Washington State Health Care Authority

School Employees Benefits Board Meeting

May 30, 2018

Washington State Health Care Authority

School Employees Benefits Board

May 30, 2018
1:00 p.m. – 5:00 p.m.

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

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TAB 1

Washington State Health Care Authority

AGENDA

School Employees Benefits Board
May 30, 2018
1:00 p.m. – 5:00 p.m.
Sue Crystal Rooms A & B

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

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

1:00 p.m.*	**Welcome and Introductions**		Lou McDermott, Chair	
1:05 p.m.	**Meeting Overview**		David Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information
1:10 p.m.	**Approve December 11, 2017 Minutes**	TAB 3	Lou McDermott, Chair	Action
1:15 p.m.	**Follow-up Board Questions from April 30 Meeting**		David Iseminger, ERB Director	Information/ Discussion
1:20 p.m.	**Uniform Medical Plan (UMP) Follow-Up**	TAB 4	Shawna Lang, Senior Account Manager Portfolio Management and Monitoring Section, ERB	Information/ Discussion
1:45 p.m.	**Uniform Medical Plan Plus**	TAB 5	Michael Arnis, Account Manager, UMP Plus Portfolio Management and Monitoring Section, ERB Barb Lantz, Clinical Policy Development, Implementation, and Oversight Manager, CQCT Division	Information/ Discussion
2:10 p.m.	**Uniform Medical Plan (UMP) Pharmacy Benefits**	TAB 6	Ryan Pistoresi, Assistant Chief Pharmacy Officer Clinical Quality and Care Transformation	Information/ Discussion
2:35 p.m.	**Proposed Self-Insured Medical Plan Resolutions**	TAB 7	David Iseminger, ERB Director	Information/ Discussion
2:50 p.m.	**Break**			
3:00 p.m.	**Fully Insured Medical Plan(s) Procurement Update**	TAB 8	Lauren Johnston SEBB Procurement & Account Manager ERB Division	Information/ Discussion

3:45 p.m.	**Policy Resolutions**	TAB 9	Barb Scott, Manager Policy & Rules Section, ERB	Action
4:10 p.m.	**Eligibility & Enrollment Policy Development**	TAB 10	Barb Scott, Manager Policy & Rules Section, ERB	Information/ Discussion
4:40 p.m.	**Public Comment**			
5:00 p.m.	**Adjourn**			

***All Times Approximate**

The School Employees Benefits Board will meet Wednesday, May 30 2018, 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 May 28, 2018.

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@siginsures.com	Employee Health Benefits Policy and Administration
Pete Cutler 7605 Ostrich DR SE Olympia WA 98513 C 360-789-2787 p.cutler@comcast.net	Employee Health Benefits Policy and Administration
Patty Estes Eatonville School District PO Box 1364 Eatonville WA 98328 C 360-621-9610 p.estes.sebb@gmail.com	Classified Employees
Dan Gossett 603 Veralene Way SW Everett WA 98203 C 425-737-2983 dan.gossett@comcast.net	Certificated Employees

SEB Board Members

Name	Representing
Katy Henry Spokane Public Schools 200 North Bernard Spokane WA 99201 V 509-325-4503 khenry@washingtonea.org	Certificated Employees
Terri House Marysville School District 4220 80th ST NE Marysville WA 98270 V 360-965-1610 Terri_house@msd25.org	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@mead354.org	Employee Health Benefits Policy and Administration (WASBO)
Alison Poulsen 12515 South Hangman Valley RD Valleyford WA 99036 C 509-499-0482 alison@betterhealthtogether.org	Employee Health Benefits Policy and Administration

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2/24/18

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

2017-18 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. The meetings begin at 1:00 p.m., unless otherwise noted below.

October 23, 2017

November 6, 2017

December 11, 2017

January 17, 2018

January 29, 2018

March 15, 2018 - 9:00 a.m.

April 30, 2018

May 30, 2018

June 13, 2018

July 30, 2018

August 30, 2018 - 9:00 a.m.

October 4, 2018 - 9:00 a.m.

November 8, 2018 - 9:00 a.m.

December 13, 2018 - 9:00 a.m.

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: August 30, 2017
TIME: 1:26 PM

WSR 17-18-043

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

8/28/17

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

2019 School Employees Benefits Board (SEBB) Meeting Schedule

DRAFT

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. The meetings begin at 9:00 a.m. unless otherwise noted.

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 13, 2019 - 9:00 a.m. – 1:00 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 22, 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 5/25/18

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

School Employees Benefits Board
Meeting Minutes

D R A F T

December 11, 2017
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:00 p.m. – 5:00 p.m.

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

Members Absent:
Alison Carl White

SEB Board Counsel:
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 1:03 p.m. TVW, Washington's Public Affairs Network, taped the meeting. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

Agenda Overview
Dave Iseminger, ERB Division Acting Director, provided an overview of the agenda.

Follow Up on Prior Meeting Questions
Dave Iseminger, ERB Division Acting Director: I have a variety of different questions that you've asked from the last two meetings. First, there was a request for Katy to give legal advice on the AGO's representation related to Open Public Meeting Act violations. Katy responded directly to the Board in an attorney-client privileged email. If you have additional questions or don't feel you got that email, please let me know, or you can email questions directly to Katy.

Second, there was a request for Bree Collaborative information and you'll be getting that shortly with Dr. Lessler's presentation.

Next, there have been a variety of questions at prior meetings about what the agency knows or hears could be improved, clarified, or fixed in House Bill 2242's SEBB Program laws. For some general information, I want to make sure you're aware that state agencies provide technical assistance to other parts of state government. Examples of that would be other state agencies, Office of Financial Management (OFM), and even individual legislators. That technical assistance can include doing an impact analysis of draft language that someone else has produced, or even drafting language to achieve a goal that the requester is asking for so they can consider using it in an upcoming bill. I want to respond to your questions by giving you high-level descriptions of some of the topical areas that we have been asked to provide technical assistance on. This doesn't mean that it will or won't be in legislation.

The first area relates to a question from Katy Henry, who asked for some insight about giving HCA the authority to reimburse school districts for substitutes related to Board Member duties.

Second is data collection requirements. The legislation (HB 2242) allows HCA to use data to assist you with benefit design, procurement when we do the actual procurements, and then the rate-setting process. The date that data is due to the agency is January 1, 2019, which is after the procurements will likely need to be completed. There have been some questions about how to address those statutory provisions to make sure that the data is here to be able to do those functions. I'll also address the relationship of data from the school districts with the agency, as well as the Insurance Commissioner's Office (OIC), because there were multiple pieces of legislation passed last session that impacted the same section of the RCW.

A third area is clarifying that the salary reduction plan, the Cafeteria Plan, is something that can be accessed and utilized for school employees.

Fourth, we've been asked about what other fiscal accounts the agency uses that weren't created in the original legislation. There are about seven different accounts that are used on the Public Employees Benefits Board (PEBB) side of the world to be able to track funds separately for separate benefits, and not all of those were created in House Bill 2242. We've been asked what other accounts would need to be created for future use to be able to separately track those funds for the SEBB Program.

