've given a verbal representation that had to do with plans that they had all along. But frankly, we've also had nothing that explains why they twice got written communication saying these are your final rates or once saying send us your final rates and then after they did saying these are your final rates. Why they believe the process allows that basically to be thrown out as immaterial.

It's looking at the contract language, I mean, I believe that actually, either the Health Care Authority or Premera should bring the contract language to the Board and the RFP process and show how much flexibility it provides. Therefore, it's Kaiser that's unreasonable in assuming that those rates were final when they were called final rates.

Frankly, based on information I have so far, and based on the information that's been provided by Kaiser in their letter, all the facts they laid out, all the specific representations and the fact that there's been nothing in writing from Health Care Authority, or anybody else that refutes those facts or those representations, like I said, nothing in writing, as a Board member, I can't see how I could come to accept the revised Premera rates for the two basic reasons laid out in the Kaiser Permanente letter back from July 22.

One, I don't have enough information to be confident that those revised rates are based on sound actuarial assumptions. And secondly, accepting rate changes after carriers have submitted their final rates and after those rates have been made public would undermine the integrity of the whole contracting and rate-setting process. While that would be very politically popular, it doesn't make it right and it's not fair to, in this case, the other carriers involved. And I think that, with all due respect to the others who have spoken, I think the integrity of the rate-setting process is very important to building stable long-term relationships with carriers. And I think going for a short-term financial gain at the sacrifice of integrity in your process would be a bad decision.

I'm happy to give support to the motion for giving another week to collect more information, and Lord knows, maybe I will see things I haven't seen so far and change my mind. But at this point, I have to admit, that integrity issue is so important, I don't really see that it would make much of a difference. Thank you.

Sean Corry: I'd like to second what was just said. In my view, seeing the words that have been referred to in the letter and in our discussion is important to me to judge how clear or unclear final really means. It's that information that I'm particularly interested in seeing. I think considering this and considering what Pete just, I'm definitely in favor of a one-week delay for this little extra task to make sure that we're acting properly as a Board in a responsible way. Thank you.

Katy Henry: I don't know that we're going to get information that will change my mind but in trying to be collaborative in working with the Board. I'd be willing to support delaying it so that you can have more information in helping you determine what your final decision would be. I will have to state that representing the voices of almost

90,000 school employees who are very fearful about this transition, it would not be in their best interest, I think, for me to say no to lower rates because that will help them. They don't have all this background. Many of them won't look deeper to know what has been going on at the Board and to see how we arrived at this. They will just see how much plans are going to cost and what the plan benefits are. And while I share and I think the questions that you have all asked today bring up a lot of wonderings in my mind, that still holds as my top priority. That's where I am. But I can support waiting so that there's more information for the Board to look at.

Alison Poulsen: I think as Dave has done a great job of explaining the journey that we were going to be on, it's pretty incredible how smoothly things have gone. At this point, the integrity with which Kaiser has put forth their information is to be commended. I think anytime you have some level of interpretation, others could interpret differently, and I feel confident that a better price point for members to have a choice is in the best interest of what is going to make our state healthier. There is no more information that would be provided to me that would change how I'm ready to vote. So while I would appreciate the thoughts that Katy had about being collaborative, I think we are delaying a vote that is maybe not necessary.

Wayne Leonard: I would echo some of Katy's comments. At this point, I've probably heard enough to vote, but I would be willing to defer to other members if they would feel more comfortable waiting a week. As you all are probably aware, I've had, over the last year or so, a lot of concerns about the cost of the SEBB Program to the employer, to the state, and how school districts would be able to afford it. I'm concerned about the integrity of the process the last, the eleventh hour submission of this. Essentially, I agree with pretty much everything that the KP representative said about the process. But I'm really having trouble with saying that we would not accept lower rates that would benefit school employees. Having said that, I will probably vote for the motion to delay a week.

Lou McDermott: So, my two cents. I think we're coming down to an issue of do we have some technical issues. Is it actuarially sound? Is it viable? Are we going to have increases next year? I think those discussions by our finance team, by Megan, she did a good job articulating that. When KP came back and reduced their rates, we had the same exact questions to the point where we asked them for a rate guarantee, trying to insulate ourselves from big increases. I don't think it's hard to extrapolate out that in this moment in time, folks are trying to acquire as much market share as they can. Insurance is sticky. Once you have it, once you have your provider, it's sticky.

This is the moment in time when people have the opportunity to get their insurance, and barring any plans not being offered next year, the switching assumptions that are made by the actuaries are fairly minimal. So then we jump into trying to cost contain, trying to control those rates. Again, we asked for a rate guarantee. Premera said no way and KP came back with a number that's unreasonable. So now you get into the fairness issue. There's a technical side and then there's the fairness issue. Overlaying all this, there's a legal component, which I've been told by my AGs to stay away from. So I'm not going to dive into that. But there is the legal component that's hidden in the background.

On the forefront, we have a fairness issue and we also have a sustainability issue. And are these real rates? They're real for today. That's what we have today. They're real. That other stuff, the fairness issue, I understand that. And I understand we all, as Board Members, have our own calculous, and I understand that the vote I cast today, I am a part of the Health Care Authority, and when I spoke with our AGs and asked if I am voting for me or am I voting for HCA? She said I am voting for me. Do what you think is right. And so each of us has to do that and I love that we're all talking about it. I love that we have strong feelings about it because this is hairy. Those are my two cents and I think we're ready to vote unless anybody wants a last comment.

Voting to Approve: 5
Katy Henry
Wayne Leonard
Sean Corry
Dan Gossett
Pete Cutler

Voting No: 3
Patty Estes
Terri House
Alison Poulsen

Lou McDermott: My vote, actually, is unimportant. We have enough votes to carry the motion. **The motion to delay the vote on Premium Resolution SEBB 2019-15 – Premera Medical Premiums to August 1, 2019 passes.**

Premium Resolution SEBB 2019-16 - UMP Medical Premiums

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

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: **Premium Resolution SEBB 2019-16 passes.**

[break]

Member Experience

Rochelle Andrake, SEBB Program Communications Supervisor. Jesse Paulsboe, Michelle George, and I are here to walk you through the member experience for school employees as they prepare for their first annual open enrollment.

Slide 2 – Information Pathways. We recognize there are different circumstances and preferences that affect the member experience so we've created multiple paths for school employees to learn, decide, and enroll in SEBB benefits. The main information pathways school employees will use are online, paper, and in person. Most employees will use a combination of these methods to prepare for open enrollment.

Our online communications provide access to a variety of information on demand. The information is searchable and updated frequently as more details become available. We also provide paper communications so employees have tangible resources accessible without a computer. Even some who have frequent access to computers or mobile devices prefer to hold paper documents in their hands when given the choice. Since paper documents are physically present, they may be more noticeable to some than email. Finally, in person communications can come from anyone who knows about the SEBB Program, whether it be a benefits administrator, union representative, fellow employee, or even a neighbor or family member. These opportunities for two-way in-person communication allow employees to get customized information specific to their situation. It can also help influence decision making based on experience.

Slide 3 – Communications to date. The first communication about the SEBB Program was our toolkits. These were emails monthly to benefits administrators, unions, and associations from November 2018 through June 2019. The toolkit materials include fact sheets, infographics, articles, and posters. This allows for online or print communications to employees and provides a resource for benefits administrators to be able to address employees' questions in person. Organizations can use the toolkit materials in whatever format is effective for their employee population. We understand that some organizations began using the toolkits earlier than others; however, we've learned that the number of organizations using the toolkits continues to grow.

In March we sent an introductory letter directly to employees' homes using data we collected from SEBB Organizations back in February. For some, this mailing may have been the first time employees learned about the SEBB Program.

The *Intercom* newsletter mailed in June provided information about eligibility, the enrollment process, and what benefits will be available. It also had helpful resources about how to prepare for the transition to SEBB Program benefits. For your reference, this newsletter was handed out at the last Board Meeting.

I also wanted to mention that all communications include information about how to access our materials online and everything that we send to an employee's home or distribute as a toolkit is also available on our website. If you ever want to see anything, that's where to go.

Slides 4-5 – Upcoming Communications. In just a few weeks, we'll send a reminder postcard, which directs employees to our Preparing for Enrollment webpage and gives them information about gathering dependent verification documents. It will go out to employees' homes.

The SEBB Program webpages will be updated with final premiums, benefit offerings, and benefits fairs details no later than September 3.

In mid-September, we will mail the *School Employee Initial Enrollment Guide* to employee's homes. We will also provide SEBB Organizations with an additional supply of printed enrollment guides and forms packets, enough for approximately 20% of their eligible employee population. This will account for new employees, those who need paper enrollment forms since they won't be included in the guides, and anyone who may not have received an enrollment guide in the mail.

The in-person benefits fairs begin on September 30 and will occur throughout the state during open enrollment.

The first annual open enrollment begins October 1. On that day, employees will have access to enroll online using SEBB My Account and learn more about their benefits through the virtual benefits fairs and ALEX, the online benefits advisor.

Slides 6-9 - Member Experience Examples. We recognize people have different ways of learning and comfort levels with technology. We've created multiple pathways to get information about the SEBB Program. These are examples of how our communications can be used by school employees to help them learn, decide, and enroll in SEBB Program benefits.

Slide 7 – Online Path Example. Dave has a job with regular access to email. He receives frequent communications from his benefits administrator, including links to toolkit materials. He is curious about the SEBB Program so he visits the SEBB webpages regularly to get the latest updates. He's able to access the site from his computer, tablet, or smartphone. Dave likes self-service and convenience. He uses the virtual benefits fair and ALEX to get advice and compare benefits. Once he's researched his options and picked his plans, he uses SEBB My Account to enroll and upload his dependent verification documents.

Slide 8 – Paper Path Example. John does not have access to a computer at his job. He does see some of the printed toolkit materials and resources like posters and fact sheets shared by his benefits office. He receives mailings from the SEBB Program to his home like the *School Employee Initial Enrollment Guide*, which allows him to learn about his plan options. As he receives information from the SEBB Program, he's encouraged to use the online options available. In the *Guide*, he learns about the in-person benefits fairs. At the benefits fairs, John sees information about how to use SEBB My Account but John likes his paper. So he chooses to go through his benefits administrator to get paper forms and submit his enrollment and dependent verification materials.

Slide 9 – In-Person Path Example. Margot is a new employee hired in September. She receives her *School Employee Initial Enrollment Guide* from her benefits administrator. She's invited to attend a benefits fair with her co-workers. At the benefits fair, she sees a demonstration of SEBB My Account. Through conversations with her colleagues who informed her of how quick and easy it was to enroll online, she decides to use SEBB My Account to enroll. In addition, friends and family discuss with her about posts they've seen on social media and in the news about SEBB.

Regardless of an employee's engagement level, there are opportunities to learn about the SEBB Program through the media, which will increase as open enrollment grows closer. We've recently started boosting our Facebook posts and advertisements and we're continuing to engage with the media through media alerts, press releases, and an op-ed article that we're working on to raise awareness of the open enrollment opportunity and the equitable and affordable benefits the SEBB Program will provide.

SEBB Benefits Fairs

Jesse Paulsboe, Outreach and Training Manager. I'm going to talk about SEBB benefits fairs and how they contribute to member experience. Slide 11 – SEBB In-Person Benefits Fairs. On September 29, 2019, two teams from our Outreach and Training Unit will begin traveling across the state to conduct 20 SEBB benefits fairs between September 30 and November 7. The fairs will take place in venues located in most of the major population centers across the state. Additionally, the SEBB benefits fairs are coordinated with the following considerations in mind: the fairs will be in the evening with extended hours to accommodate SEBB Organization employees unable to attend fairs during the day due to busy work schedules.

Vendor representatives will be onsite to answer questions directly from employees regarding specific plans and benefits. HCA representatives will be onsite to assist with general questions about the SEBB Program, guidance on online enrollment, and to provide SEBB enrollment materials. SEBB Organizations may continue to host their own benefits fairs at the district and school level. While HCA will not oversee or attend the district level events, we'll continue to assist the Organizations by providing vendor points of contact upon request should they wish to invite the vendors to the district events.

Slide 12 – SEBB Benefits Fair Schedule. For reference, this is a list of benefits fairs.

Pete Cutler: I am a little taken aback. We have a lot of population in King County and it seems like only a smattering of benefits fairs relative to the population. But now that I think of it, surely what's relevant is the number of school employees. But still, I have to imagine there are a lot of school employees in Seattle and right around Seattle. Are you going to have more HCA staff there assuming that more employees will show up at those locations? Or how will you deal with that?

Jesse Paulsboe: We have the ability to adjust. We have staff on standby to attend if it is too crowded. We will get into different ways to mitigate the crowds. The school districts have a culture of hosting their own benefits fairs. And with 20 benefits fairs being offered by HCA, we didn't want to tell them they couldn't host their own. We've offered to provide them the information to go ahead and make that coordination, to supplement the 20 we have in the state.

Pete Cutler: It sounds like a great strategy. I would not want to hear that, in some major population center, Tacoma, Seattle, whatever, where the lines were so long that people didn't get to talk to anybody. I'd like to hear that maybe through school district sponsored fairs or whatever that everybody who wanted a chance for a one-on-one conversation in that kind of a venue has the chance to do it. That would be my only concern.

Dave Iseminger: And Pete, as we begin the benefits fairs we will get a better gauge as to the attendance of those. We are not exactly sure what to anticipate, but as we get real time feedback from the first couple of benefits fairs, we'll be able to adjust.

Jesse Paulsboe: Slides 13-14 – Virtual Benefits Fair. In addition to the in-person benefits fairs, we're in the process of developing the SEBB virtual benefits fair (VBF). The virtual benefits fair is an interactive online website created with the same goal in

mind as the in-person benefits fairs: to make learning about benefits and plans available to subscribers and their families easy and user friendly. The VBF, as we refer to it, offers 24/7 access to SEBB Program benefits' information from the convenience of the subscriber's home or desk.

Slide 13 is a very early prototype of the site. It's designed to emulate the appearance of an in-person benefits fair. The visitor first enters a central lobby where they are presented with an introductory video that orients them with the virtual benefits fair environment. From the lobby, the visitors navigate into a virtual benefits exhibition hall where each vendor has their own booth to display plan options and other helpful resources. Each vendor booth contains videos, digital brochures, marketing materials, the summaries of benefits and coverage and the certificates of coverage for the subscribers to peruse. Additionally, each booth has the ability to hyperlink out to the vendors' microsites should the subscriber desire to see more specific offerings in greater detail.

Slide 14. If visitors seek additional assistance, the virtual benefits fair offers single click access to ALEX, the online benefits advisor. In addition to your computer or laptop, the virtual benefits fair will be optimized for mobile devices. The entire SEBB Program initial enrollment experience, from learning about benefit options to enrollment in SEBB My Account, can be completed on a smartphone or tablet. The virtual benefits fair will go live October 1, 2019.

Sean Corry: In looking at Slide 14, will this be available to anybody? Do you have to sign in as an employee?

Jesse Paulsboe: Anybody can access the site.

Pete Cutler: My guess is that you are engaging in significant user testing so when on October 1 it won't be the first time it's been stress tested in terms of what if everybody shows up at the same time.

Jesse Paulsboe: That's correct. Our IT department is involved in the development process and load testing for the virtual benefits fair site. It is in accordance with the same standards we're doing for the SEBB My Account site.

Dave Iseminger: I do want to highlight one thing because it's come to my attention in a couple of different venues. The second bullet, Optimized for mobile devices. That is also true for SEBB My Account. I've heard that there are instances where a school employee might have an experience where the interaction they have with their district starts in electronic form but then ultimately, they have to sit at a desktop because they can access it electronically, but they can't complete a process unless they're at a desktop. People will be able to use SEBB My Account on the virtual benefits fair on as big or small a phone as they have, as big or small a tablet they have. They could be at a desktop. It is optimized that way.

I've heard there are a lot of school districts appreciating that optimization for mobile devices. They are starting to think creatively about how they can help facilitate open enrollment. Like going to a bus depot station during a break period or that time, between shift one and shift two routes and sitting with people and walking through and

having a mini benefits fair and enrollment experience with staff right there. I wanted to highlight for the Board, and for the record, that everyone will be able to use SEBB My Account and the virtual benefits fair on their own devices. And it won't have the scalability issues that sometimes happens on websites. It is optimized for that use. We're really proud of that.

ALEX Online Benefits Advisor

Michelle George, Communications Manager, ERB Division. Slide 16 – Background. I am going to talk about the ALEX online benefits advisor. The Health Care Authority procured for an online decision support tool to help school employees learn about their SEBB Program benefits and advise them about their health coverage. HCA selected Jellyvision, which provides an interactive state-of-the art benefits communication software. Their ALEX online benefits advisor does two things: it educates users on the different benefits offered and how they work. It also recommends plans based on the user's preferences on cost and how they use health care. By responding to ALEX's questions, employees can make informed choices so they know how their plans and benefits work before they choose to enroll.

Slide 17 – Purpose of online benefits advisor. The purpose of the online benefits advisor is twofold. First, we want to provide an experience that could help our new members and their families learn about SEBB Program benefits 24/7 at their own pace in an easy to learn, fun way. We also wanted to avoid placing an undue burden on the payroll and benefits offices in helping their employees learn about SEBB Program benefits at the same time that they were learning about them.

Slide 18 – Who can use Alex? School employees enrolling for the first time during the SEBB Program's first annual open enrollment, as well as newly eligible during the school year who need to enroll in benefits within 31 days. Another benefit is other family members can use ALEX to make or influence the enrollment decisions in the SEBB Program. ALEX will be available starting October 1.

Slide 19 – What can ALEX do for employees? Say I'm a school employee who doesn't have time to read all the information about my SEBB Program benefits. I can go online and use ALEX to help me understand both the benefits and the plan choices available to me. ALEX can provide me with plan choices available to me as well as a comparison tool to help me understand how the plans work and the differences among the plans as well as make recommendations about which plans may be best for me based on my preferences. Using ALEX has been described as sitting down with a really friendly guy who knows a lot about benefits and can pretty much answer all of your questions and help you make a selection.

Dave Iseminger: I know when we presented the service areas last week, it can get complicated fast when you're looking at those various charts. ALEX will only show you what plans are available for you just like SEBB My Account. When you go into SEBB My Account, the logic populates only those plans that meet those various criteria we talked about last week.

Michelle George: Slide 20 – How SEBB Program will use ALEX. ALEX will be a 24/7, easy to use interactive tool. HCA will use ALEX and its member communications to

promote it. HCA will also link to ALEX from SEBB My Account and the virtual benefits fair that Jesse talked about, as well as other SEBB Program webpages to make sure it's very easily accessible. People will see "Ask ALEX" throughout our website, including SEBB My Account and the virtual benefits fair.

Slide 21 - How does ALEX work? A simplified demonstration of ALEX shared with the Board for illustrative purposes. The SEBB Program's ALEX tool will determine specific plan recommendations based on how the SEBB Program plans work, the actual cost, such as premiums and copays, and access to providers. The SEBB Program can also tailor the questions used in ALEX to add questions not shown in this demonstration or to remove other questions to better advise users on how to select a plan available to them.

[ALEX Demonstration]

Sean Corry: I'm easily confused and so I might be different than others. In some parts of the demo the first few choices were about you, what do you want, and in small print it says something about family. I'm guessing that some people are going to think that you're talking just about me and not about the dependents? It was confusing to me.

Michelle George: The text might need to be more prominent.

Sean Corry: Just to make sure you know who ALEX is actually speaking about. It says, "You're looking for you and your family." It didn't say that before.

Pete Cutler: Did your attorneys sign off on having a software program where you actually recommend which health plan they should go into? In the past, that was considered high risk to get to the point of actually recommending.

Michelle George: One of the benefits of ALEX is it doesn't usually recommend one plan specifically. It will suggest a few plans. It will help you, when it comes to the benefits comparison and the cost comparison, showing you those different costs among the plans to help you, based on your preferences.

Pete Cutler: Does it also come with a disclaimer early in the process of whatever decisions you make really are yours?

Michelle George: I believe that's in the acceptance agreement at the very beginning.

Pete Cutler: Okay, thank you.

Lou McDermott: Pete's referring to the fact that the PEBB Program, for many years, was very agnostic towards plans that it was very dry and technical. Here are the copays, here's this, here's that. In recent years, we have expanded that to try and help employees understand based on their life circumstances what plan may be more favorable for them. If you have kids in college and they're on your plan, having them in the Uniform Medical Plan Classic, which we have a global presence, is better for you. So, yes, that is something, Pete, we have tried in more recent years to not push plans but guide members to plans that, based on their life circumstances, would be better for them. It's something that's been explored with our attorneys.