Pete Cutler: Dave, just on that last one, so there will be a presentation, or memo, or something at some point on those funds?

Dave Iseminger: Yes, we will go over the funding structure when we get further along in the process. This question we've been asked is, "were all the appropriate accounts physically created in legislation." And the answer was some of them were and some of them weren't, so this is just the actual physical

creation of the account. As we describe the fiscal impacts to you, we'll make sure that we're clear in presenting what accounts are used when and for what.

Pete Cutler: Thank you.

Dave Iseminger: The next two areas are related because of the way the SEBB Program was overlaid into Chapter 4105, RCW. There were several parts in the definitional part of the statute that when you wear your SEBB hat, you can read the statutory scheme this way and when you wear your PEBB hat, you can read the statutory scheme that way. It gets very confusing.

There were two definitions in particular that we've been asked for insight on. One is the definition of employee in statute. There's a discussion about simply inserting the word "school" in front of “employee”. Then you have definitions of “employee” for state agencies and higher education and “school employee” for the K-12 world to be able to distinguish better in the statute. The other area is actually the way the Board is referred to in statute. Our understanding is that all of the statutes that relate to Board roles and responsibilities weren't fully reviewed in RCW 41.05 in the original legislation. We've been asked to provide insight about clarifying parts of statutes that weren't addressed in House Bill 2242 that relate to Board roles and responsibilities.

Next, we've had several questions come about whether the statute includes a three-to-one premium ratio description that has historically existed in Title 28A. We've described that we don't see a three-to-one ratio expressly in statute. There have been questions about how that could be written into RCW 41.05 to be clear on this point in the Health Care Authority statutes.

Another question is related slightly to eligibility rules, which is one of your core functions. We were asked how the core eligibility statute compares to the world that the Health Care Authority administers in the Public Employees Benefits Board (PEBB) Program. One of the differences identified is the concept of “anticipated to work” was not written into the school employee eligibility statute. This concept distinguishes between if an individual has benefits eligibility based on whether they're anticipated to ultimately meet the eligibility requirements, or whether they actually have to meet the eligibility requirements before they are able to have benefits.

Finally, there are requests for some clarity around charter school employees. There were some references throughout RCW 41.05 where the bill referenced charter school employees, but it didn't systemically get all of the references. There were questions about what else would need to be amended in statute to make sure that was systemically addressed.

Those are areas I wanted to make sure you were aware of for agency technical assistance. When we come back to the Board in January, session will have

started. We'll definitely have a briefing on any legislation that's been dropped that impacts the School Employees Benefits Board (SEBB) Program.

For the fourth area of prior meeting follow-up questions, the Board asked some technical benefits questions. This is a preview of medical and dental presentations to come next month, but I will answer questions that you've asked so far. There was a question about whether the medical out-of-pocket maximum in the PEBB Program plans applies to out-of-network costs. The answer is no. Co-insurance paid to an out-of-network provider does not count for out-of-pocket maximums, nor do balance billed amounts that result from going to an out-of-network provider. We'll go through more granular details when we go into the medical benefits next month.

The other high-level benefit question so far is what is the annual cap on PEBB Program dental benefits? For the Uniform Dental Plan, which is the self-insured state plan, the annual benefit maximum is $1,750. There is no maximum on the two managed care plans, administered by Delta Care and Willamette Dental.

The next two follow-up question areas are still in pending status. Wayne, I believe you asked the first question of the Board, which was about whether the eligibility requirements include School Board Members. I just want to assure you that is still on our radar. We want to address that whenever we start presenting about the eligibility framework for you as a Board to be discussing. The agency does have experience with elected commissions and their eligibility, so we have a framework that we'll be able to pull from to answer that question.

The other prior meeting question we'll wait to answer until we get more into the medical benefits. You asked for testimonial information about how different public employees are experiencing their benefits. In particular, this came up in the concept of the Uniform Medical Plan Plus, as well as the Centers of Excellence Total Joint Hip Replacement Program. As we're presenting benefits, we will find ways to get you information about how members are experiencing those benefits.

The last thing I want to revisit from the last meeting were your questions about why Dr. Lessler gave a presentation on value-based purchasing. I want to make sure you understand that the value-based purchasing efforts for the Health Care Authority were established by legislation. In particular, in 2014 House Bill 2572 was passed and directed the Health Care Authority to increase value-based purchasing contracting in the agency's work. Over the past several years, medical and dental insurance products developed through HCA's contracting efforts have been modified to include value-based purchasing concepts promoting quality, efficiency, cost-savings, and health improvement. Dr. Lessler talked about all of those things at the last meeting. I wanted you to know how the products that the Health Care Authority has developed over the past years

changed as a result of the value-based purchasing legislation and to give you that background information.

The Bree Collaborative and the Health Technology Assessment Program

Dan Lessler, HCA Chief Medical Officer: As Dave mentioned, there was a request from a Board Member for a briefing on this topic. I'm very familiar and very involved with these programs in my role as Chief Medical Officer. Both the Bree Collaborative and the Health Technology Assessment Program illustrate ways that the Legislature can influence directly or indirectly benefit design. It's particularly important to note that these two programs demonstrate the state's commitment to evidence-based medicine, which is very important.

I want to begin by discussing the Robert Bree Collaborative and a word about Dr. Robert Bree. This effort is named after him. Dr. Bree died tragically a number of years ago. I knew him well and I worked with him at Harborview. He was a very respected radiologist, both nationally and internationally. He was very committed to evidence-based care, and evidence-based radiology, and especially the appropriate use of advanced imaging techniques like MRI and CT Scan, and so forth. The Bree really was preceded by a group that was looking specifically at evidence-based imaging and how to promote appropriate evidence-based imaging across the state. It was that effort that subsequently evolved into The Bree.

Slide 4: The Bree was created in legislation in 2011. Its purpose is to identify areas where there is high degrees of variation in how care is delivered, or very high levels of cost and utilization, or salient safety concerns. What the bill directed was the creation of a committee that is multi-stakeholder with 22 members. There is broad representation, including purchasers, plans, clinicians, etc. The Bree is directed to meet every two months to undertake its work in addressing these areas of high variation and high utilization. They are areas where there are salient safety concerns.

Slide 5: The committee itself if appointed by the Governor and this slide is a list of those people who are currently on the Committee, myself included in my role as Chief Medical Officer. You'll see quite broad representation in terms of the different sectors related to health care.

Slide 6: How does The Bree select topics? The process begins by casting a very wide net for ideas, including from Bree members themselves and their experience, their professional understanding of health care delivery; the Agency Medical Directors Group, on which I participate, which is a cross-state agency group of physicians who come together and look at our own experience in our respected programs; and also the public. Through that process, there is an identification of salient opportunities around topics that represent inefficiencies, observed variation in utilization, patient harm, etc. Then also, and very importantly within the context of those specific topics, there are strategies that

are demonstrated to really lead the appropriate use and clinical care when implemented. It's both the identification of a topic, as well as an awareness, that there's actually something we know we can do to improve how this care is provided relevant to that topic.

Slide 7: This slide shows what happens once topics are chosen. This begins with the formation of a Clinical Committee. You see that in the middle of the slide. We refer to them as clinical work groups. These clinical work groups are constituted from experts across the community, not just clinicians, but others as well, frequently, people from the community, stakeholders, advocates, and so forth. They come together to meet regularly to identify appropriate strategies that can influence and drive care in a more appropriate direction. In doing that, they work with information that they gather on evidence-based guidelines, provider feedback reports, what the influence of public reporting may have been, etc. Over that course of time, they promulgate a set of recommendations. I would emphasize that this process is entirely public; the work of the work groups is open to the public and the work of The Bree is open to the public. Everything that goes on is completely transparent.

Lou McDermott: Dr. Lessler. Where do you meet? Is there a call-in number?

Dan Lessler: We meet in Seattle at the Puget Sound Business Council close to Pioneer Square. There's always a call-in number. All of the information is at The Bree Collaborative website.

People who participate and do this work do it voluntarily, which I think is truly remarkable and represents an incredible collaborative commitment on the part of the people of this state. Once the recommendations have been formulated, they are reviewed and voted on by The Bree. If approved by The Bree, they come back to the Health Care Authority for review and formal endorsement.

Lou McDermott: I want to do a quick update. Katy Henry had a family issue and needed to leave the meeting.

Dan Lessler: Slide 8 lists the topics on which The Bree has made recommendations. The details and recommendations themselves are available at The Bree website. They are well done. If people have an interest in a particular topic, I would encourage you to take a look at those products.

Slide 9 is a list of current topics that The Bree has been working on in 2017. The formal recommendations have been promulgated by each work group. Most of them, except for the hysterectomy topic, have been voted on and approved by The Bree and are now at the HCA for review.

Slide 10 is a list of topics that are on The Bree's plate for 2018. The suicide prevention has special meaning for The Bree as Bob Bree's daughter

participated as a member of the public in advocating for this topic. The family is very public about that fact that Bob Bree took his own life. He had suffered with depression for much of his life. In some sense, it has come full circle that this Collaborative is named after him and that his daughter would be there. She is a family physician advocating for this topic, very publically discussing her father's death.

Slide 11 has two examples of how the HCA takes action on Bree recommendations. The first example and the two top bullets are about The Bree total joint replacement (TJR) bundled purchasing model. This recommendation describes best practices for providing knee and hip replacements. There are four cycles described in the model. It impressively includes the notion of a warranty – if a person experiences certain complications within a certain timeframe and needs further care, then that care should be covered within the initial cost of the procedure.

The Health Care Authority actually procured a total joint bundle in 2016. The benefit began in January 2017 and is currently active with Virginia Mason for many PEBB Program members. This example, which does involve a benefit change, was discussed with and approved by the PEB Board. The final bullet relates to what Dave mentioned earlier regarding our work on fulfilling the legislative direction to undertake value-based purchasing. We have incorporated many Bree recommendations into care transformation elements in our Health Care Authority contracts as part of the Uniform Medical Plan Plus. Those are the Accountable Care Programs that the Uniform Medical Plan has contracted with the UW Medicine Accountable Care Network and the Puget Sound High-Value Network. Again, that was done in consultation and approval of the PEB Board.

Lou McDermott: Dan, would you share a bit about what we discovered? I think The Bree does a great job of standardizing a protocol in saying, "This is how it should be done." When we looked at bundles, we felt hip and knee was a good example of that. Can you talk about some of the variation we discovered in that RFP process to highlight why something like Bree is important?

Dan Lessler: That's a good question. When we issued the RFP, we actually thought we would contract with multiple Centers of Excellence. The Bree has set a very high bar in terms of expectations around those four cycles of care. We had around 14 RFP responses. We made site visits to four sites. In looking at the data that was submitted and the data we had, there was a two and a half fold difference just in charges or costs for the hip and knee joint replacements across the state. There was wide variation in readmission rates and in infection rates. It really was clear that there was not just practice variation but incredible price variation. Working with the recommendations in The Bree really allowed us to address concerns that arise in that context.

Dave Iseminger: Dan, would you describe some of the aspects of The Bree decision that are helping ensure a good outcome for patients, like the number of surgeries that would be performed, no after hours surgeries, etc.?

Dan Lessler: There's good data that demonstrates the number of surgeries performed in a hospital, or the number of surgeries performed by a provider, correlate with outcome. The Bree recommendation actually requires that a provider have performed at least 50 surgeries in a year, they're doing that on an ongoing basis, and the hospital has provided at least 100 such surgeries. There can be no surgeries on the weekends and no surgeries starting after 5 p.m. Again, there's good data around all of this in terms of The Bree recommendation.

Dave Iseminger: I want to add that when Dan referenced the role of the PEB Board, you could insert SEB Board in its place. That's exactly how the benefit process will work. We'll talk with you about benefit design, get your general insight about what you want us to go out for procurement, do a procurement, and bring back the results. Ultimately, when it's a benefit design decision, you'll let us know whether to include it in the benefits offering. I want to be clear that just because the PEB Board did something that doesn't mean you have to do it. The same framework though will apply for this Board.

Dan Lessler: The Health Technology Assessment Program, like The Bree, was created in law. There was legislation in 2006 which created the Health Technology Clinical Committee (HTCC) and directed it to use an evidence report and a clinician panel to make coverage decisions about whether agencies can pay for certain medical procedures and tests based on safety, efficacy or effectiveness, and cost effectiveness. The Health Care Authority administratively supports the Health Technology Clinical Committee. The Office of Technology Assessment defines health technology assessment as a structured analysis of a health technology, a set of related technologies, or a technology-related issue that is performed for the purpose of providing input to a policy decision.

In terms of that structured analysis, I would emphasize that what we're talking about is bringing to bear a thorough and careful evaluation of research literature in terms of what that literature is saying around the effectiveness and the safety of a particular technology. The purpose of the HTCC, or Health Technology Clinical Committee, is stated very simply, which is to pay for what works. The literature just on health care costs and the health care cost inflation in this country over decades is pretty clear that one of the major contributors to health care inflation is health care technology. And not just health care technology per se, but many technologies that have not been well evaluated and are finding their way into practice quite widely. The purpose of this Committee is really to sort through the evidence and say we're going to pay for those things that work and we're not going to pay for those things that don't work.

Slide 16 is a description of the agencies that are required in law to participate in the Health Technology Clinical Committee decisions, and required by law to implement the coverage determinations of the Committee. That includes the Health Care Authority, and under the Health Care Authority the self-insured medical plans and Medicaid.

Pete Cutler: Dr. Lessler, for the Medicaid Program, does that include the managed care organizations? Are they subject to this?