Pete Cutler: I want to be clear. I think it is very helpful to the members. I think it is a very complex area. I know there are certain legal risks, depending on whether there's disclaimers or whatever. But as long as you've worked it out with the AG's office or whomever helps you with that analysis, I'm sure it's fine.

Michelle George: Slide 22. ALEX also asks members about their experience using it. Jellyvision offers a data analytics tool that provides the Health Care Authority with real time snapshots of employee engagement with ALEX, including which plans are being explained and highlighted the most. It also compiles employee feedback that lets us know how they feel about their experience with ALEX. Users who choose to answer a survey after using the ALEX tool will have their answers retained anonymously and made available to be used in aggregate form to report on the user experience.

In addition to the survey results, ALEX collects information about things like total visits to the site, the duration of the sessions, what type of device or browser is being used, the plans being discussed and the plans recommended to be able to report on how users are engaging the ALEX tool. All of this data is stored anonymously so it cannot be associated with any one individual.

Slide 23 – How ALEX handles users' privacy. ALEX ensures that the collected answers are limited and do not directly identify any one individual. It does not store or share any personally identifiable information or any protected health information. The data shared with HCA will only be anonymous and in an aggregate form. Any aggregate data collected and stored by ALEX is encrypted both in the transmission and storage.

Slide 24 – Other employers use ALEX. There are other large employers who have used ALEX with great success such as the Oregon Health Authority, Teacher Retirement System of Texas, the Commonwealth of Virginia, the state of Rhode Island, and Princeton and Harvard Universities.

Pete Cutler: With Oregon Health Authority, do you know do they use it with their Public Employees Benefit Board?

Michelle George: Yes.

Pete Cutler: -- Oregon educators?

Michelle George: I don't know about educators. They do use it with their public employees.

Pete Cutler: Definitely with PEBB. Okay, great.

Public Comment

Brian Simms, Washington School Directors Association (WASDA). I was watching the meeting from home thinking this is going to be boring. It certainly wasn't. [laughter] I threw a jacket on and came down because I want to make one comment about the rates. Are the revised Premera rates legally and contractually appropriate in front of you? If they are, I believe you really have to adopt them. And the reason for that is I think, just as we saw the last part of this meeting, the open enrollment process, if we

end up in court over this, that's going to be what gets jammed and you'll have hair on fire for the HR people in the school districts. Families will be worried about continuing coverage for critical care, all that kind of stuff. I think it's really a legal question for you and you may have to get briefed on that next week in Executive Session. The rates aren't so far out of line that there'd be an actuarial issue. They're really in sync with a lot of the other ones. Are those revised rates legally and contractually and according to rules in front of you? I don't think fairness is the issue. I think it's a legal matter. And I just hope that gets resolved clearly so we don't end up in court and we don't end up jamming the implementation of SEBB. Up until late December, WASDA has advocated for this for over a decade and we're looking forward a smooth transition. Thank you.

Lou McDermott: Thank you. The next Board Meeting is August 1. On a personal note, I will be in Central Oregon next week on vacation with my family so I'm trying to figure out if I'm coming back the night before, the day of, how that's going to work. There's no way I'm going to let you cross across the finish line without me. So I'll be here. I've got to negotiate with my spouse [laughter] as to when I depart. If I come back the night before, I'll probably ask Dave to make the meeting earlier. If I come the day of, probably a little later. We won't know that until I get home tonight. [laughter] So we'll keep everyone informed.

The last part is, I want to make sure all the Board Members have the documentation or information they need so they are prepared to vote next Thursday. Dave, I don't know if we want to collect that here publicly, if you want people to ping you and you send it all out? I don't know how you want to handle that today.

Dave Iseminger: Well, the interesting thing, Chair McDermott, is we will be trying to get you a Briefing Book as fast as we can. We have historically tried to get the Briefing Book to the Board the Friday before. That has not always been the circumstances. As we sit here at noon on Thursday, I'm not sure exactly if you'll get your Briefing Book tomorrow or Monday. I know of a few things the Board has specifically asked for. I can outline a few things that I know you're probably interested in and we'll evaluate what can be shared with you and whether or not there's pieces that need to be in Executive Session or not, so stay tuned.

This isn't a complete commitment of a list of things, but these are things I think you're interested in and they're on the evaluation list, so to speak. I think you're interested in having the parts of the RFP contract, RFC that were cited in KP Washington's letter. You are interested in whatever information we may or may not be able to share about actuarial comparisons or trend comparisons among the different parts of the portfolio. I'm curious if people want to populate this list a little bit more now. I'm sure you'll walk away and think of something as soon as you enter your cars. You can always drop me an email and say please add this to the list.

Pete Cutler: What occurs to me, I'd like to see what letters or emails were actually sent to the carriers saying, "Submit your final rates," or whatever that was.

Next Meeting
August 1, 2019
9:00 a.m. – 11:00 a.m.

Preview of August 1, 2019 Meeting

Dave Iseminger: Usually I do a preview of the next meeting but I think everybody knows the agenda will have one agenda item, action on Premium Resolution SEBB 2019-15.

Meeting adjourned at 12:07 p.m.

Washington State Health Care Authority

D R A F T

School Employees Benefits Board
Meeting Minutes

August 1, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 11:00 a.m.

Members Present
Pete Cutler
Terri House
Patty Estes
Wayne Leonard
Lou McDermott

Member on the Phone
Katy Henry
Sean Corry
Dan Gossett
Alison Poulsen

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.

TV Washington (TVW) is livestreaming our meeting today. You can watch at WWW.TVW.org.

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

Approval of April 10, 2019 Meeting Minutes
Terri House moved and Pete Cutler seconded a motion to approve the April 10, 2019 SEB Board Meeting minutes as written. Minutes approved by unanimous vote.

July 25, 2019 Board Meeting Follow Up
Dave Iseminger, Director, ERB Division. There are more and more people viewing the SEBB Program website pages. I wanted them to see the suite of benefits worked on by

this Board and the Health Care Authority, through the procurements for the last two years, and anything that could continue to get this information out. Slides 2-9 are an overview. These documents were provided multiple times. I want to keep repeating it to make sure you have access to it. I also wanted to make sure you had it handy today in case there was any need to refer to benefit design. All other questions will be handled in the next presentation.

2020 Premium Resolutions Continued

Megan Atkinson, Chief Financial Officer, Financial Services Division. I've asked Ben Diederich, with Milliman to join me today. Ben's the lead on our actuarial team. There was quite a bit of conversation last week, some of which got into areas around the actuarial underpinnings of the rates, our rate calculation, and our rate development conversations that occur. I've asked Ben to be here to walk you through some documents and then possibly answer questions you might have that go outside my scope of understanding.

Slide 2 – Employee Premium Contributions – Medical. We will walk through the employee premium contributions still awaiting action. You took action last week on the full suite of the Kaiser Permanente offerings, as well as the Uniform Medical Plan. We still have the outstanding Premera resolution. You know where we are in the story, we have two different rate offerings from Premera, those presented to you on July 25, shown on Slide 3, and those presented on July 18, shown on Slide 4.

Slides 3 and 4 are formatted the same. The only changes are the rates from Premera. Slide 3 are the rates presented on July 25. Slide 3 are the lowered bids they presented. The first table is set up to show the Single Subscriber Tier Employee Contribution; the Employer Medical Contribution (EMC), which benchmarks off of our UMP Achieve 2 Plan; and the Proposed 2020 Total Composite Rate. We've been through these tables many times. I think you are familiar with how the math works, so I won't belabor the point. On the lower half of Slide 3 is focusing on Premera's offerings, how the employee contributions vary by tier. Slide 4 are the rates presented on July 18.

The only difference between Slide 3 and Slide 4 is the total composite rate, which impacts the employee contribution. The employee contribution goes down as the total composite rate goes down.

Slide 5 – Rate Comparison. This slide is transitioning to bring forward information to address the concerns from our conversations last week and questions we received. We have spent quite a bit of time over the last week going back into the data we have available. Looking at the entire suite of data points we have, pulling from that data and trying to come up with visual representations of the data, to both help you understand more about the rate development process, as well as understand the plans relative to each other, and were there significant diversions that occurred.

When we do rate development, we ask the plans for quite a bit of information. The vast majority of that information is proprietary and confidential to the plans. While we receive that information, and it is information that Ben and his team can use in assessing the rates and assessing the carriers' offerings, it's not information we can share. What we do per the statute is we allow the carriers the opportunity to designate things as proprietary and confidential and we respect that designation.

As we were looking at the information we have, and preparing things to bring forward to you today, we went back to each of the carriers and asked them to redact what they did not want shared publicly.

The table on Slide 5 was an attempt to show how the rates change from the point in time, I believe it was back in February, that we received the Not-to-Exceed (NTE) rate, and then the ending point of negotiations with the total composite rate, as we presented on July 25, showing the rates changed over time. We had several rounds of negotiations that occurred. We have information on this slide blacked out because the carrier asked us to redact that information.

Looking at the bottom half of the table to Premera and UMP, from the point in time we got the total, Not-to-Exceed rate, and the ending point, the rates went down. I don't know if that's really that revolutionary. We would expect that. It's a rate negotiation and the starting point was Not-to-Exceed rates. You would hope they had gone down.

Pete Cutler: Megan, I'm curious how, for Premera, the Not-to-Exceed rate compared. Is it identical to the rates they were sent as their final proposed rates back in June? Or was there a difference between, so it's like a staircase, or I don't know which way it's going, but there were other changes.

Megan Atkinson: The Not-to-Exceed rates you see from Premera, if you compare those with the rates we presented on July 18, you will see they went down. It's just they went down again, to the rates presented on July 25. Does that answer your question?

Pete Cutler: Yes. I guess it answers my question. What I was most curious about was how much their rate had dropped between the rates they proposed in June and then what they proposed on July the 25, just to get a sense of what magnitude of actuarial adjustments were made in that period of time, as opposed to anything that happened before June.

Megan Atkinson: You can see in the data points here on Slide 5. Let's take one as an example. Premera Blue Cross High PPO, their Not-to-Exceed rate was $680. If you go to Slide 4, that same plan, the rates presented on July 18 went from $680 to $653. If you look at the rates on July 25, it went down to $625.

Pete Cutler: So that $680 represents what their proposed rate was as of June?

Megan Atkinson: No. The $680 is the Not-to-Exceed rate received in February. We had several rounds of rate negotiations that got us to the June rate. Then Premera submitted one more round of rates in July.

Pete Cutler: This is useful. But I also, as I indicated, the question came up, was there rigorous review of the actuarial assumptions that went into the new rates that were proposed on July 17 by Premera? And that point of analysis would have had to do with what had they proposed, what assumptions did they have underlying the rates they submitted in June versus what rates they were proposing on July 17. That's the gap I was most interested in as a Board Member, to get a sense was that 1% or 2%? Was it 4%? Was it 11%? I didn't have a sense of the magnitude.

Megan Atkinson: I think it's comparing the rates presented on July 18, which were the June rates, and the rates presented on July 25, the July rates.

Pete Cutler: Now that you mention it, that seems very logical, thank you.

Wayne Leonard: In rate negotiations or the development process, there are other things being discussed besides just the rates, correct? We've talked about the expansion of the geographic coverage area.

Megan Atkinson: Right. Wayne, I'm going to hold on that comment a little bit because it's one of the things Ben's here to walk you through. We have a rate development sheet the plans prepare and provide us. Ben and his team prepare it for UMP on each round. Those submissions come in from the plans along with an actuarial memo. The plans have their own in-house actuaries. As they submit additional bid rates in each round of the negotiations, that also comes with a memo from their actuary certifying the bids are in compliance with actuarial standards of practice. Those memos are marked confidential and proprietary. I can't share those with you, but we do receive them with a full bid sheet. Ben is going to walk you through a blank sheet in a bit so you can see the information we receive. Because you're absolutely right, we don't just get the per member per month (PMPM). We get more than that.

Lou McDermott: Ben, I think the bottom line is that as we go through rate negotiation, there's a lot of twists and turns. Things go up and down, service area, plan design, bid. On the final rates that came in, is there anything from an actuarial perspective that was alarming to you? Was there anything that was extra concerning?

Ben Diederich: No. For the first year of this program, we have a lot of uncertainty. That amount of uncertainty is going to create a range, especially within the rate development process, and that last final step that Premera took is well within the reasonable range of what that uncertainty is worth.

Megan Atkinson: Slide 6. My team has spent a lot of time this last week pulling data together and using the chart wizard in Excel trying to come up with tabular representations of the data to help you with this decision you have. Slide 6 shows a graphical representation of how the rates change from the point in time we have the Not-to-Exceed rate to the final. These are blinded out of respect for the Not-to-Exceed being marked as proprietary and confidential. What you can see, though, is the rates went down during the course of negotiations. I don't know if that's very insightful. We started with the Not-to-Exceed rate so they wouldn't have gone up. You would hope they would go down. In addition, I'll remind everyone even our UMP rates went down because as we were moving through rate development, we got an additional year of claims data. That claims data drove a reduction in our own UMP rates. It was a more favorable experience than what I think a lot of us had been carrying in our initial assumptions.

Dave Iseminger: Megan, I want to make sure it's clear on the record that although these are blinded, the scale in the underlying images is the same. They're all scaled the same. You just made five different blocks for each carrier because 19 lines on a single chart got cumbersome, correct?

Megan Atkinson: Yes. Slides 7-8 – Rate Comparison, are our attempt to distill key statistics we believe are informative when looking across the portfolio of offerings. Last week we discussed how the lower Premera rates compare to the other offerings in the portfolio. We tried several different ways to see if we could get anything informative to help answer the question Pete struggled with earlier, are these rates reasonable. Are these rates responsible if you vote to accept them? One thing we learned, when you think at the high level, all of the decision points and the information feeding into a rate development, it's a ton of things. It is the carrier's individual business model. It is the carrier's efficiency contracting with their providers and their networks. It is the carrier's own utilization statistics, their own unit cost information. Then, it's their read of the riskiness of the population. All of those things feed into the rate development. When you get into the rate development for a specific plan, you have things that vary across the plans. The benefit offerings, the deductibles, the out-of-pocket maximums. All of those things feed into the actuarial valuation of the plan, which is the fourth column on the chart, the AV column.

We didn't find any one thing that we could pull and display for you to help you assess across the portfolio of offerings how the rates are falling. The cream settling up to the top is when you look at the deductible of the plan. Remember you took action and gave us direction to standardize the deductibles on the single tier. Slide 7 is the single tier. The deductibles, combined with the out-of-pocket maximum, are statistics people can understand even if they don't have a high degree of health insurance literacy. Those impact the value of the plan to them, their own pocketbook. You can see how the employee contribution goes in those groupings. We've shaded the groupings by deductible. At the top of the table is UMP High Deductible. It's in a class by itself, with a high deductible. We've given you the out-of-pocket maximum and the AV. Those numbers are from the 2019 federal AV calculator. It has an employee contribution on the single tier of $25.

I'll walk through how the table is set up. The green shaded blocks are the plans across the portfolio that have a $1,250 deductible on the single tier. The out-of-pocket maximum varies from $4,000 to $5,000. The actuarial value also varies. It's clustered starting at 79.6% up to 83%. The employee contributions range from $13 to $39 and the last column is the bid rates. There are other key statistics about this plan design like the amount of the copay, etc. We didn't do additional statistics on variability from the low employee contribution of $13 to the high contribution of $39.

Looking at the yellow rows, the $750 deductible plans, the out-of-pocket maximum is tightly grouped. There is only one with $3,000. Everything else is at $3,500. And the actuarial values are tightly grouped, from 84% to 86%. Again you can see the variability on the employee contribution, from $19 to $70. That's a bit bigger spread.

The salmon colored rows are the $250 plans and the purple rows at the bottom are the $125 plans. Because the deductible and the out-of-pocket maximums don't scale mathematically with our tier ratios the way that employee contributions and bid rates do, we prepared this same table for you at Tier 4.

Slide 8 – Rate Comparison. The groupings aren't as clean because the deductibles don't scale in the same way. We didn't require the same deductible groupings in Tier 4.

The plans at the top of the chart have the highest deductible ranging from $3,100 to $3,700. The out-of-pocket maximums increase. The actuarial values are tightly grouped because the AVs of the plans don't change. And then there is a bit more variability on the employee contribution. You can see the math impact of the variability on Tier 1 because all of these employee contributions multiplied by the same tier ratio.

The groupings are shaded to group deductibles in the same general area, but it's not the same pure breakage by group on the deductible. These tables pull enough statistics together to help get a sense of how the plans positioned. It's not clean, however because there are many things going into the rate development. It doesn't break cleanly across the plans.

Dave Iseminger: I've noticed some confusion about the actuarial values. I want to remind the Board we presented AVs early on that had one AV number, and then there was a refresh. The AVs on these slides are the most recent. There are citations with old AVs in various documents, but I want to be very clear these are the most recent since the last time Lauren presented to you.

Megan Atkinson: Ben's going to walk you through one of our bid rate proposal templates so you can get a sense of the information we receive for each round of bids, and give you a sense of the entirety of the information.

Dave Iseminger: We will post a copy of it later with the other Board materials already on the website.

Megan Atkinson: This Excel spreadsheet is what we receive back from the carriers. There is a limitation sheet and a description about the general inputs.

Ben Diederich: This template is used for bid development and the carriers are responsible for the values they input and making their determination of how they're going to price this product. We've generally structured this worksheet combination in a manner similar to how the federal government developed the Uniform Rate Review Template, known as the URRT, that's used for the individual and small group markets.

What we're representing on worksheet one is the base period of experience and we're projecting that forward through a whole slew of factor adjustments that, at the end, gets to the final claims projection on an allowed basis for 2020 plan year. Allowed claims are the amount of claims the health plan expects the population to utilize before application of benefit design provisions. We've started with a representation of what the base period experience is going to be and we've provided a few different data points for them to consider when they're developing that base period experience. Those come from the data book we've collected of various carrier data submissions, and we've summarized, aggregated, and reported back to them as, "Here's the overall statewide data book average from an allowed cost perspective repriced to Medicare, and here is what your individual slice of that experience looks like repriced to Medicare." If they want to take and use that to represent their base period experience, they're more than welcome to or they can interject their own outlook on what they think a historical period would be.

These first set of factors take that base period experience they've entered, if it's different than the data book, and we normalize to a statewide average. These bid rates are

functioning on a statewide average basis for calculating employee premium contributions. When we get actual enrollment calculated in the spring, we will apply a series of adjustment factors to these bid rates to determine how much revenue the individual plans will receive. We're at a high level starting point of what the individual carriers are projecting the entire SEBB Program population to look like under their statewide program.

Megan Atkinson: I want to focus for a moment on column A, on the far right, the Service Category. That's breaking out the bid. The first grouping is inpatient (IP), inpatient medical/surgical, inpatient psych, AD&D, inpatient maternity. SNF is skilled nursing. The next category is outpatient. On line 23 ER; that's typically a high cost area. Down rows 30 to 32 are professional fees. Rows 30 through 37 are pharmacy. This gives you an idea of the information we get that is broken out in a more granular fashion, not just a gross per member per month (PMPM).

Dave Iseminger: I want to make sure it's clear that when a carrier submits their bid, they're bidding as if they're getting the entire population. There's not an enrollment assumption of a subset of the slice of the population. They're bidding as if they get everyone. Correct?

Ben Diederich: Correct. That's what the normalization section of worksheet one is doing. It's taking whatever population they chose to input into the base period experience and normalizing it so it represents the entire statewide population of SEBB Program. Since we're still in the base period of time, we now have the two trend assumptions to move that forward to now be the 2017-18 statewide base period experience. We're still at 100% of Medicare. One of the processes we introduced for this bid rate development was to have all the carriers submitting their data and we are repricing that data to represent what a Medicare reimbursement level would be. At this point of rate development, we can make comparisons across all bidders where everyone has the same level of unit cost reimbursement. Now we're at a base period.

Sean Corry: Megan said something before in terms of serving categories that confused me. You said AD&D, what is that?

Ben Diederich: I think there was a misquote. It's alcohol and drugs, substance abuse treatment that's bundled with psych, Sean.

Sean Corry: I see. Thank you very much.

Ben Diederich: Now we're progressing to project the 2017-2018 period into what we believe the 2020 plan year will be. We have another period of trend factors and some additional management, if they think the management of their program is going to change relative to what they reported in their base period experience. We have some seasonality that was a function of the initial data book, where we had some different periods of run out that we were trying to give them the opportunity for adjustment.

We have the reimbursement column, which is the percent of Medicare base period experience converted over to represent what they anticipate their reimbursement levels are going to be in 2020. Finally, we have morbidity shift adjustments. When they

represented their statewide population for 2017-2018, if they think the new enrollees in 2020 are going to have a different morbidity, they would make that adjustment here.