Dan Lessler: Yes.

Dave Iseminger: Related to that, Pete, your underlying question is that you don't see on that list PEBB Program fully insured medical plans. In statute, there's a specific carve out for health care services that are purchased by the Health Care Authority in a fully insured model for entities that are Health Maintenance Organizations (HMOs) or Health Care Service Contractors (HCSCs) that are specific regulated entities and are defined under the Insurance Commissioner codes. Fully insured medical plans for the SEBB Program would be carved out from Health Technology Clinical Committee (HTCC), but a self-insured medical plan offered to SEBB employees would be subject to HTCC determinations.

Dan Lessler: Slide 17: As I mentioned, the agencies are required in law to implement the coverage decisions of the Health Technology Clinical Committee. This would be relevant to one of the purposes of this presentation just to describe certain times where SEBB would not, in the case of self-insured, be able to direct a benefit. This would be a specific example of that. There are a couple of exceptions and they're noted here where there is conflict with the existing statute or law and then in certain cases where we're talking about experimental treatments.

Slide 18 goes into more detail about the program, its organization, and operation. The Health Care Authority administratively supports the HTCC through the Health Technology Assessment Program that is staffed as described here. Then there is the independent Clinical Committee. It is composed of eleven professionals. There are the technology assessment centers with which the program contracts for these detailed clinical reviews of specific topics.

Slide 19 describes the composition of the Clinical Committee. There are eleven members, six physicians, five other practicing licensed health professionals, at least two members having professional experience treating women, children, elderly persons, and people with diverse ethnic and racial backgrounds. Particularly important is that there can be no conflict of interest. Committee members cannot be contracted or employed by a health technology manufacturer or a participating agency during their term, or in the 18 months prior to appointment. They all agree to conflict of interest conditions and disclosure.

Slide 20 lists the key attributes of the HTCC. There are some overlapping themes with The Bree transparency. In a moment, I'll walk through the process from start to end. But all along the way, everything is open to the public. The meetings of the HTCC are open to the public, the reports that get generated are open for comment before they're finalized, etc. The assessments are thorough and independent. Decisions are made only by the committee.

Slide 21 provides an overview of the Health Technology Clinical Committee process. It begins with identification of a topic. Again, the Agency Medical Directors Group participates in generating ideas, but the public also has the opportunity to submit topics. Topics are reviewed, prioritized, and decided on by the Committee. Once the topic is decided, there is deeper level work and analysis that's done to specify the key questions that need to be answered about the technology. Those questions and that process are all open to the public and public input. Ultimately, the key questions get finalized and a vendor undertakes its work reviewing the literature and providing an evidence-based report. That report is open to public comment before it's finalized. The report then is used to inform the Committee deliberations about the topic when the Committee meets to hold a hearing and make a coverage decision. The hearings that the Committee have are open to the public. The draft decision is reviewed and is open to the public before it's finally finalized by the Committee and sent on to this agency and the other agencies to implement.

Since 2007, the Committee has issued about 60 coverage decisions. Slide 22 lists those decisions that occurred in 2016-2017. There's a website if people are interested in reading more about any of these. You can actually get the full detail. It's all online and quite accessible.

Pete Cutler: What kind of organizations do the assessment of the efficacy?

Dan Lessler: There is a formal procurement to identify those organizations. This year the Oregon Health Sciences University evidence-based practice center is one. The evidence-based practice center at the University of North Carolina is the second. The third is Spectrum, which is an organization that does technology assessment.

Pete Cutler: At least the first two are academic-based.

Dan Lessler: Yes, but they are not always academic-based. They can be. Those first two are. Spectrum is not academic-based.

School Employees Benefits Offerings Survey Results

John Bowden, HCA School Employees Benefits Section Manager:

Today, I am here to present information obtained from the most recent S275 and a recent HCA survey of school district officials about benefits currently offered to school employees.

Slide 3 is a reminder about SEBB Program statutory provisions about benefits. The SEB Board is to "study all matters connected with the provision of health care coverage, life insurance, liability insurance, accidental death and dismemberment (AD&D) and disability insurance,…with relation both to the welfare of the employees and the state." (RCW 41.05.740(6)(a)).

The second bullet is to "…leverage efficient purchasing by coordinating with the Public Employees Benefits Board." (RCW 41.05.740(6)(v)).

Slide 4 lists the employers included in the SEBB Program. In statute, school districts are included. They're responsible for providing the basic education to students in this state. The common schools are maintained at the public expense. Educational Service Districts (ESDs) are regional agencies that provide types of services usually on a fee basis to the school districts. Funding for many of these comes either through the fees that are charged or from grants that the ESDs write. Lastly, charter schools. They're also publicly funded schools. They're operated by nonprofit organizations, and they are alternatives to traditional common schools.

Slide 5: The data I'm going to be talking about comes today from the Office of Superintendent of Public Instruction's (OSPI) school personnel report, sometimes referred to as the S275. Secondly, most of the data comes from the high-level benefits offering survey that HCA conducted.

Slide 6: We have about 144,000 school employees across the state. 295 school districts have the majority of those employees, a little over 142,000. There are nine educational service districts with a little more than 2,000 employees and ten charter schools with a little more than 200 employees. A little over 144,000 school employees total.

Slide 7 is a map of Washington school districts. The colors have no designation other than to help you see the 295 school districts. The first public school in Washington was opened in 1852. By 1910, there were 2,888 schools in the state, which is more than we have currently, and 2,710 school districts. Basically, every school was its own school district. In the 1940s, a huge effort was undertaken to start consolidating school districts. The aim was 270 and we now have 295.

School districts are not all contained within county boundaries. Some school districts cross county boundaries. Much of the health care benefits provided in Washington are by county. We will be keeping an eye that as we go forward.

The number of employees in the school districts ranges from five employees up to 6,500 employees. The number of bargaining units in school districts range from two to 19. The SEBB Program consolidation is more than just school districts, it is also across many bargaining units.

Slide 8: There are nine educational service districts. They were created in statute in 1969 to help school districts. They are entrepreneurial, which means they receive most of their funding through fees they charge for services or grants. The size and number of school districts can only change by approval of the School Board of Education if the majority of the school district superintendents within that region petition the School Board to do so. The employee count in the ESDs range from a little over 100 employees to about 550 employees.

Slide 9: The map shows eight of the ten charter schools. They are either in the Seattle/Tacoma area or in Spokane. The two schools not shown on this map are also within the Seattle/Tacoma area. By statute, there can be up to 40 charter schools across the state. That would be the high end of it if charter schools are opened in each area. Charter schools were created by the initiative process in 2012. The State Supreme Court struck down that initiative in a decision in 2015 and the Legislature recreated the charter schools in 2016. We now have ten of them with more planned. Employee ranges for the charter schools are somewhere in the 10 to 25 range.

Slide 10 looks at where the employees are by the size of their employer. Employers with fewer than 500 employees are to the left of the red line. That is 239 employers and 32,000 employees. This equates to approximately three quarters of the employers and one fifth of the employees in the state that come under the jurisdiction of the SEB Board.

The over 575 employers with more than 500 employees are to the right of the red line, which is about a quarter of the employers and four fifths of the employees in the state that come under the jurisdiction of the SEB Board.

Slide 11 is another way of looking at the percentage of the employees by the size of the employer. In the 1,000 or fewer employees' box, there are 286 employers or 91% of all the school employers in Washington have less than 1,000 employees.

Slide 12 - High-level Benefit Offerings Survey Design: The survey design was a voluntary online survey collection. We looked for a snapshot of the benefits currently offered to school employees. The Washington Association of School Business Officials (WASBO) and Educational Service District 113 provided design input. We sent an invitation to the Superintendent's Benefit Officers, HR, and finance people in school districts, as well as leaders in the charter schools. We sent the survey to all 314 school districts, ESDs, and charter schools. We

did follow-up reminder emails and made phone calls to some of the employers trying to get as much information as possible.

Slide 12: We had 239 responses, however, some of these responses were duplicates and some of them were incomplete and not usable. Once the duplicate and unusable surveys were removed, we had 189 solid responses. Of these responses, 182 were from school districts, six from the ESDs, and one from a charter school. While this data represents 60% of the employers, we did have over 83% of all school employees in the state represented by the survey responders.

Slide 14: The survey included questions about medical plans, if employees had access or were offered preferred provider organization plans (PPOs), health maintenance organization (HMOs), a high-performing network (HPN), which is basically a PPO with more exclusive provider network. We asked if these plans included or excluded prescription drugs. We asked about dental plans, PPOs, dental maintenance organizations (DMO), high-performing networks for the medical. We also asked about indemnity, which basically means that the employee can go anywhere and be reimbursed for the medical/dental/vision service received. We asked if any of these plans were included within a medical plan and did the same with the vision PPO, HMO, HPN, and indemnity.

Slide 15 shows the first set of survey results of what is offered to employees. Enrollment information will come after more data is collected. This slide shows the percentage of employees from the responding employers that have access to these types of benefits. 100% of employees for the responding employers have access to a preferred provider network; 93% have access to a plan that includes prescription drugs and 7% have access to a plan that does not; 93% have access to an HMO; 49% have access to an HPN.

Sean Corry: It might be helpful if you explained circumstances in which school districts offered medical plans that did not have prescription drugs.

John Bowden: In those cases, I can't say absolutely in all the cases, the employees would have stand-alone prescription drug plans. The employees had a choice of a plan without prescription drug and they could marry it up with a choice that also had a prescription drug plan specifically. I believe there were five instances of this reported and a little under 6,000 employees that had stand-alone prescription drug plans offered to them.

Slide 16: In looking at dental coverage that is offered to employees, 100% of employees are offered dental coverage. This slide shows the different types of plan options offered to them. 72% have a preferred provider organization dental plan offered; 42% have a DMO; there are some in an HPN; and some that have indemnity. An interesting piece is that thirteen had dental coverage described as being included within their medical plan. We didn't get enough information to

explain that to you, whether that was something beyond regular dental checkups. We can look into that when we get information on the types of enrollment and the claims data.

Slide 17: In terms of vision, 100% of employees are offered vision coverage, but when you look at these numbers, they add up to more than 100 because multiple options are available to employees. PPOs 71%; HMOs 13%; and so forth.

Slide 18 takes us to other types of benefits like life, accidental death and dismemberment, long-term disability, and short-term disability. We also asked questions about employee access to wellness programs.

Slide 20: For life insurance, 100% percent of employees are offered some type of life insurance benefit; 96% are also offered optional increases in life insurance ability to cover family members. However, life insurance options are widespread across the state. Survey results show 84% of employees are offered accidental death and dismemberment coverage.

Dave Iseminger: It's good to remember that this is self-reported data. The numbers may not make sense with expected numbers based on how the question was interpreted.

John Bowden: Dave's point is very pertinent in terms of long-term insurance. The survey shows 63% of employees are offered long-term disability from the responding employers, but I believe it's 100%. It varies in terms of the payout with the benefits, the cost of what purchasing optional pieces might be. For short-term coverage, 96% of the employees for the responding employers indicated they have access to this coverage.

Pete Cutler: Does this indicate that those are the percentages of employees that the school districts indicated are offered these options? Does that include those who offered the option where the employee paid 100% of the premium cost?

John Bowden: We don't know all of the funding mechanisms for all of the employers across the state. There are basic coverages, which include the medical/dental/vision/life and long-term.

Pete Cutler: So do I understand correctly? The question was just to the school district, what percentage of your employers are offered each of these? It didn't ask them to explain what the fund source was when they offered it?

John Bowden: Correct. The employers that we asked also included the ESDs and charter schools. While the majority of the responses are based on what we heard from school districts, we did include those two types of employers as well.

The far right of Slide 19 is the response to a question about wellness programs offered to employees. From the responses, 29% of employees have access to a wellness program and for 13% of those employees it includes some type of incentive.

Slide 20 identifies additional survey questions having to do with Cafeteria Plan options and what types of things are currently offered. One question addressed asked how many of these different types of Cafeteria Plan options are available on a pretax basis. We asked about the medical Flexible Spending Arrangement (FSA) offerings, Dependent Care Assistant Program (DCAP) offerings, Health Reimbursement Accounts (HRA), Health Savings Accounts (HSA) tied to a high deductable plan available to the employee, and the Voluntary Employee Benefits Association.

Slide 21 shows the responses from employers: 95% of employees have access to the pretax types of plan options; Flexible Spending Arrangement was 99%; DCAP was 87%, HRA at 59%; HSA at 17%; 87% have some sort of VEBA offering, which may differ in terms of what you hear about VEBA offered on the Public Employees Benefits side.

Slide 22 shows procurement questions we asked about whether the employer utilized the services of a broker, whether they secured commercial products on their own, whether they used any of the Health Care Authority's benefits through the Public Employees Benefits Board Program, and whether they used the services of the Washington Education Association.

Slide 23: Previous slides dealt with the numbers referencing percentages of employees. Here we have the number of employer responses. This is useful in terms of what assistance various employers use when securing benefits to offer their employees. Out of 189, 135 use a broker, which is about 71% of the employers; 57 do some by trying to secure commercial products on their own; 37 use the Public Employees Benefits Board; and 120 use WEA.

While I don't think the survey responses really impact what is offered to employees in terms of percentages, the non-respondents to the surveys tended to be the smaller to midsize school districts. I think the percentages using brokers and WEA would be higher if the percentages were based on these numbers. There are actually 71 school districts and five ESDs that either partially or fully use PEBB products.

On the survey we asked them to submit high priority questions or concerns that school employees may have so we can build FAQs to post on our website so anyone in the school districts, ESDs, and charter schools that have questions can find the latest information.