They're going to apply any area or charge adjustment they're anticipating relative to the area factors for all the rating areas we will be making adjustments for in 2020. The carriers have presumably reviewed those. If they think their own area factors are different than how we're going to be reimbursing them, they would make an adjustment to their overall bid rate so their revenue would be whole. And then we have the last sort of catch all and we ask them to itemize it.

Pete Cutler: Ben, I love getting into actuarial detail. This is great, by my standard, even if a lot of it is going over my head. Am I correct that the carriers, Premera, Kaiser Permanente, whatever, for each of their plans they submitted this Excel sheet with the data filled in and that would have been a worksheet like this underlying each of the rates that were their "final" rates that were submitted? Am I correct that when Premera submitted new rates with whatever changes?

Ben Diederich: Yes.

Pete Cutler: Okay. Was it relatively easy for Milliman to identify where those changes were and review?

Ben Diederich: Yes.

Pete Cutler: Great. Thank you.

Ben Diederich: We could see where the changes were in each of these factors listed. What we've now projected and maybe I'll clarify a little bit, Pete, worksheet one is submitted at the carrier level. This represents the aggregate average across all plans that the carrier is submitting. We've illustrated here $210 PMPM is the allowed composite across all benefit plans that they're expecting. The last few columns we gave them an opportunity in case there was something different from an experience projection they wanted to represent. They could simply blend in a manual claims cost estimate, and then credibility weight the two. The overall experience period average the $210 of projection then flows to start the starting point of worksheet two.

Worksheet two represents what the plan's specific projections are going to be. We no longer have the category of service detail on worksheet two. Worksheet two is now done in the aggregate. All of our reviews of category, service, reasonableness, and their projection of individual categories, that's done on worksheet one at the aggregate level across all plans.

Now we have plan-specific adjustments they can incorporate. There's a benefit design induced utilization factor, which is to say that one plan, for example, may have a richer benefit design relative to the portfolio at large. That plan's allowed cost is going to have benefit-induced utilization increases represented in the overall average that was short of what the dollars they anticipate needing for this individual plan. Or in excess, depending on the induced utilization factor.

The other is if they're making adjustments to covered services. If covered services are different between plans, if they're excluding some sort of specific service, they would make that adjustment here. And then the third on an allowed basis is any sort of network impact. If they're proposing a different network, they would incorporate that network adjustment within this row of factors. Then we have two other adjustments they can incorporate so the product of all these factors and the overall carrier allowed equals the plan specific allowed PMPM projection.

Now we get into the consideration of benefit design. We had a little bit of benefit design introduced in these first two factors, induced utilization and covered services, but this is the lion's share of the benefit design impact, which is the pricing actuarial value, which represents the ratio of paid to allowed for each individual plan.

Megan Atkinson: For the people following along on the telephone, Ben's moved over to worksheet two in the Excel file. He's in column D down to rows 22 to 26.

Ben Diederich: Yes, I forget we're navigating on the phone as well. Sorry about that. The plan specific pricing actuarial value is going to be slightly different than the federal actuarial value that was on the table Megan presented earlier. This is the carrier specific evaluation of what they think their particular benefit plan performance is going to be, based on their own internal modeling, not based upon what the federal government modeling is indicating off of the federal AV. We expect the pricing AV to be somewhat in line with the federal AV, but certain carriers could have an outlook on their benefit design that's different from the federal AV calculator considerations. The product of plan specific allowed PMPM in row 20, with the total plan paid adjustments in row 26, gets you to the plan specific paid PMPM in row 28.

Lastly, we have the input of the retention PMPM, which is going to get added to the plan specific paid PMPM to become the standardized premium equivalent PMPM. For those on the phone, we're still on the retention PMPM components, or the administrative costs, on row 32, taxes and fees on row 33, and the margin, or contribution to surplus, in row 34. Those total retention items then get added together to create the standardized premium equivalent PMPM.

Now we're still at a per member per month level and so the next step is to convert that PMPM premium equivalent into the per adult unit per month premium that's going to be included on the bid rate. We do that by representing what they anticipate their member months to be across their entire portfolio because we don't know how the enrollment is going to break differently across the individual plans. They estimate their total number of member months, as well as their total number of subscriber months by tier, and then the product of their enrollment by tier, with the tier factors develops the number of adult unit months. The adult unit months is going to be the same for each individual plan. We haven't allowed them to vary any sort of rate relativity at the plan level for enrollment mix. And then that conversion factor of member months to adult units then gets multiplied by the PMPM so that it converts it from a PMPM to a per adult unit per month value. This per adult unit per month value then is input into the bid rate template as the single employee rate.

Megan Atkinson: Thanks, Ben, for walking us through that. That is the rate sheet we get. As Ben clarified, we get it on every round as we move through rate negotiations. I

am hopeful that having some insight into the type of information we're gathering, as well as some of the summary statistics we pulled forward and the representation of those statistics, is helpful to you.

Dave Iseminger: Although we hadn't planned to go through the entirety of the appendix, I just want to overview for the Board and the public what is in the Appendix. Megan tackled the actuarial soundness questions that the Board had and the appendices to Megan's presentation are the various documentation referenced and requested at the Board meeting last week. Included is the premium resolution as it was presented to the Board last week and there is one word change that was recommended. If you go to Slide 10, the word “revised” was added before "Premera." We always show you wording changes from one meeting to another.

Slide 10 is the resolution we have for your consideration today. The word "revised" has been added solely because, if you look through the materials form the July 25 meeting, you see both versions of the rate and the recommendation to add “revised” would make it as clear as possible. The version presented last week is in your appendices.

The second part of your appendices are rate tables, both of the single subscriber and all the tiered levels, of all the employee premium contributions you took action on last week. As you continue through the appendices, it begins with a packet of seven letters that were exchanged between the Health Care Authority and the Kaisers, back and forth between July 22 and July 29.

The next piece of the packet is a copy of the letter I believe each Board Member received directly from Kaiser Permanente Washington and Washington Options sometime yesterday. We did go through and look at the official SEBB Correspondence email account and did not identify any other kind of advocacy or comments from the public. We have always batched those together for you when we send you the Board Briefing Book.

The rest of the appendices for the most part are the components cited in the original July 22 letter from Kaiser to the Health Care Authority. There's the Request For Proposal 2.20, as well as any questions that were asked during the procurement process related to Section 2.20.

Then the next part of the appendices is the Request For Completion (RFC). You'll note it's labeled as a "non-ASB" or Apparently Successful Bidder version. When sent to carriers, they were carrier specific, so we put in your packet the document just before making it specific to each carrier. Included is the template used to make the carrier-specific documents as we went through the RFC process. Also, there are each of the amendments to that RFC just like we have amendments during any procurement process.

Next in the appendices are email chains between the carriers. I believe Pete asked for those. We did present those to the carriers for them to make any asserted proprietary or confidential redactions. The redacted marks are requests from each of the carriers. There's a chain for KP Washington and Washington Options, a second chain for KP Northwest, and a third chain for Premera.

At the end of the packet is Exhibit 3 from the contracts that were executed. The reason you have four versions are some slight additional wordings in some of the amendments versus others. We wanted to give you complete copies. Those are the versions of everything we believe the Board asked for last week.

Lou McDermott: Thank you, Dave. The next item is the vote. We're going to go through discussion but if a member of the Board wants to make a motion to amend, it would probably be good to do it in the beginning, as the resolution is on the screen. It is for the July 25 revised rates.

Vote - Premium Resolution SEBB 2019-15 – Premera Medical Premiums

Lou McDermott: **Premium Resolution SEBB 2019-15 – Premera Medical Premiums**

Resolved that, the SEB Board endorses the revised Premera employee premiums as presented at the July 25, 2019 Board Meeting.

Patty Estes moved and Terri House seconded a motion to adopt.

Pete Cutler: I propose amending the motion to read that the SEB Board endorses the Premera employee premiums from July 18 as shown on the wall.

Dave Iseminger: I'll clarify for those on the phone. The motion is to strike the word "revised" and replace it with "initial," and strike the date "July 25, 2019" and replace it with "July 18, 2019."

Lou McDermott: The proposed amended resolution reads: "Resolved that, the SEB Board endorses the initial Premera Employee Premiums as presented at the July 18, 2019 Board meeting.

Sean Corry seconded the motion to approve the amended resolution.

Doug Nelson, Public School Employees of Washington: Good morning, Chair McDermott, Members of the Board. I think this is your 19 meeting, right?

Dave Iseminger: This is the 22nd meeting of the Board.

Doug Nelson: Wow. Congratulations. I would urge you to oppose the amendment and it really goes to why I'm actually going to ask you to support the actual motion that was made. I'll get started. The process issue that's being raised is an interesting process issue. I refer to your Attorney General's opinion on what to do in this issue. I think your advice has been to go ahead. You can do this. And I urge you to approve the updated Premera rates. Kaiser has made a point of "this is unfair." Well, actually, it is fair because they were given the same opportunity as Premera took. So there isn't a fairness principle that's been violated. They were given the same opportunity but chose not to adjust their rates.

Having drafted the SEBB legislation, competition was one of the major features of the SEBB Program in first place. What you're seeing is competition, robust competition.

Robust competition for the first time that this is being offered. I'm not surprised that there were some machinations going on. These are businesses that are out to make money. I am not surprised and I urge you to acknowledge that a part of SEBB is competition.

I have to say that to deny rate reductions is contrary to your charge to develop affordable insurance plans. To deny substantial rate reductions is unconscionable. Don't take $35 million from employee pocketbooks and give it to Premera, when Premera has said they don't need it. We urge you to support the motion to approve the updated rates, and deny the amendment. Thank you.

Julie Salvi, Washington Education Association. I won't repeat everything Doug just said and everything I said last week, but thank you for the work you've done over the years of developing this. You are so close to being done and launching the first year. We appreciate all of that. We also support the underlying amendment and oppose the revised amendment because we have looked at the HCA provided materials and the communications that point to the broad timeline in the underlying contract. We think you have the authority to go forward. To not accept a lower rate on behalf of our members, and to ask them to pay more than they otherwise would have to - we just cannot agree with that.

We understand the concerns on both sides, and we do hope the Board will continue these discussions so that none of you are in this position next year. I don't think anyone wants to land in that place again. But given where we are today, and the underlying contract language, we encourage you to accept the revised rates, and going forward, have conversations about how we don't all end up here again next year. Thank you.

Melissa Putman: I'm with Kaiser Permanente. I think the Board is well aware of our concerns, as it goes to the integrity of this process. We all know relationships matter, and we want to be the best partner that we can be to Health Care Authority. I think we want to see this process followed, and understand the position you're all in today. So we just want to say thank you, and would urge you to support the amendment.

Pete Cutler: First of all I want to acknowledge that this is, I imagine, an issue that especially those who don't have a lot of experience with dealing with health care contracting, to them it looks very simple. Here's an opportunity to get lower rates. Why not do it? And I have to admit that I think it's reasonable, especially for members of the Board, to count on generally the Health Care Authority's recommendations or advice, whether a situation is acceptable under principled rate setting processes.

Having said that, to me the facts of the situation are simple. First, in June the carriers submitted their final supposed rates for 2020 to the Health Care Authority for the SEBB Program. The Health Care Authority told them the rates would be submitted to the Board at the July 18 meeting. On July 15 those proposed carrier rates were posted on the web, became public knowledge, and of course I would assume came to the attention of Premera. Two days later, Premera asked the Health Care Authority if it could submit lower rates than the final rates it had submitted in June. From its letter it was clear it did not believe it had a right to insist on that. It did not even indicate that it thought the rate setting process was open to changes. But it asked.

On that day, Health Care Authority did permit Premera to submit proposed changes to its rates, and on July 22 we have Kaiser Permanente Northwest and Kaiser Permanente Washington who both sent letters protesting the Health Care Authority's decision to allow Premera to change its proposed rates. Those letters explain that they believe the Health Care Authority's actions undermine the integrity of the negotiation rate setting process, and also were not permitted under certain provisions of the Request For Proposals and contracts.

The response from the Health Care Authority to date has been to not discuss at all the integrity of the rate negotiation process -- to just set that aside and not even acknowledge that is an issue. In effect, it is saying that since the contract doesn't explicitly prohibit the Health Care Authority from accepting changes to the final rates that carriers submit, it is free to do so. It doesn't point to any contract language that would affirmatively provide or even hint that there is discretion to the Health Care Authority to wait until the last minute before a Board Meeting, to allow changes up to the very last minute before a Board Meeting, which it appears to believe.

So as you might guess, I am disappointed in the Health Care Authority's responses and how it's handled this situation. I know this is something where reasonable people can disagree, but for me, conducting one's affairs with integrity involves enacting ways where your actions are consistent with what assurances you've given to others and what you say your stated values are. In my view, that's a higher standard of conduct than merely not violating explicit contract requirements. I was also raised to believe that acting with integrity is important, and good things happen over the long term to persons and organizations that act with integrity and bad things happen to those who don't. So I'm disappointed in the Health Care Authority's handling of the situation.

Like I said, I understand why Board Members would reasonably be inclined to accept the rates, but at the end of the day, HCA represented to all the carriers that the rates they submitted in June would be their final proposed rates, to be submitted to the Board. It did not mention any opportunity for later changes. And then later decided to act inconsistent with that representation. And obviously the attraction of lower rates for members is a very powerful attraction. But in my view, the fact that it believes that it's not prohibited from accepting those revised rates, it's not prohibited by any explicit contract provision does not mean it's acting with integrity. And for that reason I urge this Board to adopt the rates that Premera originally proposed as its final rates. Period.

Sean Corry: Thank you, Pete. You said everything that I would have wanted to say but much more eloquently than I would have. I'm going to support this motion largely because of the things that Pete laid out for us with respect to the integrity of the process, which has been essentially my concerns throughout the last week, week and a half, however long it’s been since we’ve seen these documents. I do want to add one point of a personal nature. In conversations in the past few weeks, it's been implied to me that my position on this, that my questioning, sometimes harsh questioning about the process, was a function of my favoritism towards Kaiser Permanente. And I want to assure you all, and for the record, that if the companies actions were reversed, they had been reversed in Kaiser Permanente's offer to lower their rates same as it did with Premera, I would be against adopting those new rates because of the process that was implied if not explicitly in the associated documents. I think the integrity of the process

has been violated here and that's the reason I am going to be voting to support this motion.

Alison Poulsen: I really appreciate the comments from Pete and Sean about the integrity of the process and I think there's a lot of learning that we will carry forward in this process. But at the end of the day, I think the opportunity for us to get as many competitive products to our enrollees is really at the top of my priority list. So I will be voting to oppose the amendment and support the revised rates.

Wayne Leonard: Last week we asked for the staff to provide some additional information including some actuarial data. Thank you for going through the rate development sheet. I will admit that this is not the kind of bidding I'm normally used to. We don't really have rate negotiations and rate development processes. I do hope in the future this process can go a little bit more smoothly, because I do agree that doesn't feel right. But I'm satisfied with the information I saw that there's just a lot of vagueness or whatever in this whole process. And so I am going to vote to oppose the amended resolution as well.

Lou McDermott: Just some thoughts from me. You know, the agency has been put in a difficult position. The staff have been dealing with our AGOs, with our actuaries, with each other. We've had leadership communication. It's been difficult. The position we're in today is a result of a process that is, in my opinion, intentionally vague to allow the back and forth to occur. And I think everyone is aware of that. The Board is the final vote. And to be honest with you, one of my old friends, our previous CMO, used to say, "is the juice worth the squeeze?" In this case, if those Premera revised rates would have been insignificant, we probably would not have brought them to the Board. But it was significant. And we felt it was out of our domain to make that final call, because it did fit within the parameters of the rules. It is legal. And so that's why we're letting the Board make that final decision.

Voting on the request to amend SEBB 2019-15

Voting to Approve: 2
Pete Cutler
Sean Corry

Voting No: 6
Terri House
Dan Gossett
Wayne Leonard
Alison Poulsen
Patty Estes
Katy Henry

Lou McDermott: My vote is not necessary. The request to amend Policy Resolution SEBB 2019-15 Fails.

Premium Resolution SEBB 2019-15 - Premera Medical Premiums

Resolved that, the SEB Board endorses the revised Premera employee premiums as presented at the July 25, 2019 Board Meeting.

Voting to Approve: 6
Terri House
Dan Gossett
Wayne Leonard
Alison Poulsen
Patty Estes
Katy Henry

Voting No: 2
Pete Cutler
Sean Corry

Lou McDermott: My vote, again, is not necessary. Premium Resolution SEBB 2019-15 passes.

I want to thank everybody, thank the staff, the Legislature who passed this. It's a historic day. The Board Members who have stuck this out, 22 meetings, a lot of work going from ground zero. It's been a heck of a journey. I'm really thankful for Sue Birch, our Director, for letting me chair this meeting. It's really been an honor. It's a big deal, and I really appreciate everybody who has worked on this.

Next Meeting

August 29, 2019
9:00 a.m. – 12:30 p.m.

Preview of July 25, 2019 SEB Board Meeting
Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the August 29, 2019 Board Meeting.

I also want to echo Chair McDermott's comments. I had a moment yesterday. I was looking through video that the team is producing about how open enrollment will go. There was this moment as I got to around minute 10, where it said here is the online enrollment portal where you check your plan selection box. Here's the plan names, the premiums, the icon to go to Alex and say "help me navigate these plans." And just the embodiment of what it took to get to this two-minute segment of a video, and the work that has been done by staff, by the Board, by the Legislature. It really was a very humbling moment to realize this has been a 30-year debate in the state and we're now 61 days from employees choosing their plans. It really struck me. We didn't bring tissues, Patty or Alison. Alison, you've told me you've had some tissue needs in this last month. But I just wanted to say that it's really incredible when you step back and think about all the work staff have done, the Board has done, the agency has done, the

Legislature has done, the Governor's Office support, stakeholders -- it really has been quite a two-year journey.

Lou McDermott: On that note, congratulations. We have a SEBB Program! Let's go do it.

[applause]

Meeting adjourned at 10:15 a.m.

TAB 4

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

School District Optional Benefits

Cade Walker, Executive Special Assistant
Employees and Retirees Benefits (ERB) Division
August 29, 2019

Outline

- What are we talking about?
- SEB Board's authority for review
- SEBB Program's responsibility regarding reviewing school districts' optional benefits
- Review process

What are we talking about?

Optional Benefits: term used to describe the benefits offered by school districts that are separate and distinct from the mandatory and supplemental benefits authority under the School Employees Benefits Board Program.

SEBB Program Benefits Authority

- Health care coverage, including all forms of:
  - Medical
  - Dental
  - Vision
  - Prescription drug
- Life insurance (all forms, including but not limited to whole and term)
- Accidental death and dismemberment (all forms)
- Liability (all forms, including but not limited to home and auto)
- Disability (all forms, including but not limited to long- and short-term)
- Medical Flexible Spending Arrangement (FSA) (all forms, including but not limited to general- and limited-purpose)
- Dependent Care Assistance Program (DCAP)

School District Optional Benefits - Authority

RCW 28A.400.280(2):

- *Beginning January 1, 2020, school district optional benefits must be outside the school employees' benefits board's authority in RCW 41.05.740(6).*
- *Beginning December 1, 2019, and each December thereafter, school district optional benefits must be reported to the school employees' benefits board and health care authority.*
- *The school employees' benefits board shall review the optional benefits offered by districts and: (a) Determine if the optional benefits conflict with school employees' benefits board's plans offering authority and, if not (b) evaluate whether to seek additional benefit offerings authority from the legislature.*

SEB Board Responsibility

- The SEB Board is to review school districts' optional benefits and determine if the optional benefits conflict with the Board's offering authority.

- Based on the evaluation, the SEB Board may seek additional benefits offering authority from the Legislature.

Review Process

- School districts submit optional benefits information to the SEBB Program for review by December 1 of each year.

- The SEBB Program will review the additional benefits and present an analysis to the SEB Board.

Review Process (*cont.*)

- The SEBB Program will provide a response on behalf of the SEB Board to school districts responding either:
  - The additional optional benefit is in conflict with the SEB Board authority and the benefit is not permitted to be offered by the school district, or
  - The additional optional benefit is not in conflict with SEB Board authority
    - For benefits that do not conflict with the Board's offering authority, the SEB Board cannot approve, endorse, sponsor, or otherwise authorize school district's optional benefits.

Questions?

Cade Walker, Executive Special Assistant

Employees and Retirees Benefits Division

cade.walker@hca.wa.gov

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Appendix

SEBB Program optional benefits: What can districts offer?

What benefits are the School Employees Benefits Board (SEBB) Program authorized to offer?

Under **RCW 41.05.740** and **41.05.300** through **41.05.310**, the SEBB Program includes authority to offer the following health insurance and other benefits to Washington State school district and charter school employees, and union-represented educational service district (ESD) employees:

- Health care coverage, including all forms of:
  - Medical insurance
  - Dental insurance
  - Vision insurance
  - Prescription drug insurance
- Life insurance (all forms, including but not limited to, whole and term life insurance)
- Accidental death and dismemberment insurance
- Liability insurance (all forms, including but not limited to home and auto insurance)
- Disability insurance (all forms, including but not limited to short- and long-term disability)
- Flexible spending arrangement (FSA) (all forms, including but not limited to "general-purpose" and "limited-purpose" FSAs)
- Dependent Care Assistance Program (DCAP)

All forms of the above insurance benefits are within the exclusive offering authority of the SEBB Program.

Under state law, **RCW 28A.400.350(6)**, SEBB Organizations' authority to offer any of the benefits listed above ends December 31, 2019.

SEBB Organizations cannot offer, endorse, or make available any benefits under the SEBB Program's authority, even if the benefit (or a specific form of the benefit) is not offered to school employees by the SEBB Program. For example, a SEBB Organization cannot offer or endorse short-term disability insurance even though the SEBB Program is not offering this benefit.

What optional benefits may school districts offer?

There is no preapproval process between a school district and the SEBB Program to offer optional benefits. Any optional benefits offered outside of the SEBB Program are considered an enhancement to the state's definition of basic education, which means the state will not fund them. Optional benefits can be paid for by the employee, the employer, or both.

Some examples of optional benefits (which at this time may be outside of the SEBB Program's authority) that school districts may offer:

- Voluntary Employees Beneficiary Association (VEBA) plans
- Travel insurance
- Pet insurance

This list may change over time as HCA evaluates the optional benefits that SEBB Organizations are offering outside of the SEBB Program. Refer to the next page for reporting requirements a school district must follow each year if they offer optional benefits.

For more information visit **hca.wa.gov/sebb-employee**.

20-0157 (8/19)

Can a SEBB Organization invite a vendor to their benefits fair?

SEBB Organizations can't offer, endorse, or make available any benefits that compete with those authorized as part of the SEBB Program.

This restriction includes, but is not limited to, inviting a vendor to attend a benefits fair to endorse products that directly compete with any form of a benefit under the SEBB Program's authority — even if the vendor's product would be fully paid by the employee. It also includes providing vendors with employee contact information for marketing purposes or facilitating payroll deductions.

Can SEBB Organizations offer additional FSA or HSA benefits?

HCA maintains the authority to offer cafeteria plans (as identified in **IRS Section 125**). This means SEBB Organizations cannot offer health savings accounts (HSAs), a flexible spending arrangement or flexible spending account (FSA), or a dependent care assistance program (DCAP).

A SEBB Organization also cannot make additional employer contributions for employees who enroll in an IRS qualified high-deductible health plan. The employer contribution is limited to the annual amount authorized by the SEBB Program and deposited into the HSA account by HCA on behalf of the SEBB Organization.

Why can't SEBB Organizations offer or endorse certain benefits?

These limitations are in place to maintain the purchasing power that comes from consolidating all eligible school employees into one statewide risk pool through the SEBB Program. If some school employees accessed a competing, non-SEBB Program insurance product with the help of their employer, it would impact the risk profile of the SEBB Program population, which could affect the rates or benefit structure of SEBB Program benefits.

Reasons a SEBB Organization cannot offer a benefit that is authorized (but not offered) as part of the SEBB Program include:

- Policy considerations that maximize the value of all benefits when they are used in combination; and
- Rate development that may have taken into account not offering certain benefit structures.

Does the SEBB Program have any authority over retirement benefits?

No. The SEBB Program does not have authority over contributions made to pensions or any form of retirement accounts. The SEBB Program's benefits portfolio includes health insurance and other non-pension benefits.

How will school districts report their optional benefit offerings to HCA?

Under **RCW 28A.400.280(2)**, beginning December 1, 2019, and each year thereafter, school districts that elect to offer optional benefits must submit a report to HCA describing any optional benefits they are offering to school employees. HCA will provide school districts with more information this fall on how to report these optional benefit offerings.

If HCA determines a school district is offering a benefit that falls under the SEBB Program's authority, or competes with a SEBB Program benefit, HCA will work with the school district to address the issue.

TAB 5

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

Long-Term Disability (LTD) Benefit Strategy

Beth Heston
Procurement Manager
Employees and Retirees Benefits Division
August 29, 2019

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Agenda

- Timeline for improving the Basic LTD benefit as early as the 2021 plan year

Basic & Supplemental
2020 LTD Design

- **Basic Insurance**

  Monthly Benefit: 60% of the first $667 of your Predisability Earnings reduced by Deductible Income

  Maximum: **$400/month** before reduction by Deductible Income

  Minimum: $100/month

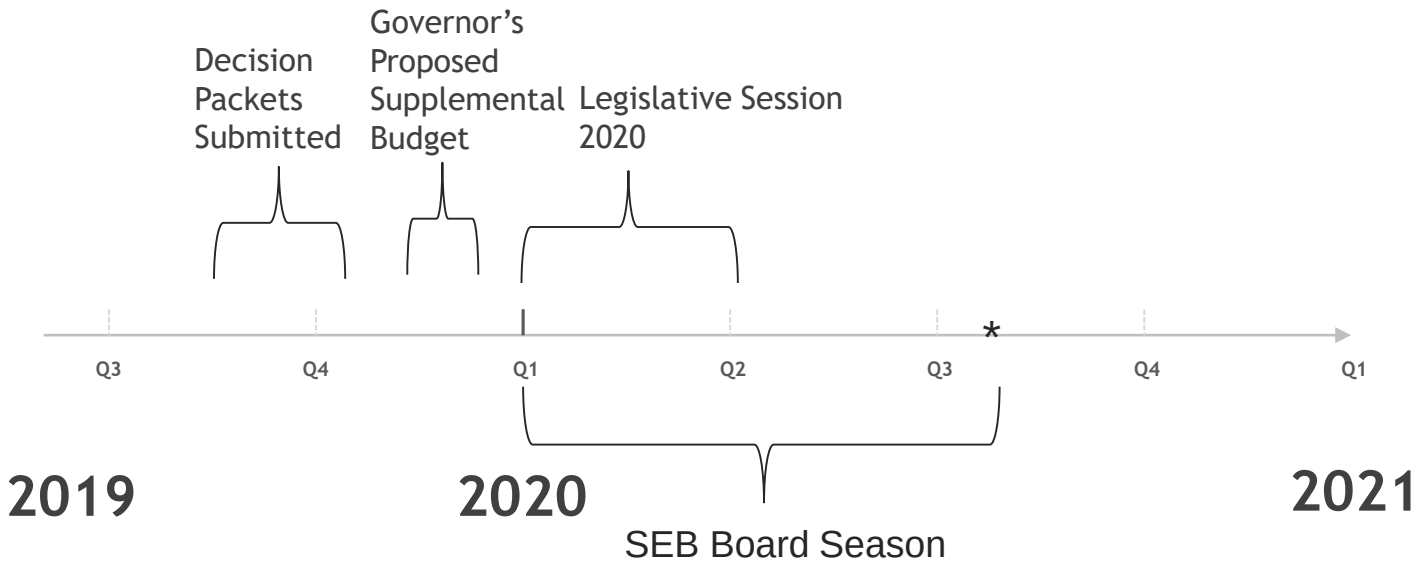
- **Supplemental Insurance**

  Monthly Benefit: 60% of the first $16,667 of your Predisability Earnings reduced by Deductible Income and by any benefits paid under the Basic benefit

  Maximum: **$10,000/month** before reduction by Deductible Income and by any benefits under the Basic benefit

  Minimum: $100/month

Timeline for Decision Making

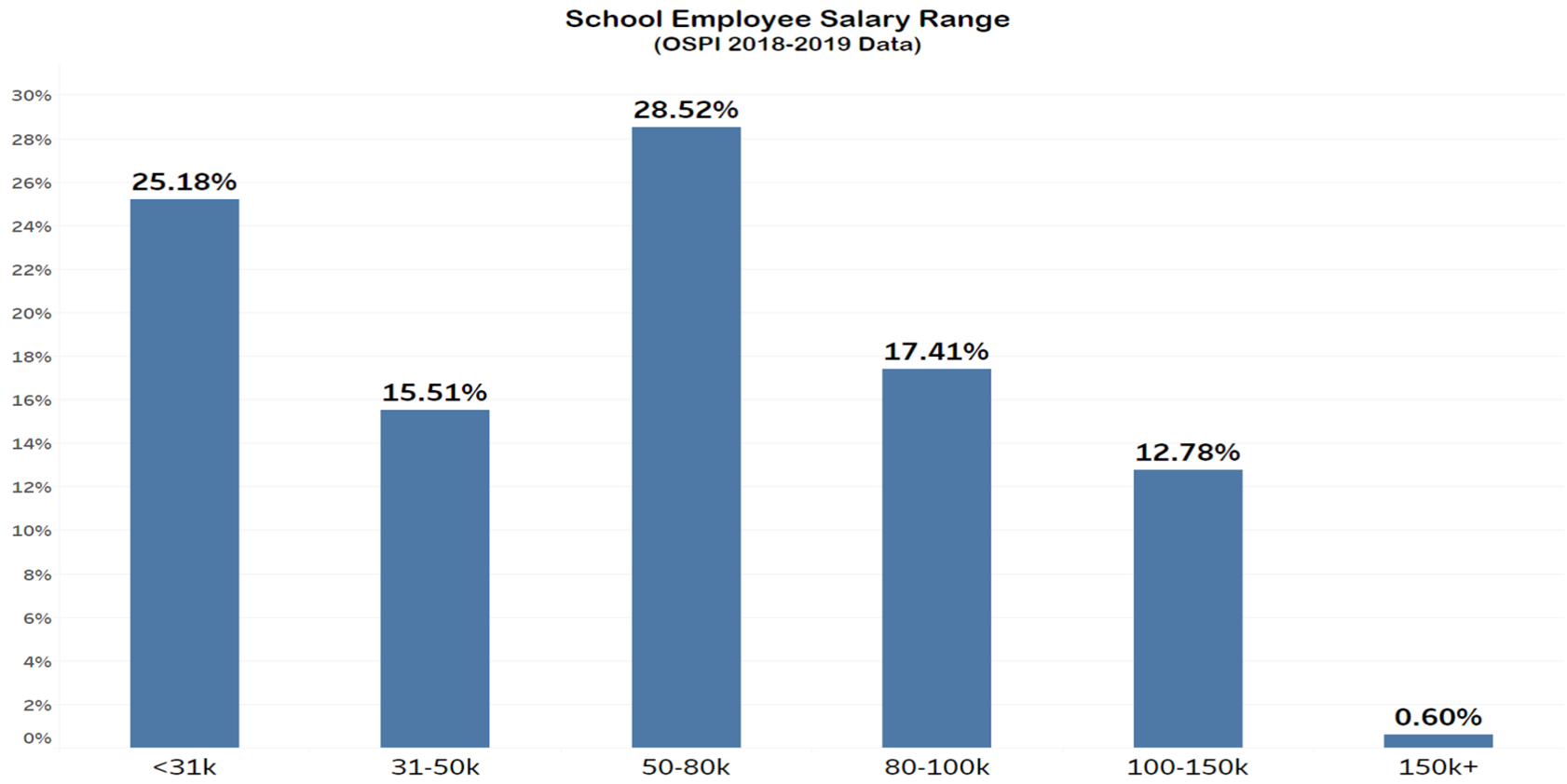


*Board Decision Point

2021 LTD Basic Benefit Design

- Today we're seeking Board insight about the recommended range of incremental improvements to the Basic LTD benefit

Washington School Districts – Income*



*OSPI S-275 2018-2019 Certificated and Classified Salary Data

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

SEBB Employer-Paid Basic LTD Plan Design

	Current Plan	Benefit Waiting Period: Later of 90 days or end of WA Paid Family & Medical Leave							
Annual Salary Covered	$8,000	$10,000	$20,000	$30,000	$50,000	$80,000	$100,000	$150,000	$200,000
Benefit Percent	60%								
Maximum Monthly Benefit	**$400**	**$500**	**$1,000**	**$1,500**	**$2,500**	**$4,000**	**$5,000**	**$7,500**	**$10,000**
PSPM* Cost	Current PSPM	+ ~$0.42 PSPM	+ ~$2.59 PSPM	+ ~$4.4 PSPM	+ ~$8.3 PSPM	+ ~$14.23 PSPM	+ ~$14.98 PSPM	+ ~$15.31 PSPM	+ ~$15.37 PSPM
Total Annual Cost	~$3.3M	~$3.9M	~$7.4M	~$10.2M	~$16.4M	~$25.8M	~$27M	~$27.5M	~$27.6M

*PSPM – Per Subscriber Per Month

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Questions?

Beth Heston
Procurement Manager
Employees and Retirees Benefits Division
Beth.Heston@hca.wa.gov

TAB 6

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

Contractor Implementation Progress

Lauren Johnston
SEBB Senior Account Manager
Employees and Retirees Benefits Division
August 29, 2019

Completed Activities As of August 20, 2019

- Contractors who have successfully completed eligibility/enrollment file testing:
  - Davis Vision, EyeMed Vision, DeltaCare, Uniform Dental Plan (UDP), Willamette Dental, Navia, and MetLife (for Life/AD&D)
- Completed certificates of coverage (COC):
  - **Medical:** Kaiser Permanente Northwest (KPNW), Kaiser Permanente of Washington (KPWA), and Kaiser Permanente of Washington Options, Inc. (KPWA Options)
  - **Dental:** Uniform Dental Plan and Willamette Dental
- MetLife (Life and AD&D) policy approved by OIC

Completed Activities As of August 20, 2019 (*cont.*)

- Microsites:
  - Medical: KPNW
  - Vision: Davis Vision and EyeMed
  - The Standard (LTD)
- Medical provider search tools are live (see appendix)
- SmartHealth Activity Tiles:
  - DeltaCare
  - UDP
  - Willamette Dental
  - EyeMed Vision

Current Activities

- Continued review of remaining COCs (full completion by September 10):
  - Medical: Premera and UMP (all)
  - Dental: DeltaCare
  - Vision: Davis Vision, EyeMed, and MetLife
  - The Standard (LTD)
- Microsites (scheduled for full completion by September 3):
  - Medical: Premera, KPWA, KPWA Options, and UMP (all)
  - Dental: DeltaCare, UDP, and Willamette Dental
  - MetLife (vision, life, and AD&D)
- Virtual Benefits Fair and Open Enrollment (OE) communications and marketing materials:
  - Carrier direct communications with introduction to SEBB Program
  - Open Enrollment fliers
  - Webinar materials
  - Virtual Benefits Fair video

Current Activities (*cont.*)

- Carriers are working with SEBB Organizations to prepare for supplemental billing:
  - MetLife is setting up payroll deductions and list billing processes for Life/AD&D
  - Standard is setting up the processes for remitting payment for LTD
  - Navia is gathering payroll calendars and testing payroll deduction files for Medical FSA/DCAP
- Getting organized for SEBB benefits fairs
  - Both 20 HCA hosted and district-based benefits fairs they're invited to
- Ongoing provider network enhancements
- Benefits set-up in systems

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Future Activities

- All plans filed with the Office of the Insurance Commissioner (OIC)
- Finalize system plan design set-up
- Receive initial production eligibility/enrollment files
- Toll-free numbers activated by early September, but no later than September 30

Provider Disruption Report

- Based on 2017-2018 K-12 provider data
- Providers with a Washington State zip code
- 90.4% of K-12 providers are in either the Regence UMP or Premera networks under SEBB*.
- Findings do not indicate there will be widespread provider disruption for medical providers.
- School employees should verify the network(s) their provider(s) are in prior to making a plan selection.

*Analysis does not address provider network adequacy for the carriers.

Provider Disruption Report (*cont.*)

- K-12 members currently enrolled in a KPNW or KPWA Core plan will have no provider disruption so long as they select a SEBB KPNW or KPWA Core plan.
- K-12 members enrolled in a KPWA Core plan today and select the KPWA SoundChoice plan may have minimal provider disruption for members who live in the Spokane area, since SoundChoice is a smaller network than the KPWA Core network.
- K-12 members currently enrolled in a KPWA Options Access PPO plan today will have no provider disruption if they select a SEBB KPWA Options Access PPO plan.

Questions?

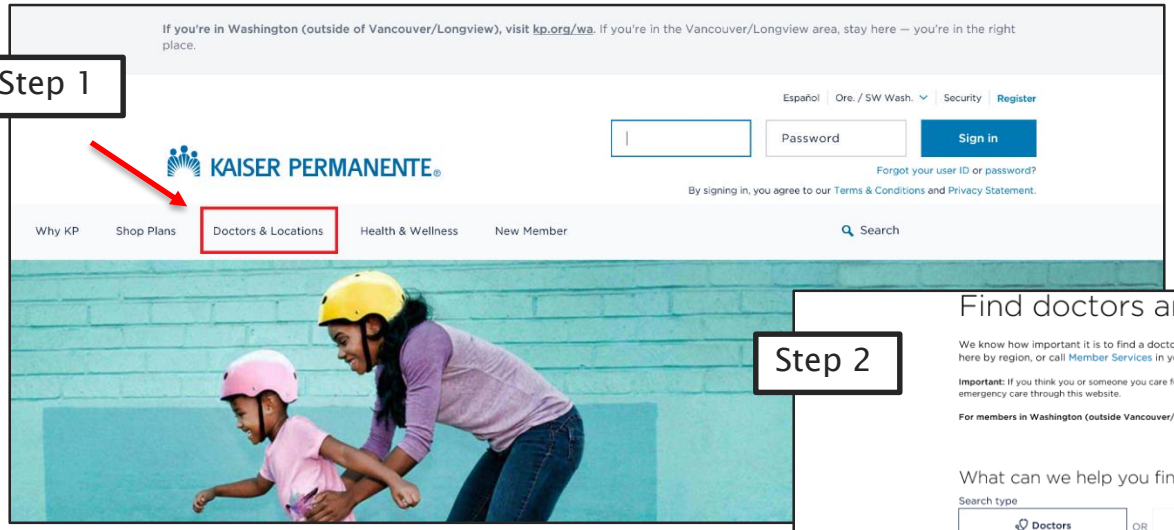
Lauren Johnston
SEBB Senior Account Manager
Employees and Retirees Benefits Division
Lauren.johnston@hca.wa.gov

Appendix

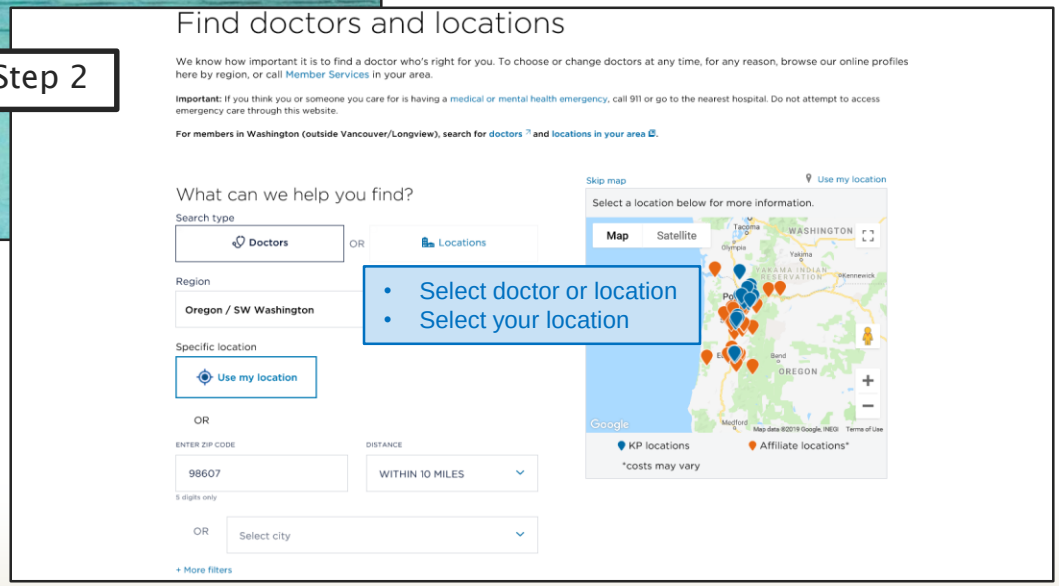
KPNW Provider Search Link

Link	Notes
Direct link: https://healthy.kaiserpermanente.org/oregon-washington; or www.kp.org (and selecting the Oregon-Washington region)	Provider search is accessible to the public and can be searched by location/zip code.