Slide 24 lists some of the questions we received. A lot have to do with what types of plans will the program offer, will they be able to keep their provider, how much is it going to cost them; and eligibility questions, how many hours a year, do I need to work in order to be covered? Statute indicates 630 hours, but there might be additional eligibility pieces. The question has also come up of what happens if I want to waive coverage. Currently, school employees can waive coverage and the funding goes into pools.

Dave Iseminger: We are capturing questions even if we don't have answers yet so that people know we're aware that the questions are being asked and that there will be a place for them to get those answers. We're posting information even if we are only acknowledging that we don't have the answer yet.

John Bowden: Slide 25 is next steps. We have two more data collection efforts underway. Profile Data is collecting the best information we can on each school employee in the state. Milliman, our consulting actuary, is working with the Washington School Information Processing Cooperative (WSIPC) for districts that utilize their financial packages, specifically those related to benefits. I believe there are 17 districts that are not utilizing WSIPC products to get the profile information. The profile data is enrollment information, information about hours an employees works, and things that will be used for more than just decisions about what benefits to offer. We hope to have that information collected by the end of this month. We'll do the analysis as quickly as we can and tell you about what types of benefits school employees have actually enrolled or signed up for.

Secondly is Claims Data. This is specific to the health types of benefits. Milliman is making a voluntary data request directly to the carriers, signing data sharing agreements to make sure that the information about claims data are only used for the purposes that this Board and the Health Care Authority will need in doing procurement. This is protected information and does not come to this agency. It stays at Milliman. The projected completion date for obtaining the claims data is the end of January of 2018. Milliman will provide an analysis that will be shared here.

Dan Gossett: I know this is a high-level survey that you did. I think it would be helpful for me if I could see the specific questions that were asked so I could interpret the responses and answers. I would really appreciate that.

Dave Iseminger: We'll definitely follow up with the Board. We'll get a copy of the survey itself.

Lou McDermott: We will take a 15-minute break.

[BREAK]

Overview of Benefits

Scott Palafox, Acting Deputy Director for the Employees and Retirees Benefits (ERB) Division. Today I'll give an overview of the benefit offerings we'll be providing to the SEBB Program members on January 1, 2020. We'll talk about procurement, life and accidental death and dismemberment, long-term disability short- term disability, the Cafeteria Plan, the medical Flexible Spending Arrangement, Dependent Care Assistance Program, and the Health Savings Account.

Slide 3: What is procurement? Procurement is the act of acquiring or buying goods, services, or works from an external source. Slide 4 gives you a high-level overview of how procurement works. The key to procurement is allowing time to complete each process before moving to the next step. It can take a lot of time from the initial researching, stakeholdering, and benefit designing in the planning phase through the Go Live phase, which is in the implementation phase. When you think about offering a new benefit for a calendar year, we look at the open enrollment date, which usually occurs in November. We start from the end of the timeline to see what other activities are needed in order to get to done.

Lou McDermott: Scott, as an example, could you talk about our Third Party Administrator (TPA) re-procurement for the PEBB Program? What is the total timeframe, sort of the worst-case procurement cycle example?

Scott Palafox: The TPA procurement actually is one of the lengthier of the examples. We had discussions on this starting back in 2014. In order to get through that procurement cycle and select the apparent successful bidder, we had a two-year implementation window to get us a Go Live date. At this point we're in the third step of that process of the negotiations and contracting with the implementation dates looming. Because of the work the TPA does, the two-year window is needed to ensure the systems, eligibility, connections, and file transfers are in place for the TPA to do their work. It's critical we have that large window of time in order for us to get there.

Dave Iseminger: On the opposite end of that spectrum, the life insurance benefit RFP we did in 2016 started in February and we had open enrollment Go Live on November 1 of the same year. There's a wide range of lengths of times for getting through the process.

The other piece I want to make you aware of is there are state procurement laws that the agencies follow. You may not be as familiar with those pieces but that's part of what the agency brings to the table, monitoring and ensuring compliance with those procurement laws. There is a vast legal framework for the RFP process and the entire contract negotiation process.

Scott Palafox: Slides 5 through 12 talk about Life, AD&D, long-term disability and short-term disability. We'll get into comparisons of benefit offerings that

we've seen in the K-12 world, as compared to the offerings of the Health Care Authority under the PEBB Program.

It's important to go over the three bullets on Slide 6 to set the stage. We are not indicating we know everything that's available, but this is for illustration purposes only. The first bullet talks about the following illustrations that show examples of the different benefit designs currently offered to K-12 employees. The second bullet identifies some of the benefit selections for illustration purposes that are offered to many of the K-12 employees and is information that was most readily available to us. The last bullet is important to know that we are not trying to convey eligibility information with regards to these benefits.

Slide 7 Life insurance: One correction note on the footnote of Slides 7 through 12. You'll see that the one, two, three, and four denote the headings of the columns of each of the benefit selections. It's Slide 20 that has the sources, not Slide 18.

Dave Iseminger: Scott, are you going to describe how we selected the four at the top or would you like me to do that?

Scott Palafox: Go ahead.

Dave Iseminger: I want to level set as to why we have the four columns we have for these comparison charts. The Health Care Authority was included in the table because there is the legislative language of leveraging some of the PEBB Program benefits that the Health Care Authority helps administer. In addition, there are 71 school districts that have some, or all, bargaining units where those members have plans through PEBB benefits. A significant portion of those PEBB Program participating school districts are in Eastern Washington, which is why we did not include a specific Eastern Washington school district.

We included the WEA select plans as many school districts and school employees access their benefits. The Seattle Public School District was included as the largest K-12 employer in the state.

Finally, we wanted to identify a school district where we had a variety of different ways to validate the information. The Lynden School District actually responded fully to our benefit survey twice. They were actively engaged and wanting to ensure their benefits were described correctly. We were able to validate that against plan documents found online. We did some outreach with the Lynden School District to make sure we were understanding their benefits. We similarly did outreach with the WEA to make sure that we were trying to convey the benefit design as best we could.

This table represents a systemic review of either plan documents of direct communications coupled with survey data of these different school districts.

Scott Palafox: An additional note for the WEA's select plans, we did have some email communications with WEA staff for that information.

The top half of this table in the light blue shows the employer paid coverage for employees. The Health Care Authority under the PEBB Program offers employer paid coverage of $35,000 with no Statement of Health required. Statement of Health, sometimes referred to as medical evidence of insurability, is a document that includes a series of questions about overall health. The bottom portion of this table shows the employee paid additional coverage. That employee can choose to opt to purchase in $10,000 increments up to $500,000 without a Statement of Health and up to $1,000,000 with a Statement of Health. And then you see the comparisons across the board.

Dave Iseminger: As we go through these comparisons, let us know if this will meet your needs as Board Members for comparisons of the current variability in the system. We wanted to start with a comparison of a benefit that has a little less variability so we can then craft the best comparison process for the medical and dental benefits. I particularly want your feedback on this structure and if this meets your needs. As you can see in these charts, there is no clear best plan. Benefit by benefit, you'll be able to go through and identify under one offering it's column A, under another offering it's column B, and there are different subsets. It really is a complicated matrix of the variability that exists in the current system for school employees.