Step 1

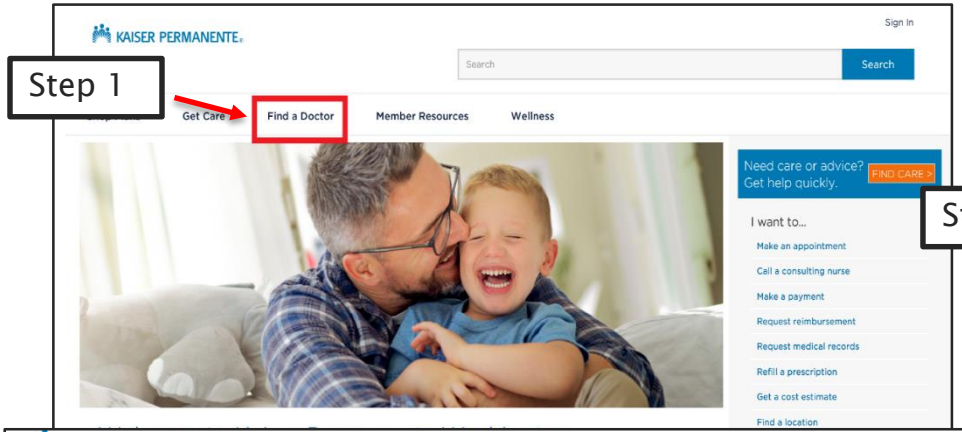


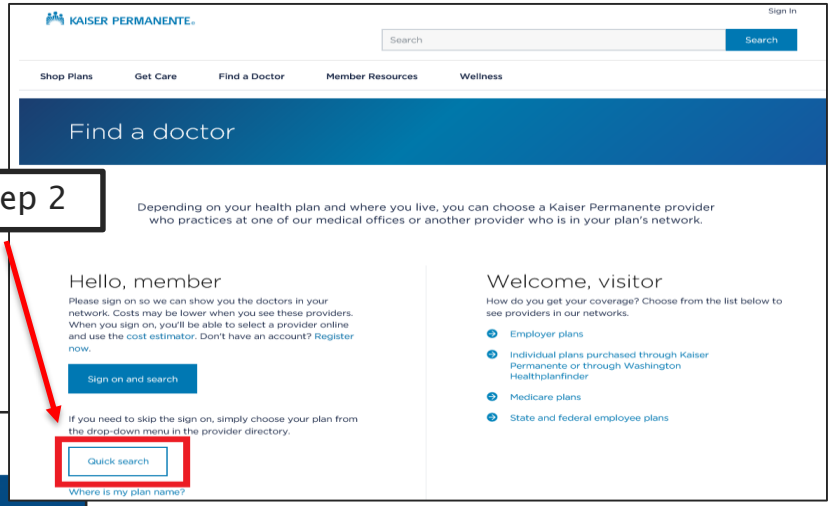
Step 2

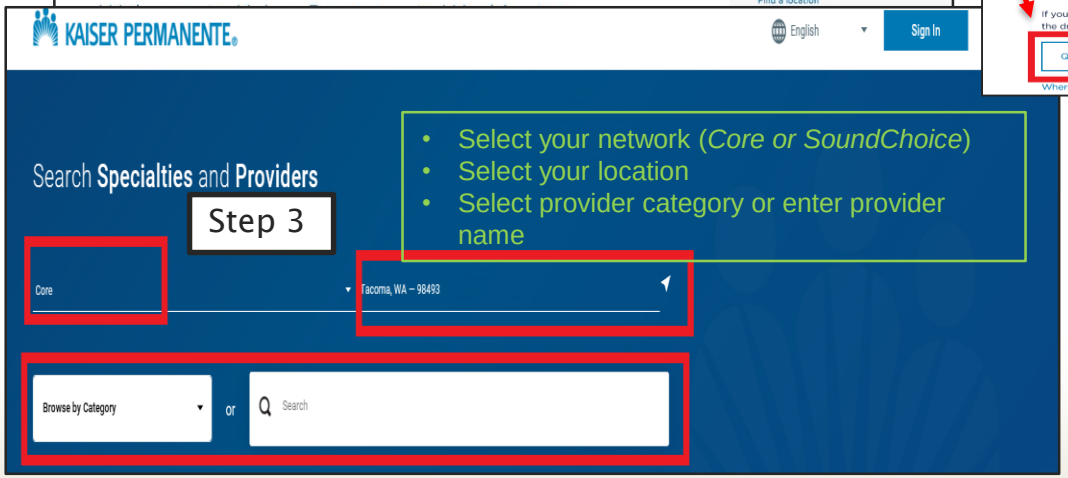


KPWA Provider Search Links

Link	Notes
• **SoundChoice (direct link):** https://kaiserpermanente.vitalschoice.com/?ci=kaiserpermanente&network_id=17&geo_location=47.460352,-122.2303744&locale=en_us • **Core (direct link)**: https://kaiserpermanente.vitalschoice.com/?ci=kaiserpermanente&network_id=9&geo_location=47.02848471162788,-122.88025084186044&locale=en_us	Provider networks are currently available and searchable today with the "Find a Doctor" tool. There are multiple networks employees with have to select from, so it'll be important for the employee to know exactly which network they need to be searching under for each plan.

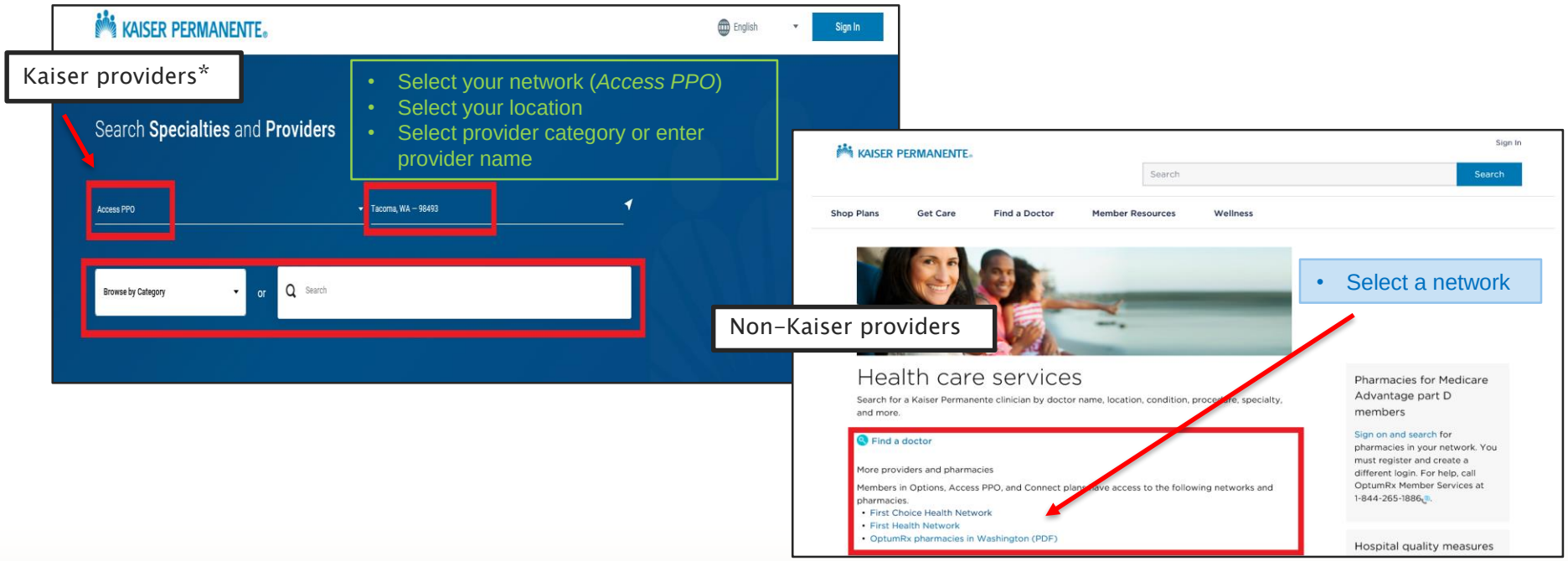






KPWA Options Provider Search Links

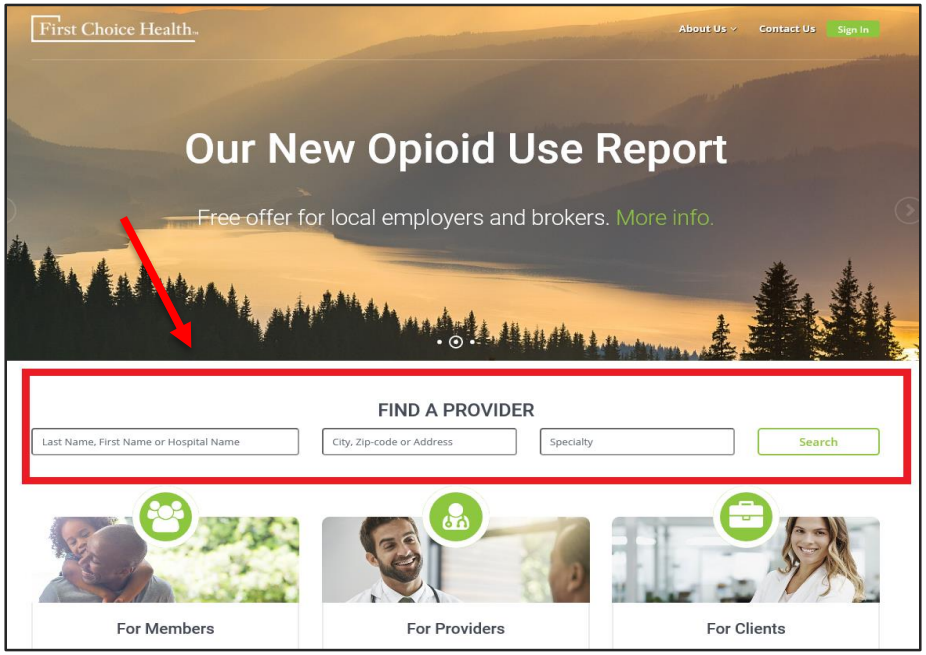
Link	Notes
• **For Kaiser providers**: https://kaiserpermanente.vitalschoice.com/?ci=kaiserpermanente&network_id=6&geo_location=47.02848471162788,-122.88025084186044&locale=en_us • **For non-Kaiser providers:** https://wa.kaiserpermanente.org/html/public/services	Provider networks are currently available and searchable today with the "Find a Doctor" tool. There are multiple networks employees with have to select from: • First Choice Health Network • First Health Network • OptumRx pharmacies in Washington (PDF)



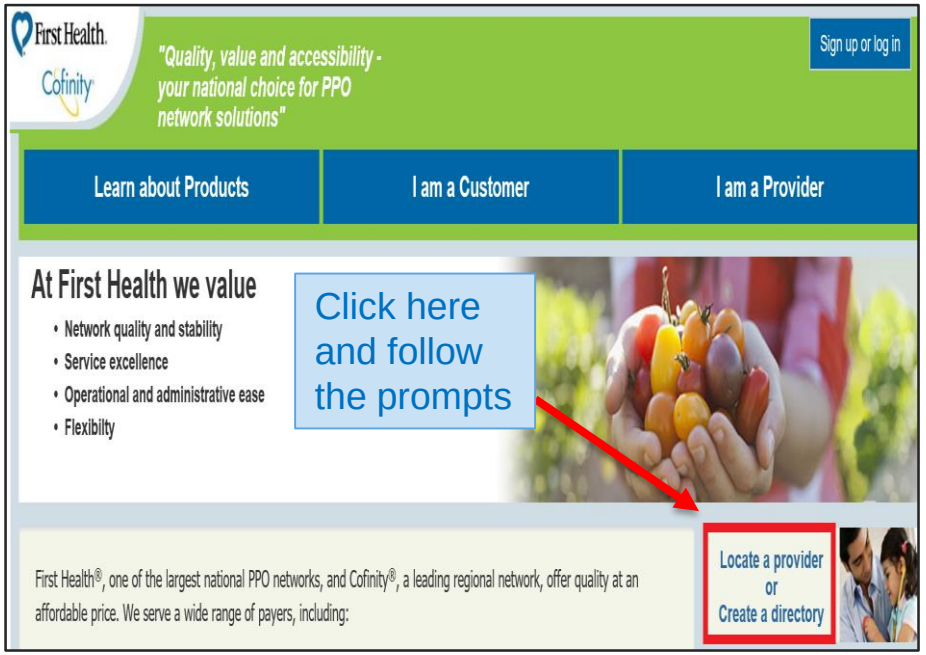
*Getting to KPWA Options' provider search tool is the same as KPWA (landing page).

KPWA Options Provider Search Links (*cont.*)

Step 3 – First Choice Health Network
(for providers in WA, OR, ID, MT, or AK)

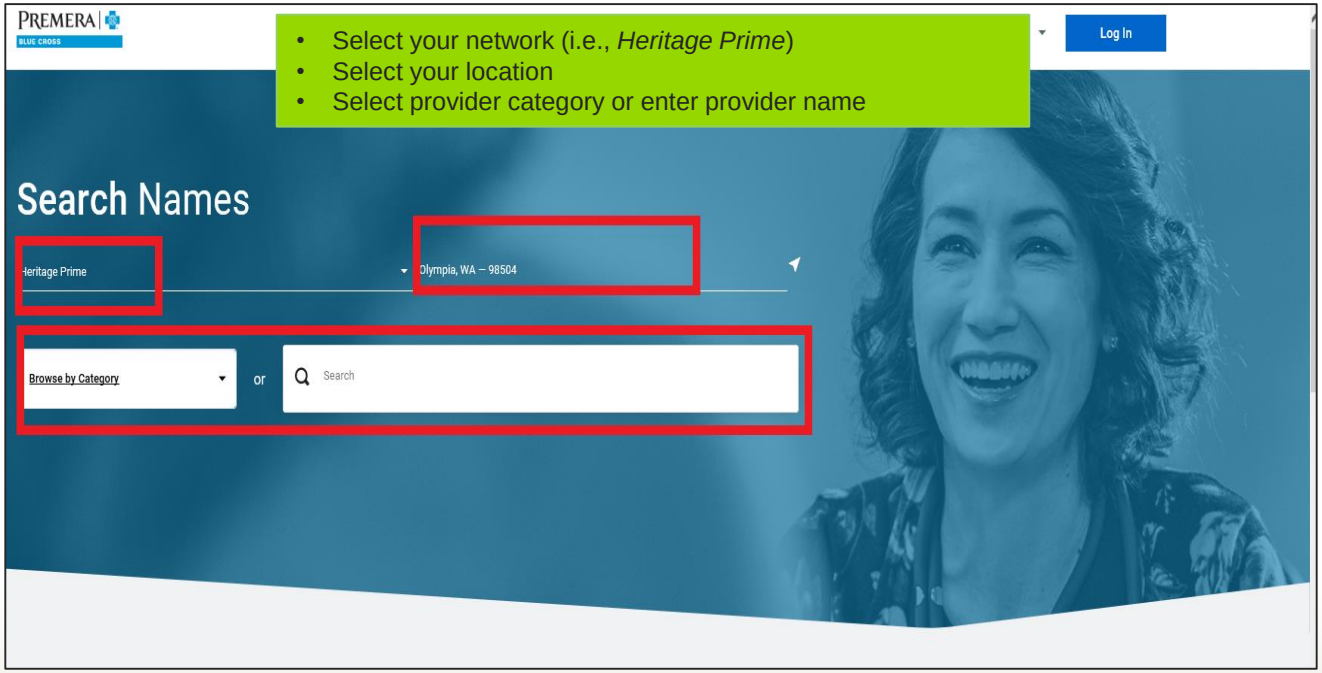


Step 3 – First Health Network
(for providers in all other states outside the Pacific Northwest)



Premera Provider Search Link

Link	Notes
Direct link: https://premera.sapphirecareselect.com	**Tools are available to the public.** • Premera High and Standard PPO members should select the “Heritage Prime” provider network. • Premera Peak Care EPO members should select the “MultiCare Connected Care: PersonalCare Partner Systems & Heritage Signature” provider network (this network excludes chiropractors, massage therapists, and acupuncturists). Peak Care EPO members can look up chiropractors, massage therapists, and acupuncturists using the "Tahoma" provider network.

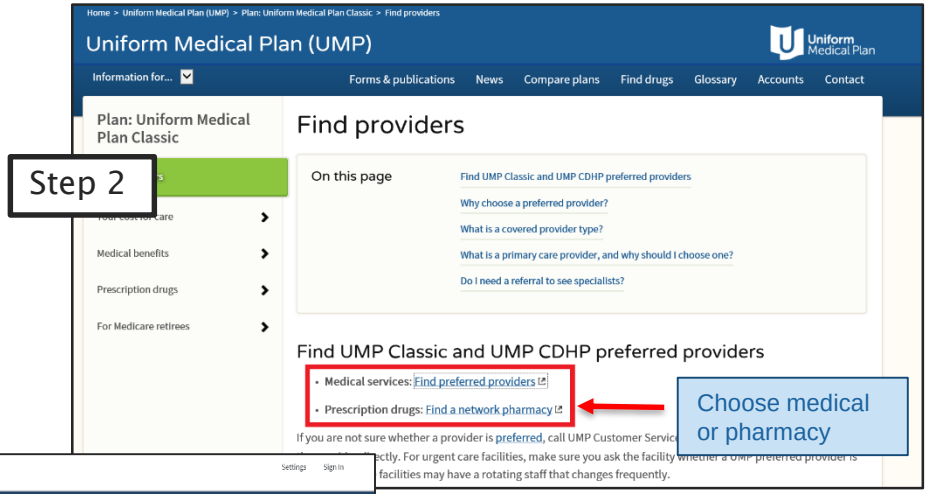


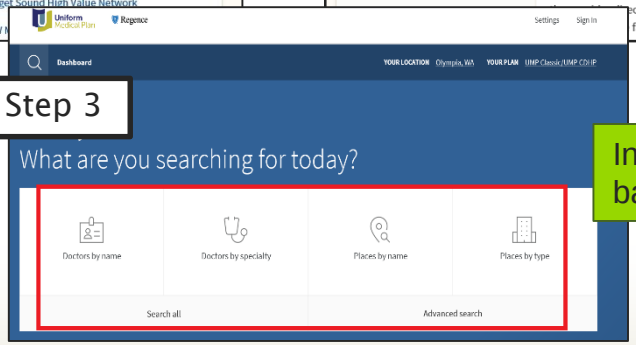
SEBB Uniform Medical Plan Provider Search Links Available September 1, 2019

URL link	SEBB Plan
http://ump.regence.com/go/SEBB/UMP-Achieve1	UMP Achieve 1
http://ump.regence.com/go/SEBB/UMP-Achieve2	UMP Achieve 2
http://ump.regence.com/go/SEBB/UMP-High-Deductible	UMP High Deductible
http://ump.regence.com/go/SEBB/UMP-Plus-PSHVN	UMP Plus - PSHVN
http://ump.regence.com/go/SEBB/UMP-Plus-UWMACN	UMP Plus – UW Medicine ACN

PEBB Uniform Medical Plan Provider Search Link

Link	Notes
Main page: https://www.hca.wa.gov/ump	**Tools are available to the public.** UMP SEBB plans have the same provider network as UMP PEBB plans. Therefore, if a provider accepts a UMP PEBB plan, then they will also accept a UMP SEBB plan. September 1, 2019, school employees will be able to identify providers as accepting UMP Achieve 1, 2, and HD plans.



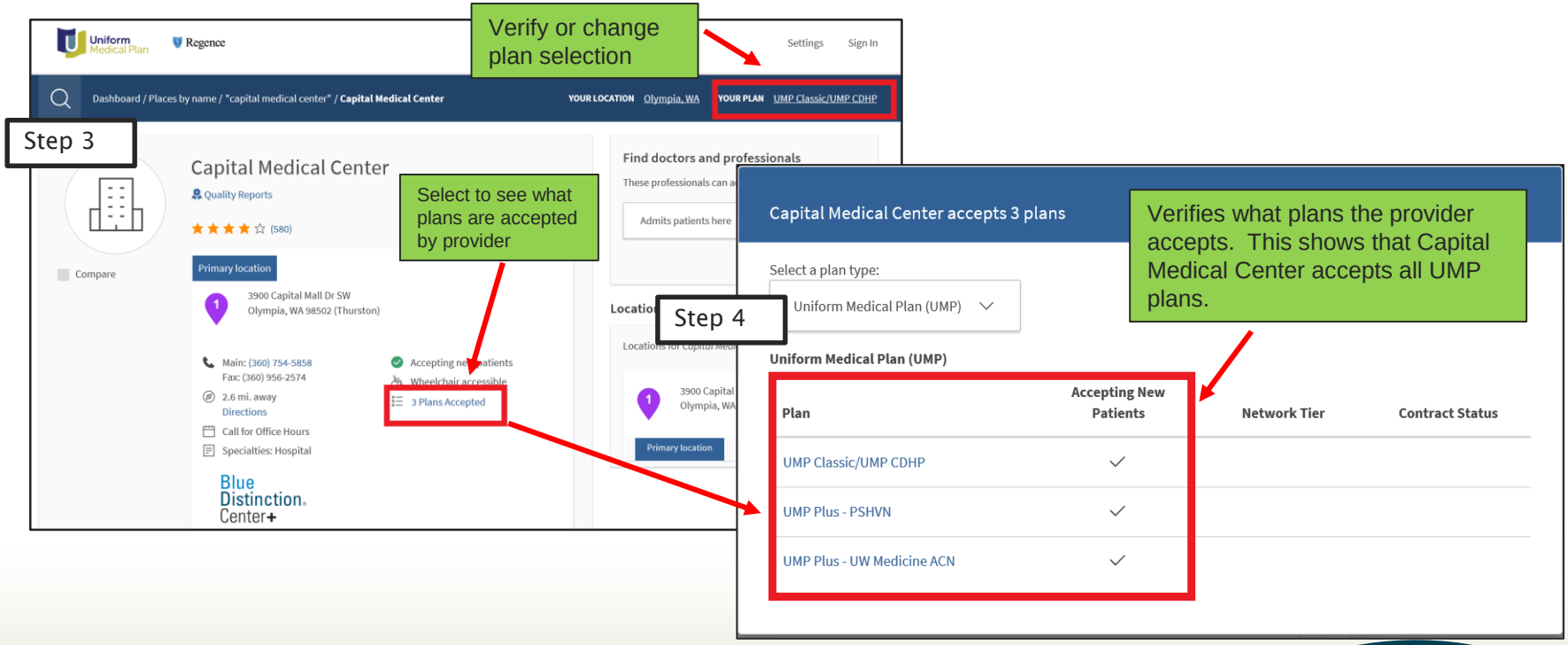


Prior to moving to Step 3, you will be asked to add a location.

Input information based on search

PEBB Uniform Medical Plan Provider Search Link (*cont.*)

Link	Notes
Direct link: https://www.hca.wa.gov/ump/ump-classic/find-providers	**Tools are available to the public.** UMP SEBB plans have the same provider network as UMP PEBB plans. Therefore, if a provider accepts a UMP PEBB plan, then they will also accept a UMP SEBB plan. Once the UMP SEBB plan is built out, school employees will be able to identify providers as accepting UMP Achieve 1, 2, and HD plans.



TAB 7

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

School Employees SmartHealth Wellness Program

Justin Hahn, Washington Wellness Program Manager
Benefit Strategy & Design Section
Employees and Retirees Benefits (ERB) Division
August 29, 2019

2019 SEBB SmartHealth Launch

- During the SEB Board's first annual open enrollment (October 1 - November 15, 2019), SEBB Program subscribers can qualify for a $50 wellness incentive by completing the SmartHealth Well-being Assessment

- A subscriber must be enrolled in a SEBB medical plan in January 2020 when the incentive is distributed as a medical plan deductible reduction **or** a deposit into a health savings account

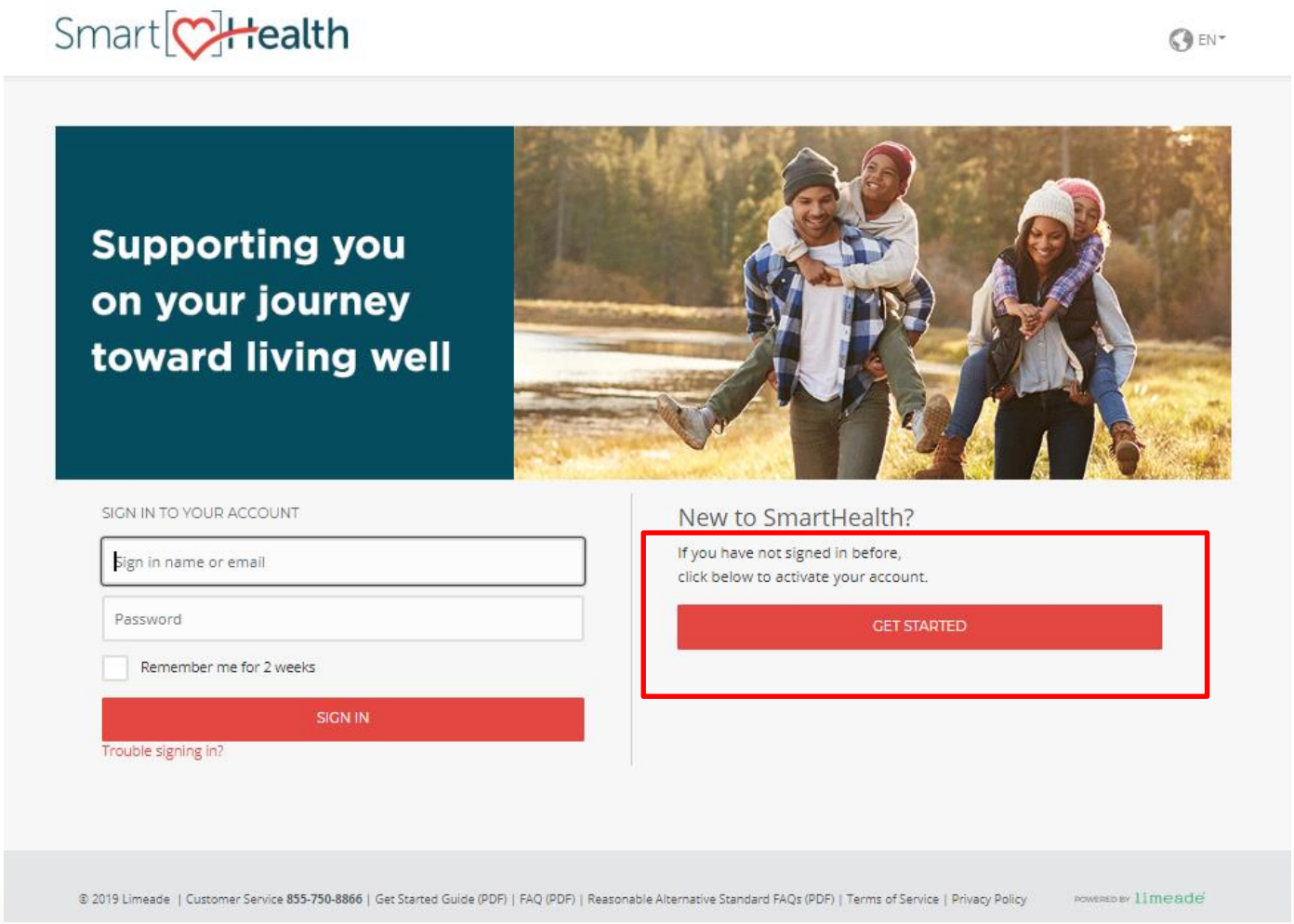
2019 SEBB SmartHealth Launch (*cont.*)

Steps to Completing the SmartHealth Well–being Assessment:

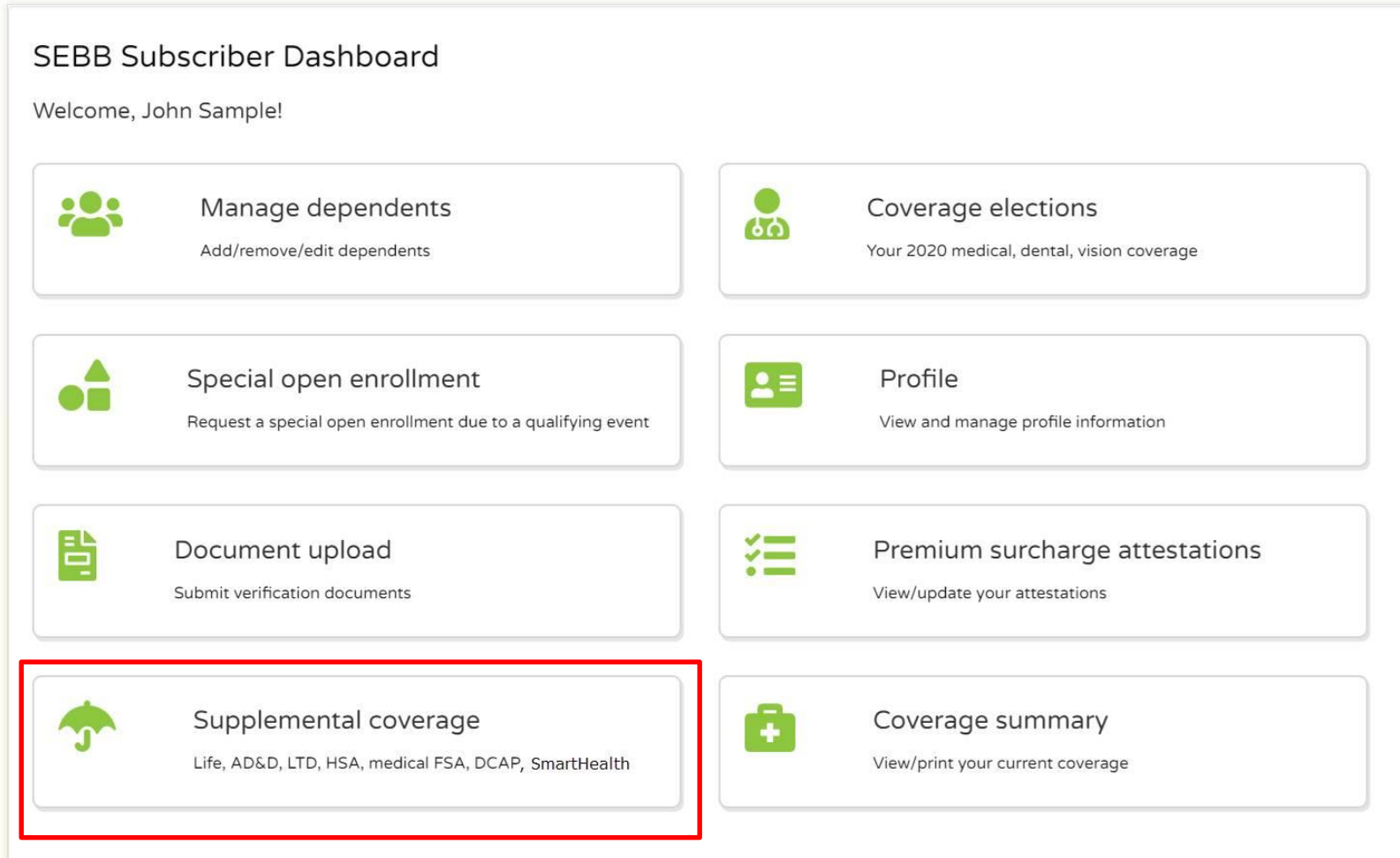
1. Register for SmartHealth on the website (www.smarthealth.hca.wa.gov)
2. Complete the SmartHealth Well-being Assessment to qualify for the $50 wellness incentive

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

2019 SmartHealth Registration



2019 SmartHealth Registration (*cont.*)



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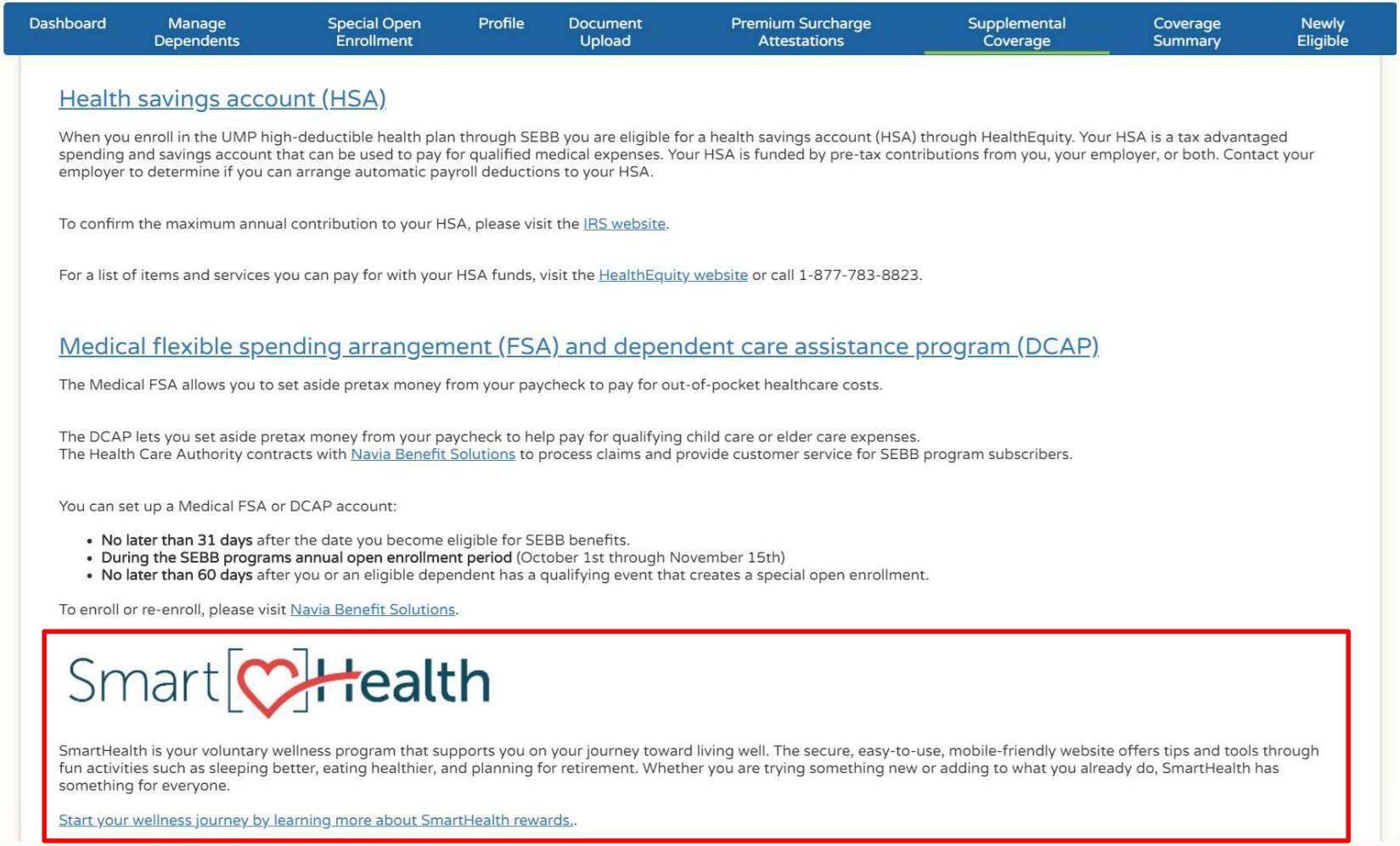
SCHOOL EMPLOYEES BENEFITS BOARD

2019 SmartHealth Registration (*cont.*)



SEBB SmartHealth Promotion

- *Intercom* (SEBB Program newsletter)
  - First edition mailed to SEBB Organization employees on June 17
- SEBB SmartHealth web page
  - hca.wa.gov/sebb-smarthealth
- Promotional items: Lip balm, hot/cold packs, stainless steel straws, etc.
- Outreach events:
  - Washington Education Association (WEA) Representative Assembly (April 2019, Spokane)
  - Charter School Conference (May 2019, SeaTac)
  - Washington Association of School Business Officials (WASBO) Conference (May 2019, Spokane)
  - Public School Employees (PSE) Annual Convention (August 2019, Spokane)
- *School Employee Initial Enrollment Guide*
- Videos: "Why SmartHealth Matters" and "How SmartHealth Works" demo
- SEBB Benefits Fairs (in-person and virtual)
- Communications: SEBB Organization benefits administrator emails, SEBB Program wellness representative emails, SEBB Program voluntary distribution email list, etc.

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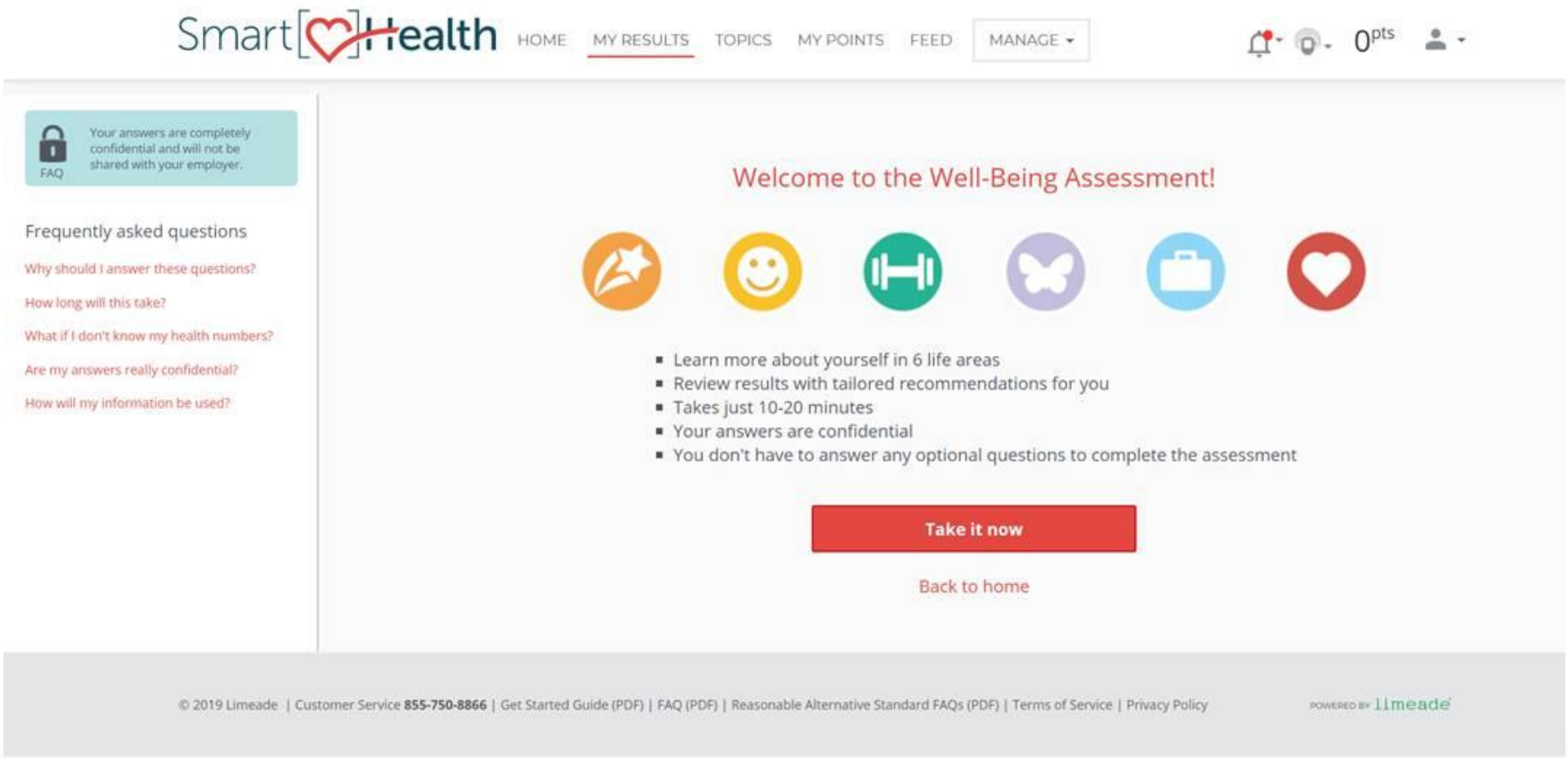
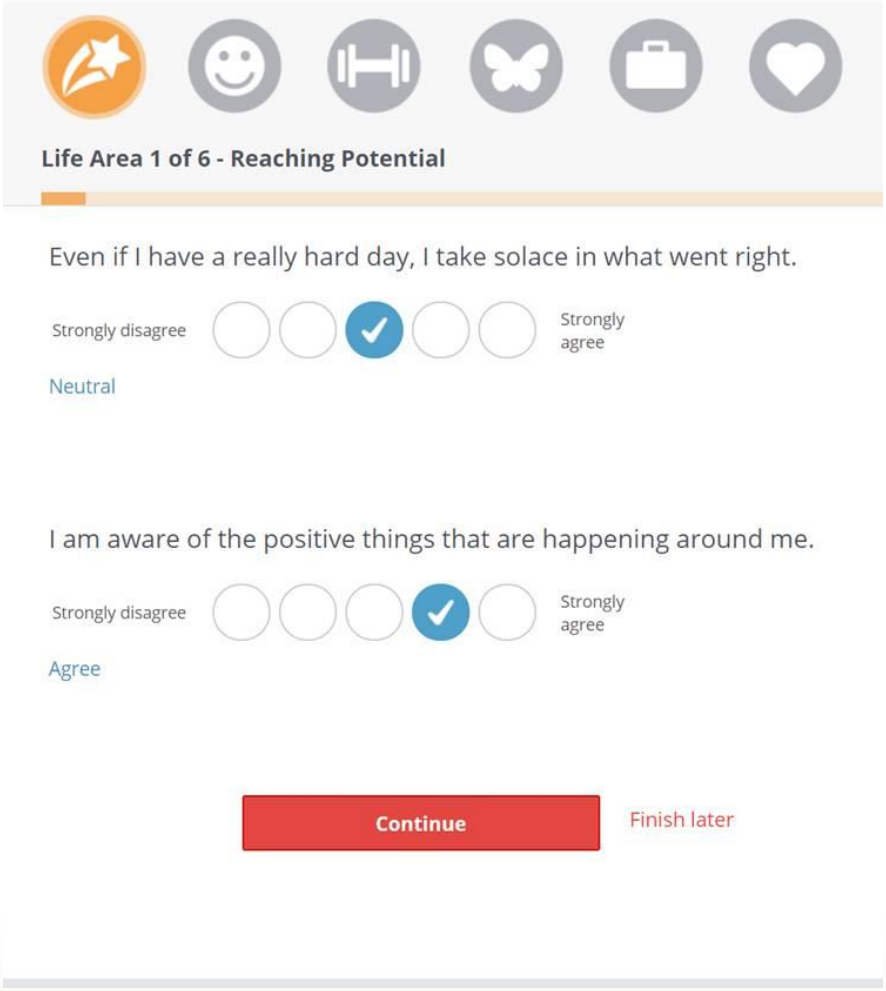
SCHOOL EMPLOYEES BENEFITS BOARD

What is the SmartHealth WBA?