Scott Palafox: Slide 8 is a continuation of life insurance for spouse or state-registered partners and children. Again, the employee can pay for these additional coverages. You can see the increments in the boxes of what those are and the maximum amounts for each.

Dave Iseminger: Before we go on to AD&D, these are the types of questions we will need your insight on in the form of either discussion or we'll tee up some resolutions about the general structure of benefit design. Do you want a benefit that crafts an employee buy-up option for a spouse? Do you want a plan that has child coverage that can be employee paid? At this point, we're not going to be asking you what exact level of coverage of life insurance you want, but what lines of coverage do you want? That's the macro structure questions we need direction on so we can identify which areas need procurements and which ones the Health Care Authority can seek to access with current contracts and see if there's a benefit that can be crafted under those current contracts. It's structured this way so we can have the lines of coverage, at least in the life insurance context. That's the type of information we need back from the Board to be able to proceed with any necessary procurements.

Scott Palafox: Slide 9 Accidental Death and Dismemberment Insurance: The table on this slide is set up in a similar way. The top half shows the employer

paid portion of coverage and then Health Care Authority (HCA) PEBB benefits. The HCA offers $5,000 employer paid coverage. On the bottom half of the table it shows the additional employee paid coverage in $10,000 increments up to $250,000 without a Statement of Health. You can compare that across the table as well. Slide 10 is a continuation of AD&D for spouse or state-registered partner, employee paid, as well as children, employee paid coverages. Each column denotes the increments and the maximum amounts based on no Statement of Health as well.

Dave Iseminger: Is this the right level of information? Does the structure make sense and does it meet your needs? What other information do you want presented, especially as we march towards creating a comparator document for medical and dental plans for next month?

Lou McDermott: I have some questions. What if someone is transitioning from one life insurance policy to another life insurance policy and you have issues with insurability, and whether you're covering the subscriber or the spouse, and what the maximums are, and if your prior plan had a maximum that was higher than your new plan? Have you started thinking about all those permutations?

Dave Iseminger: Yes. With the number of benefits there are, you've described cut-over issues that would happen from the end of December 2019 to the beginning of January 2020 on just the life insurance benefit or just the AD&D. Staff are thinking about the various challenges with that transition on a benefit-by-benefit basis. That will be something that we'll be looking at when we're going through contract negotiations or in procurements themselves, getting commitments to protect employees in the current benefits they have, especially in the context of life and disability insurance to avoid as much disruption as possible during the transition.

Lou McDermott: How are you planning on working with the Board? I'm teeing this up because you and I both know how many decisions have to be made on any procurement. If you want more of this or less of that, can they do it? Can they not? What's the trade? How long do you lock the rates in to give up something? There's all these negotiations back and forth. How do you do that and inform the Board of these twists and turns?

Dave Iseminger: Some of it depends on exactly how the Board meetings fall with where we are with negotiations. During the negotiation process, we may be able to access executive sessions to be able to talk about the status of a procurement so that we can provide insight as to the status. Other pieces we'll bring to the Board and explain, as best we can, the global picture of all the various different interests during negotiations, I don't envision going through a step-by-step negotiation with the Board. I'm not anticipating describing all the steps along the journey but rather the overall global factors that went into what the agency was able to procure from a pricing standpoint. Each of these will be

complicated negotiations because of the various efforts related to avoiding as much member disruption and harm in a process that is inherently disruptive by forming the single consolidated purchasing pool.

Lou McDermott: The one part I'm concerned about is when we renegotiate for PEBB, we know what the before is. When negotiating the after, you understand sort of winners and losers, and you understand how it's better and how it's worse. But with something like this, it seems like we won't fully understand before so we're negotiating after. I think that's going to be challenging.

Dave Iseminger: As we get more ideas and work through the various different benefit lines and different ways to minimize disruption, we'll make sure that we keep the Board as informed as we can about different ways the disruption could be avoided while also being careful about where we are in the negotiation processes.

Lou McDermott: Thanks, Dave.

Scott Palafox: Slide 11 Long-term Disability Insurance: This table is broken down in the same fashion as the others with the employer paid and the employee paid portions on the top and the bottom half.

If we look at the employer paid portion on the Health Care Authority PEBB benefits, 60% of the first $400 is a pre-disability earnings, monthly-based pay reduced by any deductible income. You get a maximum of $240 or a minimum of $50 per month. Looking at the employee paid possible additional coverage, you have 60% of the first $10,000 of pre-disability earnings, which is monthly-based pay reduced by any deductible income for a maximum of $6,000 or a minimum of $50 dollars a month.

For context, I'll give you a high-level calculation of what that would look like. If someone's monthly base pay is $4,000 dollars, for the employer paid portion of that, it would hit the maximum of $240 per month. If you're looking at the employee paid portion of that calculation, it would be $2,400 plus the $240 for a monthly payment of $2,640. Now that would be assuming there isn't any deductible income. But let's say the person is receiving $1,000 in Social Security disability, you would subtract $1,000 off the $2,640, so their monthly payment would be $1,640.

Slide 12 Short-term disability: The HCA currently doesn't offer a short-term disability benefit for either the employer paid or the employee paid portions. In looking across the table for the employer pay pieces to the illustrations we have, they're somewhat similar. The employee paid piece becomes a bit different as you look at those examples.

Slide 14 Cafeteria Plan: A Cafeteria Plan is an Internal Revenue Service regulated program that allows employers to offer employees the ability to pay for certain expenses with pre-tax payroll dollars. Under state law RCW 41.05.310, the Health Care Authority maintains and administers the Cafeteria Plan for all state and higher education employees. Benefits offered under the state's Cafeteria Plan are the Premium Payment Plan, the medical Flexible Spending Arrangement (FSA), the Dependent Care Assistance Program (DCAP), and the Health Savings Account (HSA).

Slide 15 Premium Payment Plan: This plan allows employees to pay their health plan premiums using pre-taxed dollars. Currently, for PEBB Program members this is the medical premiums only, because dental is paid by the employer.

Slide 16 Medical Flexible Spending Arrangement (FSA): This arrangement is an employer-sponsored benefit that allows enrollees to redirect a portion of their salary on a pre-tax basis to pay for out-of-pocket qualified medical expenses. These benefits operate on a plan-year basis starting on January 1 and ending on December 31 of each year. The medical FSA is a pre-funded benefit and enrollees have access to their full election amount at the beginning of the plan year. Some of the eligible expenses governed by the IRS rules include office visits and prescription co-pays, deductibles, dental orthodontia expenses, vision expenses, expenses such as lenses, frames, contact lens solutions, acupuncture, chiropractic rehabilitation. Some of the ineligible expenses include cosmetic surgery, teeth bleaching, club memberships, Sonicare toothbrush, and missed appointment fees. Some over-the-counter medications are not covered as well. The IRS maximum contribution amount for 2018 is up to $2,650. To use these funds, employees can make claims for reimbursement or use a debit card. All the elective funds are available at the start of the year and deductions are made from the employees' paychecks in equal amounts across the year.