What is the SmartHealth WBA? (*cont.*)



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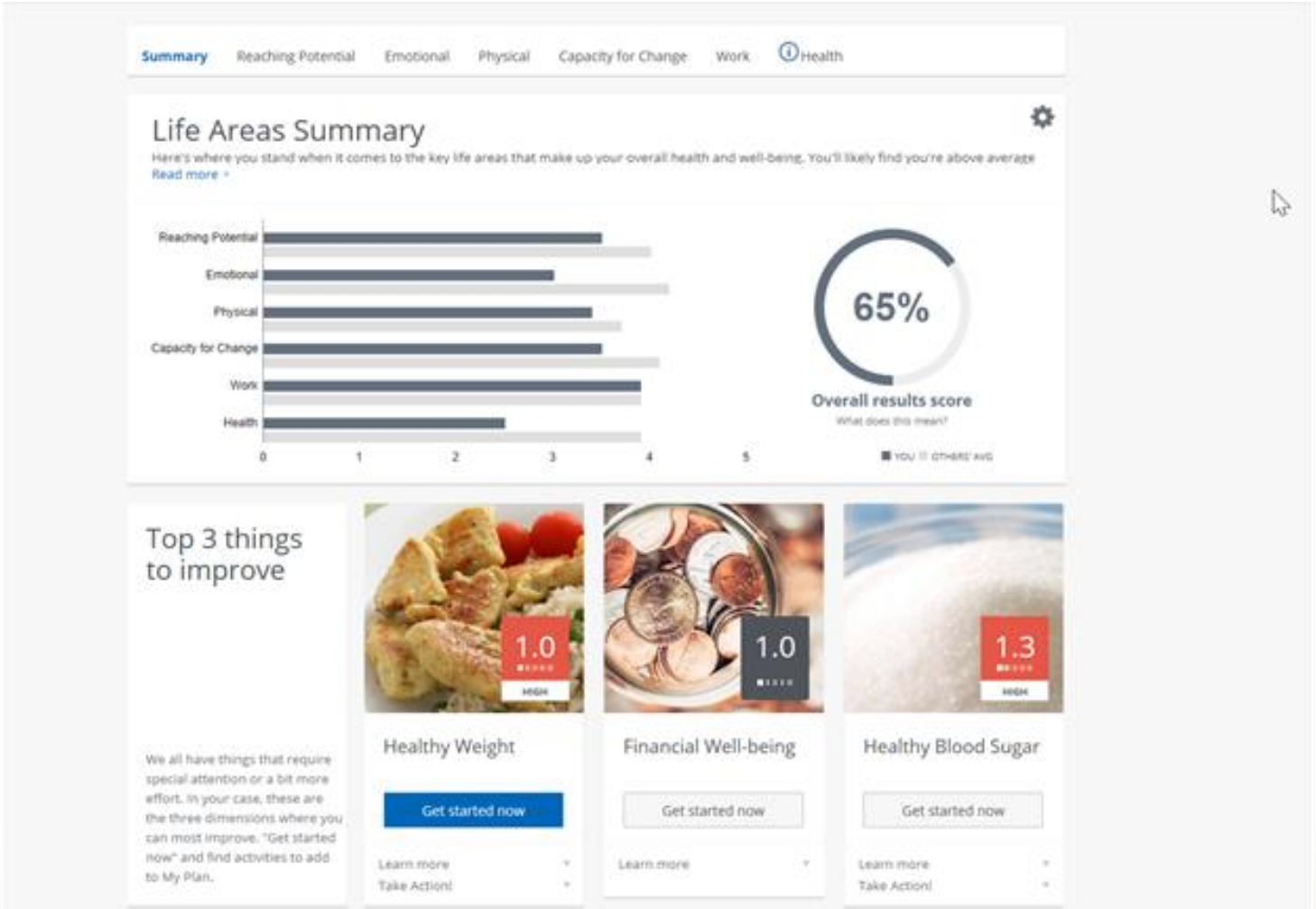
WBA Results



Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

2019 SEBB SmartHealth Tiles

Welcome School Employees

What's Your Why

0 0 200 pts

Cheer Someone On

0 0 100 pts

Walk Across Washington

0 0 200 pts

Exhale Stress with Your Team

0 0 200 pts

Questions?

Justin Hahn, Washington Wellness Program Manager
Benefit Strategy and Design Section
Employees and Retirees Benefits Division
justin.hahn@hca.wa.gov

TAB 8

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

SEBB Continuation Coverage Implementation

Renee Bourbeau, Manager
Benefits Accounts Section
Employees and Retirees Benefits Division

Alisa Richards, Customer Service Operations
Benefits Accounts Section
Employees and Retirees Benefits Division

August 29, 2019

Project Overview

- HCA will administer Continuation Coverage (including COBRA) for the SEBB Program on behalf of SEBB Organizations
- HCA will:
  - Communicate with members
  - Mail the *SEBB Continuation Coverage Election Notice* and letters
  - Invoice and collect member payments
  - Provide Customer Service through a 1-800 line
  - Verify eligibility and enroll members in coverage
- Operational teams: Outreach and Training, Communications, and Customer Service
- These teams are experienced in administering Continuation Coverage (including COBRA) for the PEBB Program

SEBB Program Operational Support

- The teams started their work early this year

- **Outreach and Training:**
  - Drafted guidance and tools for Benefits Administrators
  - Started trainings in August

- **Communications:**
  - Drafted member communications and FAQs
  - Drafted the *SEBB Continuation Coverage Election Notice*

- **Customer Service:**
  - Hired staff dedicated to work on SEBB Continuation Coverage
  - Will launch a new phone menu option in October

Implementation Process

- Transitional implementation for persons currently on Continuation Coverage through their SEBB Organizations on December 31, 2019
- Starting in 2020, once employees lose their eligibility, their Benefits Administrators will terminate their coverage in SEBB My Account
- Most termination reasons will trigger a mailing of a *SEBB Continuation Coverage Election Notice*
- HCA Customer Service staff will review returned forms for eligibility and enrollment

COBRA and Continuation Coverage Interim Process

- HCA works with Benefits Administrators for data requests such as:
  - Demographic information
  - Qualifying event
  - Type of coverage
  - Start date
  - End date
  - Date paid through
- HCA mails the *SEBB Continuation Coverage Election Notice*
- HCA reviews returned forms for eligibility

Interim Process Status

- Outreach and Training:
  - Started training the Benefits Administrators in August
  - Sent the first request to SEBB Organizations on August 7
  - Will send two more requests early December and early January
  - Will follow up with SEBB Organizations that do not respond

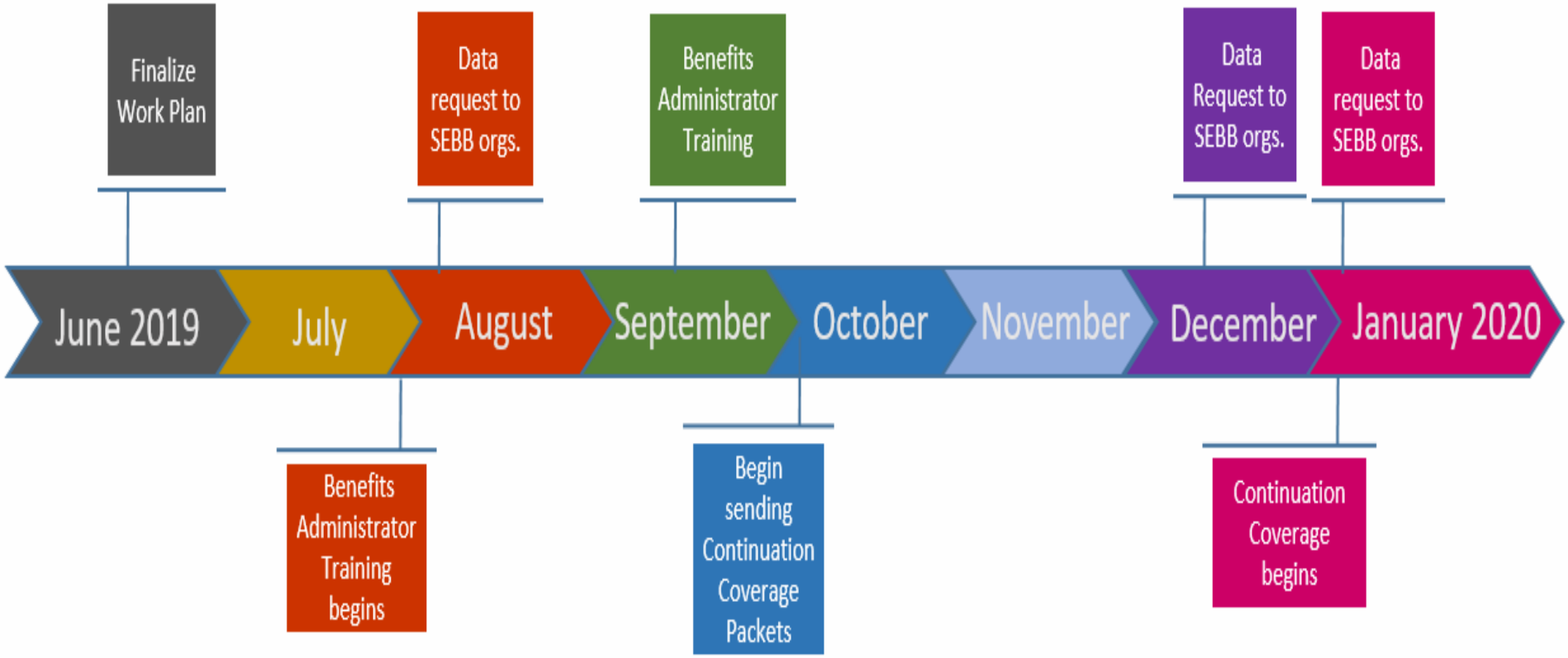
- HCA:
  - Will mail *SEBB Continuation Coverage Election Notice* starting in October
  - Will continue to mail packets regularly

Customer Service

- Answers questions and assists members with filling out the forms via phone or in-person lobby services
- Verifies eligibility and enrolls eligible members
- Sends confirmation letter for eligible members
- Sends denial letter with appeal rights for ineligible members
- Contacts member with questions
- Sends letter for additional required documentation if needed

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Timeline for Continuation Coverage Implementation



Questions?

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Alisa Richards
Benefits Accounts Customer Service Operations Manager
Employees and Retirees Benefits (ERB) Division
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TAB 9

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

SEBB Training and Benefits Fairs Update

Jesse Paulsboe, Outreach and Training Manager
Employees and Retirees Benefits Division
August 29, 2019

SEBB Two-Day Benefit Administrator Training
August 1 – September 26

Throughout August and September, ERB Outreach &Training is hosting SEBB Benefits Administrator Training events across Washington. This training covers:

- Eligibility
- Benefits
- SEBB My Account
- Websites for benefits administrators and employees
- Appeals processes
- Continuation coverage options (like COBRA) for when employees lose coverage

✓	August 1-2, 2019	Renton, WA
✓	August 5-6, 2019	Spokane, WA
✓	August 7-8, 2019	Spokane, WA
✓	August 8-9, 2019	Yakima, WA
✓	August 12-13, 2019	Pasco, WA
✓	August 15-16, 2019	Wenatchee, WA
✓	August 15-16, 2019	Mt. Vernon, WA
✓	August 19-20, 2019	Bremerton, WA
	August 29-30, 2019	Tumwater, WA
	August 29-39, 2019	Vancouver, WA

September 9-10, 2019	Renton, WA
September 9-10, 2019	Mt. Vernon, WA
September 12-13, 2019	Vancouver, WA
September 12-13, 2019	Olympia, WA
September 16-17, 2019	Pasco, WA
September 16-17, 2019	Spokane, WA
September 19-20, 2019	Yakima, WA
September 19-20, 2019	Wenatchee, WA
September 24-25, 2019	Bremerton, WA

SEBB Two-Day Benefits Administrator Training (*cont.*) August 1 – September 26

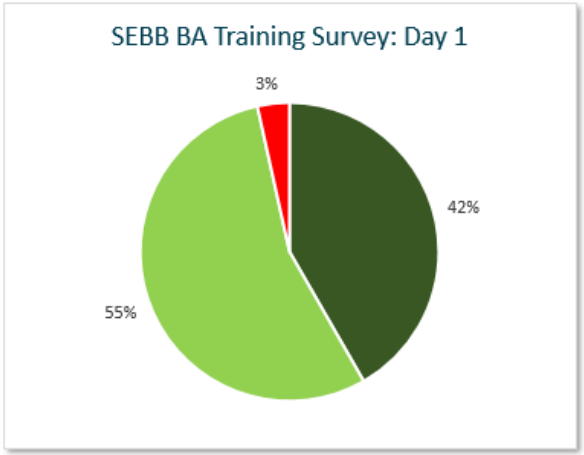
Through the August 20 Bremerton Training:

- 407 Attendees Trained
- 181/310 SEBB Organizations represented (58.20%)
- 78.64% of the total school employee population

SEBB Two-Day Benefit Administrator Training (Day 1)

DAY 1: SEBB BENEFITS AND ELIGIBILITY

GRAND TOTALS							
I felt that:	**Strongly Agree**		**Agree**		**Disagree**		**Totals**
My time was well spent	193	59%	123	38%	10	3%	326
The trainers were knowledge able	225	69%	103	31%	0	0%	328
The class met my expectations	183	55%	142	43%	6	2%	331
I am comfortable with the following resources:	**Strongly Agree**		**Agree**		**Disagree**		**Totals**
SEBB Eligibility Worksheets	62	20%	170	56%	73	24%	305
The Benefits Administrator Website/Webpage	94	29%	203	62%	29	9%	326
The SEBB Website	106	33%	197	62%	16	5%	319
I Understand the Following:	**Strongly Agree**		**Agree**		**Disagree**		**Totals**
First Annual Open Enrollment	158	47%	176	52%	4	1%	338
Employee Eligibility	117	36%	194	60%	14	4%	325
Eligible Dependents	165	49%	170	51%	0	0%	335
Dependent Verification Documents	143	45%	173	54%	5	2%	321
SEBB Medical Benefits	122	37%	202	61%	7	2%	331
SEBB Premium Surcharges	141	42%	191	57%	4	1%	336
SEBB Vision Benefits	126	38%	199	60%	9	3%	334
SEBB Dental Benefits	125	37%	201	60%	8	2%	334
SEBB Life and AD&D Insurance	131	39%	198	59%	5	1%	334
SEBB LTD Insurance	125	37%	204	61%	5	1%	334
SEBB Medical FSA & DCAP	136	40%	201	59%	6	2%	343
SEBB Annual Open Enrollment	136	41%	193	58%	6	2%	335
SEBB Special Open Enrollment	125	38%	193	59%	10	3%	328
		42%		55%		3%	

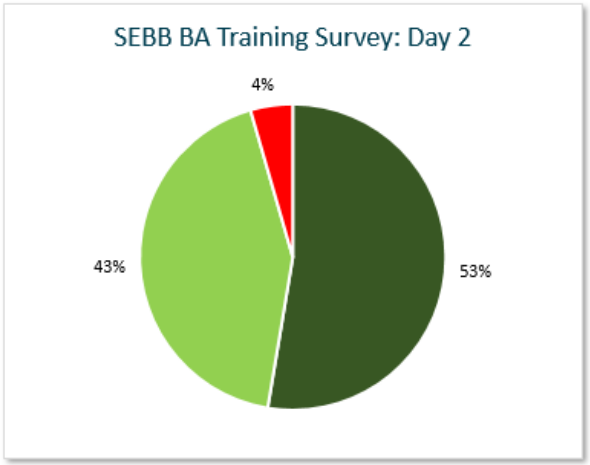


Total SEBB Orgs Trained:	181
Percent SEBB Orgs Trained:	58.20%
Total Trained Attendees:	407
Percent EEs Represented:	78.64%

SEBB Two-Day Benefit Administrator Training (Day 2)

DAY 2: SEBB MY ACCOUNT

GRAND TOTALS							
I felt that:	**Strongly Agree**		**Agree**		**Disagree**		**Totals**
My time was well spent	176	**58%**	105	**35%**	21	**7%**	302
The trainers were knowledgeable	214	**71%**	88	**29%**	1	**0%**	303
The class met my expectations	158	**54%**	107	**37%**	25	**9%**	290
I am comfortable with the following resources:	**Strongly Agree**		**Agree**		**Disagree**		**Totals**
FUZE: Secure email where I can ask questions/get help	145	**49%**	141	**47%**	11	**4%**	297
GovDelivery: How I can receive updates from O&T	155	**52%**	131	**44%**	10	**3%**	296
I am confident doing the following in SMA:	**Strongly Agree**		**Agree**		**Disagree**		**Totals**
Log into SMA	165	**57%**	116	**40%**	11	**4%**	292
Updating the first day of school	171	**58%**	117	**40%**	8	**3%**	296
Understanding the different BA roles in SMA	156	**52%**	136	**45%**	9	**3%**	301
Understanding the different tiles in SMA	165	**56%**	123	**42%**	6	**2%**	294
Adding new employee records	162	**54%**	130	**43%**	7	**2%**	299
Enrolling employees and dependents	159	**53%**	130	**44%**	9	**3%**	298
Completing dependent verification	145	**48%**	146	**48%**	13	**4%**	304
Terminating coverage	118	**40%**	156	**53%**	21	**7%**	295
Making changes to an employee or dependent record	140	**47%**	152	**51%**	6	**2%**	298
Transferring an employee	119	**40%**	136	**46%**	41	**14%**	296
		53%		**43%**		**4%**	



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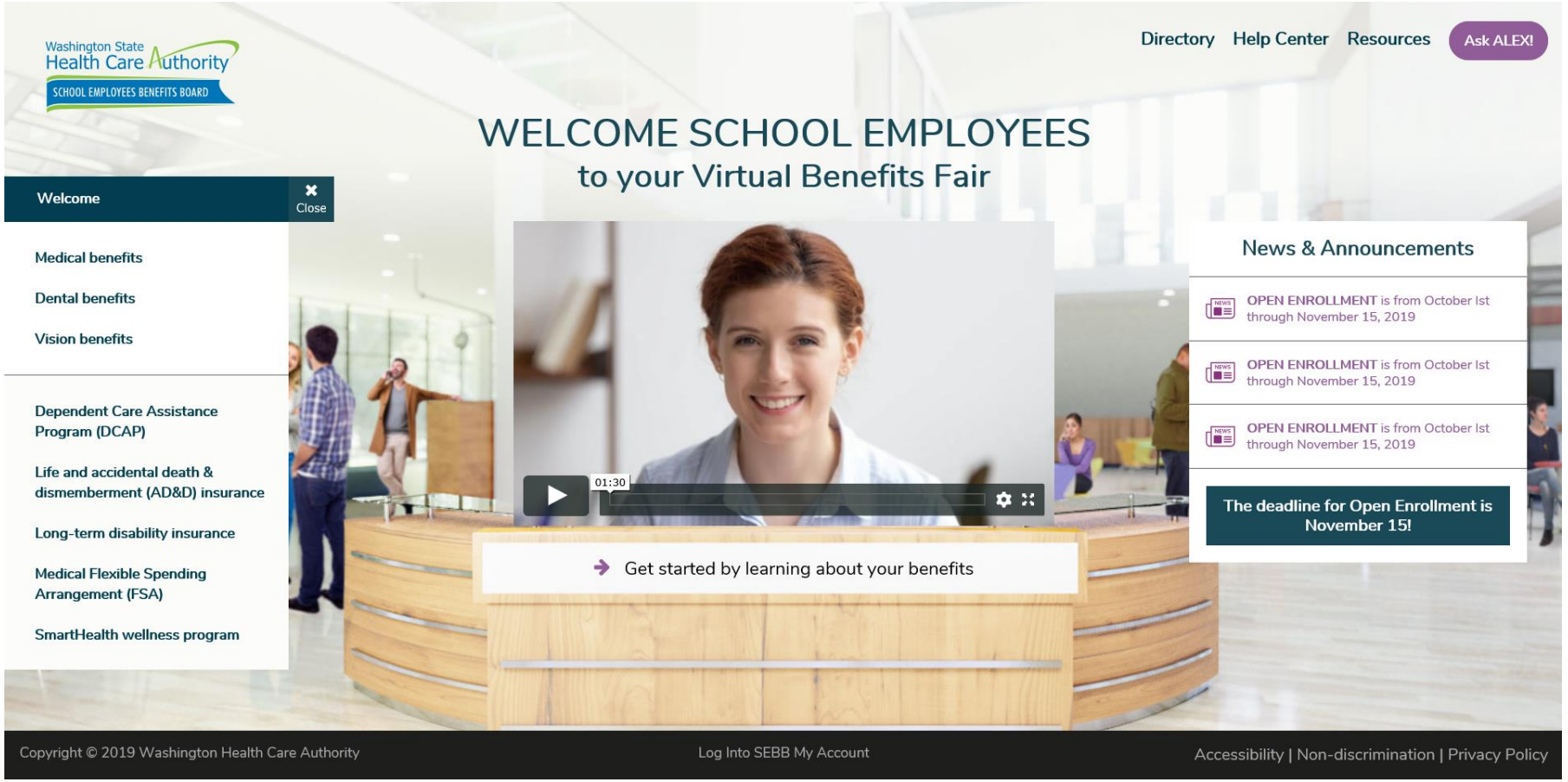
SCHOOL EMPLOYEES BENEFITS BOARD

SEBB In-Person Benefits Fairs

Date	Location	Time
09/30/19	Bellingham, WA - Bellingham Technical College	4:00pm - 8:00pm
09/30/19	Yakima, WA – Howard Johnson Plaza	4:00pm - 8:00pm
10/01/19	Mt. Vernon, WA - Skagit College	4:00pm - 8:00pm
10/01/19	Spokane, WA - ESD #101	4:00pm - 8:00pm
10/02/19	Olympia, WA - South Puget Sound Community College	4:00pm - 8:00pm
10/02/19	Pasco, WA - Columbia Basin College	3:00pm - 8:00pm
10/03/19	Des Moines, WA - Highline College	4:00pm - 8:00pm
10/03/19	Wenatchee, WA - Confluence Tech Center	4:00pm - 8:00pm
10/07/19	Shoreline, WA - Shoreline Community College	4:30pm - 8:00pm
10/07/19	Vancouver, WA - ESD #112	3:00pm - 8:00pm
10/08/19	Tacoma, WA – University of Washington - Tacoma Campus	4:30pm - 8:00pm
10/08/19	Seattle, WA - Garfield Community Center	4:00pm - 8:00pm
10/10/19	Bremerton, WA - Sheridan Community Center	4:00pm - 8:00pm
10/14/19	Bellevue, WA - Bellevue College	4:00pm - 8:00pm
10/17/19	Port Angeles, WA - Peninsula College	4:00pm - 8:00pm
10/21/19	Moses Lake, WA – Columbia Basin Tech Center	4:00pm - 8:00pm
10/22/19	Cheney, WA - Eastern Washington University	4:00pm - 8:00pm
10/23/19	Colville, WA – Agricultural & Trade Center	4:00pm - 8:00pm
10/24/19	Omak, WA - Omak High School	4:00pm - 8:00pm
11/07/19	Pullman, WA – Washington State University - Pullman	4:00pm - 8:00pm

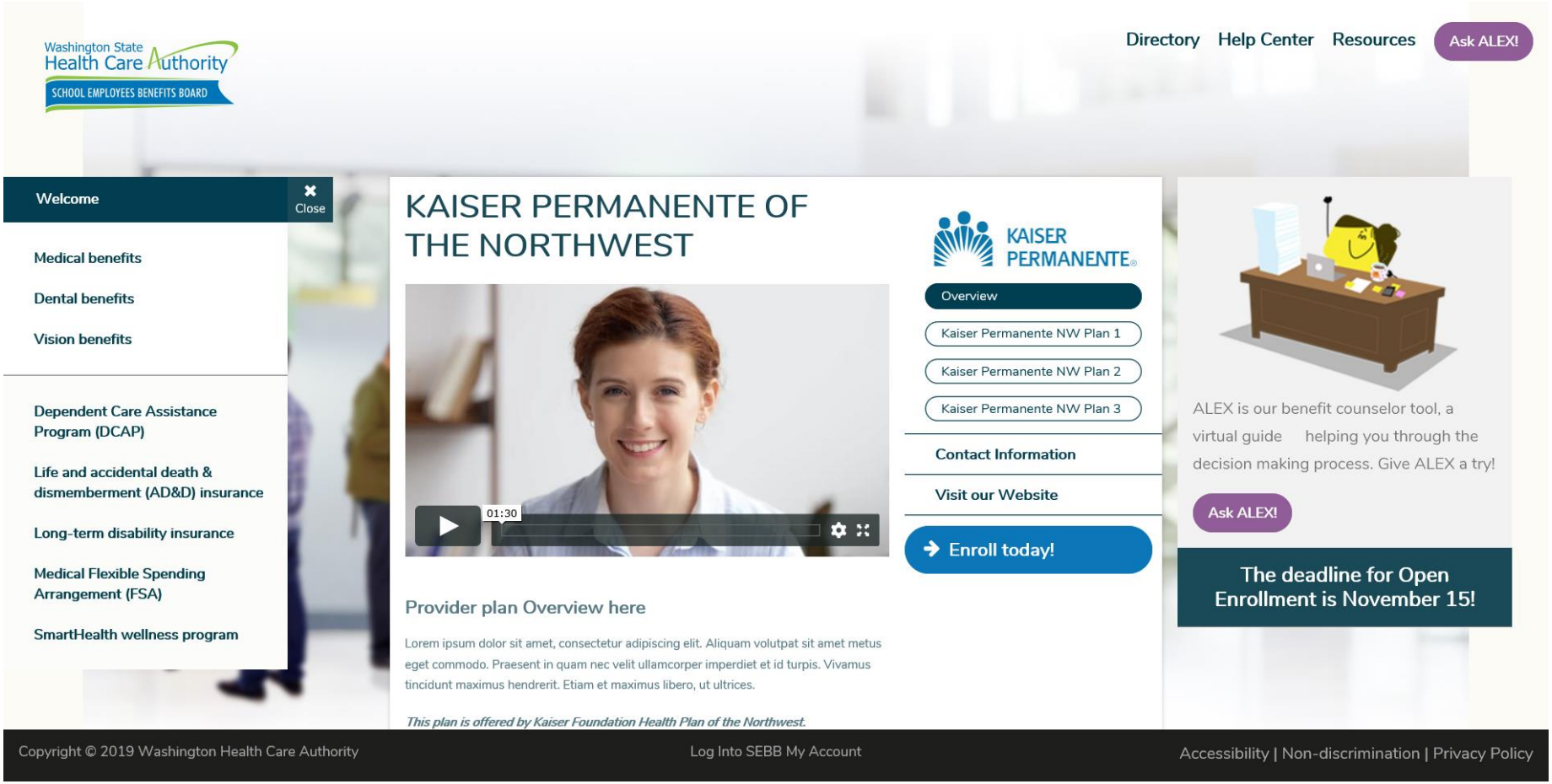
SEBB Virtual Benefits Fair

October 1 – November 15



SEBB Virtual Benefits Fair (*cont.*)

SEBB Virtual Benefits Fair (*cont.*)



Questions?

Jesse Paulsboe
Employer Outreach & Training Manager
Employees and Retirees Benefits Division
jesse.paulsboe@hca.wa.gov

TAB 10

Washington State Health Care Authority

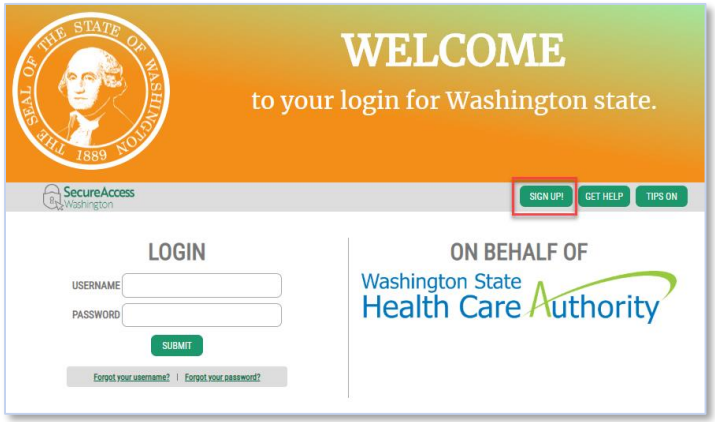
SCHOOL EMPLOYEES BENEFITS BOARD

SEBB My Account Testing

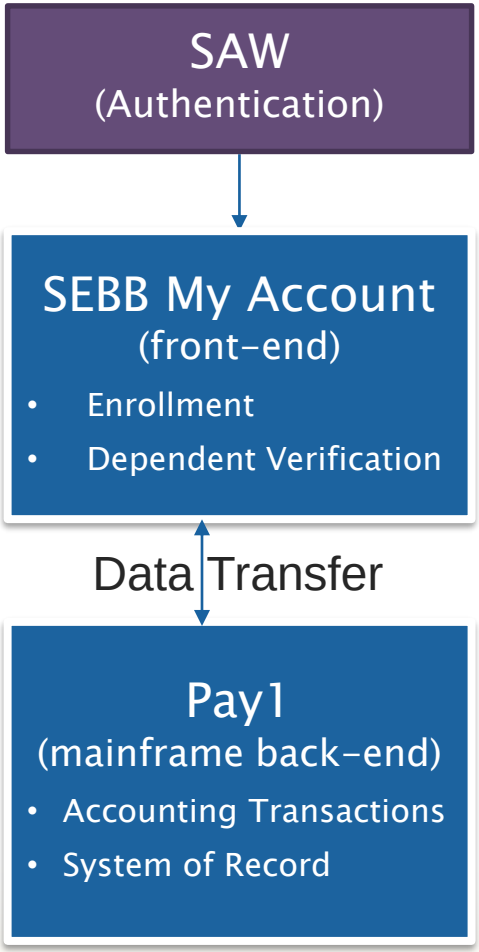
Jerry Britcher
Chief Information Officer
Enterprise Technology Services Division
August 29, 2019

Secure Access Washington (SAW) for SEBB My Account

- **What is it?**
  - "SecureAccess Washington® provides self-administered single sign-on access to multiple agency applications, shields online services from harmful activity, and allows access only to known users" – WaTech website
- **Why is SEBB My Account using it?**
  - Requirement by state policy for access to sensitive data
  - Simplifies security risk management
  - Other agencies who use SAW: DSHS, DOR, DOL, ESD, DOH, and more
- **How will users interact with SAW?**
  - Subscribers will create/use a previous account with a username and password
  - Benefits Administrators will create/use a previous account with a username and password, plus an added layer of security ("multi-factor authentication") to confirm identity with a code sent by phone, email, or text



SEBB Program IT Components



SEBB My Account for Subscribers

- Select medical, dental, vision coverage
- Select supplemental Long-Term Disability coverage
- Access portals to select Medical FSA, DCAP, supplemental Life and AD&D Insurance coverage
- Add/remove dependents
- Submit dependent verification documents
- Make spousal attestations
- Make tobacco attestations
- Identify a life change that initiates a special open enrollment event; select coverage as appropriate
- View coverage summary and coverage elections

Pay1

- Pay1 will be the SEBB Program System of Record
- Interface with the statewide accounting system (AFRS) and the Office of the State Treasurer
- Carrier payments, audit reconciliation files, and notifications
- Accounting:
  - Invoicing: Calculate subscriber invoices and roll up into group billing for SEBB Organizations
  - Accounts Receivable: Receive payments
  - Accounts Payable: Pay carriers

SEBB My Account for Benefits Administrators

- Add access for other administrators
- Manage organization's profile
- Upload or manually add/remove eligible employees
- Select coverage; make other changes on behalf of employees
- Verify/deny dependents
- Verify/deny special open enrollment events
- View billing and SmartHealth files
- View various reports
- Upload deductions for Medical FSA/DCAP and download subscriber elections
- Review enrollment documents loaded from paper forms that need intervention

SEBB My Account Testing

Internal Testing

- Performed by:
  - IT test professionals (5 staff)
  - HCA staff: (30 staff)
    - Accounting
    - Customer Service
    - ERB Policy/Rules
    - Legal
    - Outreach & Training

External Testing

- Performed by:
  - 55 different SEBB Organizations from across the state
    - 94 Benefits Administrators tested
    - 52 Potential subscribers (some of whom also tested as administrators)

IT Testing - External

- **Beta Testing** – May-June 2019
  Verified the usability and intuitiveness of SEBB My Account by SEBB Organization end users before training and in time for development changes to be made
- **Eligibility File Testing** – July-August 2019
  Verified SEBB Organizations can extract a file from their systems with eligible populations that can correctly load into SEBB My Account without errors before Go-Live
- **API Testing** – August 2019
  Configured to support a SEBB My Account endpoint can be reached and "talked to" by external interfaces in SEBB Organizations

External Testing Results

- ✓ **Beta Testing –** Success
  - 105 users logged in
  - 82% of subscribers and 85% of administrators said it was intuitive
  - Biggest pain points: logging in, defect around slowness/spinning circle (now fixed)
  - Useful information provided to training staff and contact center for support
- ✓ **Eligibility File Testing –** Opportunity Provided to SEBB Organizations

SEBB IT Testing - Internal

- **System Testing** – October 2018-August 2019
  Professional testers verified functionality meets requirements by testing navigation, expected behavior, design
- **User Acceptance Testing** – May-August 2019
  Internal HCA users verified functionality meets business needs by verifying business rules are applied correctly
- **Exploratory Testing** – May-June 2019
  Internal HCA subject matter experts and Business Analysts verified functionality and business needs
- **Performance Testing** – July-August 2019
  Verified the SEBB My Account system can handle a large volume of traffic and that response time meets business requirements
- **End-to-end Testing** – August 2019
  Verified data processing, subscriber enrollment, administrative functions, carrier uploads for all workstreams

Performance Testing

- Results assessed for:
  - Maximum number of concurrent users
  - Subscriber open enrollment
  - All administrative functions for Benefits Administrators
  - Dependent verification document upload

Internal Testing Results

- ✓ **System Testing –** A single defect, currently being resolved, that results in system/core components being down or that does not have a workaround (severity 1 defect)
- ✓ **User Acceptance Testing –** Core business users buy off; Product Owner accepts the system (System accuracy and functionality approved)
- ✓ **Performance Testing –** Successful for 25,000 concurrent users in SEBB My Account (can support 150,000 users accessing the system in a one-hour period); 5,000 concurrent users in any single module
- ✓ **End-to-End Testing –** Successfully verified multiple workstreams
- ✓ **Mobile Testing –** Successfully verified that SEBB My Account can be utilized from mobile devices (including auto-configuration for form factor)

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Questions?

Jerry Britcher
Chief Information Officer
Enterprise Technology Services Division
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TAB 11

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD

SEBB My Account Contact Center

Alisa Richards, Customer Service Operations Manager
Benefits Accounts Section
Employees and Retirees Benefits Division
August 29, 2019

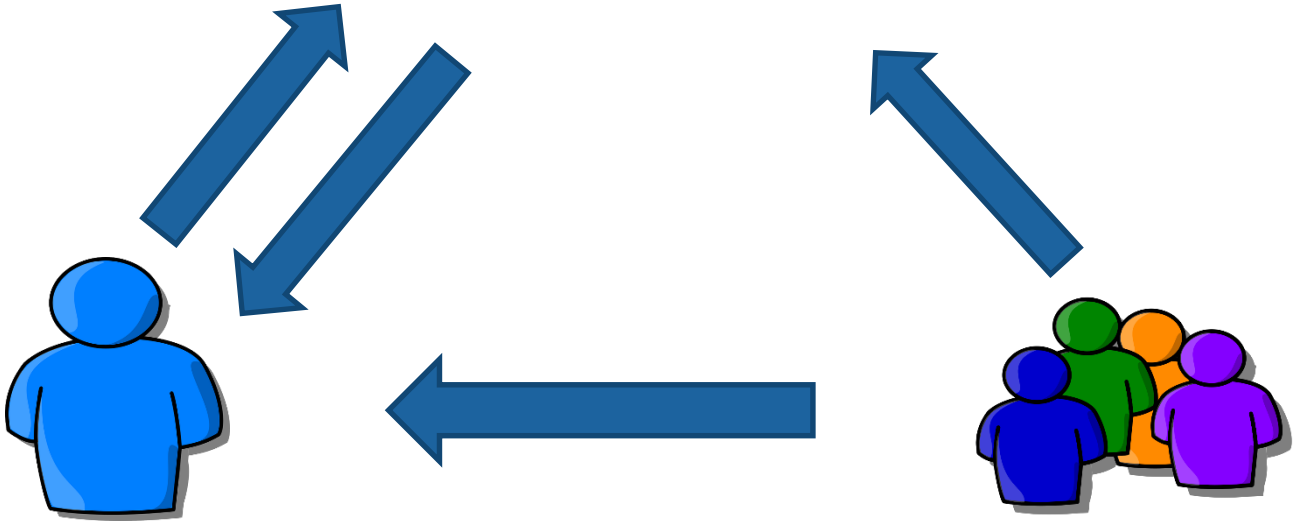
Overview

- Technical support for SecureAccess Washington® (SAW) and SEBB My Account
- Faneuil is the Contact Center vendor

Contact Center Resources

- Pre-Production SEBB My Account access
- HCA training resources
- Online navigation videos for users

Faneuil Contact Center



Benefits Administrators

SEBB Program Members

Member Support Offered to Employees

- Technical support, such as new user registration in SecureAccess Washington® (SAW) and SEBB My Account
- Navigation of SAW and SEBB My Account
- Walk users through process to upload dependent verification documents
- Walk users through screens to select plans (does not assist with selecting a plan)
- Walk users through screens to add dependent to account (does not assist with dependent eligibility questions)
- Refer callers to Washington Technology Solutions (WaTech) for SAW account issues (resetting password, forgot username, etc.)
- Refer callers to their school districts Benefits Administrators for eligibility questions

Washington State Health Care Authority
SCHOOL EMPLOYEES BENEFITS BOARD

Hours of operation

Time Period	Days of the Week	Hours of operation
9/23–9/30/19 Benefits Administrators	Monday–Friday	8:00 a.m. – 5:00 p.m.
10/1–11/15/19 Employees and Benefits Administrators	Monday–Friday	7:00 a.m. – 9:00 p.m.
10/1–11/9/19 Employees and Benefits Administrators	Saturday	10:00 a.m. – 4:00 p.m.

Questions?

Alisa Richards, Customer Service Operations Manager

Benefits Accounts Section

Employees and Retirees Benefits (ERB) Division

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