Dave Iseminger: It is important to note that the IRS maximum is what federal government allows as the ceiling for the contributions. But an employer can set a different amount that is lower. Often, the IRS releases its annual amount refresh after most employers' open enrollment for the next year, which makes it difficult to maintain perfect alignment with the IRS allowed maximum and an employer's maximum. The state has traditionally tried to maintain as much alignment as possible with the maximum IRS allowed amount, but as I said, typically the IRS allowed amount comes out after all the open enrollment publication materials are printed, which then results in a bit of a lag from year to year.

Scott Palafox: Slide 17 Dependent Care Assistance Program (DCAP): DCAP allows members to set aside pre-taxed dollars to pay for qualifying child or elder care services. Eligible and ineligible expenses are governed by the IRS. The main purpose must be that the qualifying dependent's well-being and protection while an employee and spouse, if married, are working or attending school. Some eligible expenses include daycare expenses for children that are enrolled.

Elder care expenses are for a qualifying dependent age 13 or older who is physically or mentally incapable of self-care and regularly has spent at least eight hours each day in the enrollee's household. Ineligible expenses include overnight camp, nursing home expenses, meals, activity, supply fees, transportation costs, and tuition for school at the kindergarten level or above. The maximum contributions is $5,000 if the enrollee is married and filing jointly, $5,000 if the enrollee is single, or $2,500 if the enrollee is married and filing separately.

Dave Iseminger: Unlike medical FSA, there is no indexing to any inflationary measures. These are the maximums that have been around for years.

Scott Palafox: DCAP works like a bank account. Reimbursements and claims requests cannot exceed the account balance and the enrollee cannot receive reimbursement until after the service has been provided.

Slide 18 Health Savings Account (HSA): HSAs were created in 2003 so that individuals covered by a qualifying high-deductible health plan could receive tax-deferred treatment of money saved from medical expenses. You are eligible if you are covered by an HSA qualified health plan and have no other coverage such as another health plan, Medicare, military health benefits, or a medical FSA. The IRS maximum allowed contribution is $3,450 for an individual and $6,900 for a family in 2018.

Dave Iseminger: I want to add a couple things related to this concept. The state, and the Health Care Authority in particular, manages these benefit offerings. They are carved out from the Board's authority, both this Board and the PEB Board. HCA administers those benefits directly by contracts. We will maintain those relationships and give you updates. These benefit offerings would presumably be part of our discussions, but the Health Care Authority is given the statutory basis for doing this benefits. There is a relationship with the Board's decisions because we will not administer a Health Savings Account if there is no comparable related qualifying high-deductible health plan, because there would be no basis on which an individual could put money into that HSA. There is a relationship, but whatever decisions you make, whatever benefits are able to be offered under this separate statutory authority, the Health Care Authority will proceed with and keep you up-to-date as to the implementation of those benefits.

Ethics In Public Service Act Overview

Katy Hatfield, Assistant Attorney General: I want to apologize for the incorrect title on the agenda. This is not the Executive Ethics Act, it's the Ethics in Public Service Act. I point that out because Executive Act implies that it only applies to the Executive Branch of the government but it doesn't. In Washington State, the Ethics in Public Service Act applies to the Executive Branch, the Legislative

Branch, and the Judicial Branch of the state government equally. I wanted to point that out because it is an interesting part of the legislation in Washington.

This is a brief training. I can't possibly go over every single nuance of the Ethics in Public Service Act during this presentation. I did provide you in the materials a copy of the complete law. In the presentation at the end, I'm going to point you to some other materials that are online and available for you to look at that give some training and other quiz-like functions if you want more information. Of course, you can always send me an email or call me on the phone if you have any specific questions about your circumstance or if something comes up.

The Ethics in Public Service Act is codified in law. It does apply to all branches of state government. It was created in the early 1990s when there were many different laws governing various officers and employees throughout the state. There was just too many standards. It just got too confusing. At that point, Governor Lowry and Attorney General Chris Gregoire asked the Legislature to create a special commission to address this issue and the Ethics in Public Service Act is the result of that. It passed in 1994. We are having this training because the Ethics in Public Service Act applies to you. It applies to all state employees and state officers, and that includes all persons holding a position of public trust, including members of boards and commissions.

The two purposes for the Ethics in Public Service Act are to maintain public confidence in government and to prevent abuse of state offices. It's really to remind everybody, not just people who work for the state, but also for the members of the public that government does derive its power from the people. That maintenance of public confidence is very important.

The key principle of the Ethics in Public Service Act is codified in the statute that state officials and employees of government hold a public trust that obligates them in a special way to honesty and integrity in fulfilling responsibilities to which they are elected and appointed. Paramount in that trust is the principle that public office, whether elected or appointed, may not be used for personal gain or private advantage. The Ethics in Public Service Act covers many different subject areas. Slide 7 of is an example of most of the areas that are covered in a general sense. There are more details in the law itself, as well as in some of the regulations. There is a lot of discussion about use of state resources for personal gain, gifts and limitations on receiving gifts, using your office in order to obtain special privileges for yourself or for a family member, conflicts of interest, outside employment, confidential information, and then employment after public service. I'm not going over all of these today, but there are materials online, in the law itself, and in the regulations if you have any specific questions.

I'm going to discuss topics that are the most common for people to have questions about. One of those topics is conflict of interest. The law is clear that no state officer may have a financial interest or engage in an activity that's in

conflict with the discharge of his official duties. No state officer may disclose confidential information to a person who's not authorized to receive it; and no state officer may use his official position to secure special privileges for himself, family members, or another person.

One thing we may have touched upon at one of our earlier trainings is that the protection for confidential information also would include attorney-client privileged information that I or another AAG provides this Board. The Board did get one email from me. I'll always be providing information to you very clearly marked that it is privileged so that you know and there's not any ambiguity or confusion about that. The same protections about disclosing confidential information would apply when the Board is in Executive Session. And again, that will be very clear. You'll know when you're in Executive Session and that it's not a public session where you're learning things that are available for everyone to know.

Sean Corry: I have a question about disclosure. I routinely talk with members of my staff, for example, about work that I'm doing. Usually it's work in the office. Could you help me understand the restrictions that might be in play for me or people in my position, like any Board Member who has coworkers at a school district, for example, where they need to discuss things? Can you help me see a line or two?

Katy Hatfield: One good example might be in terms of during procurements, there are certain aspects that the Board Members are entitled to learn about during procurement that is proprietary information or is confidential information from bidders. So a life insurance company or a medical insurance company, they might submit some information about their formulas or their actuarial analysis that supports their bid. That information is not available to the public but might be shared with the Board in a specially called Executive Session where we're communicating to you that this piece of information is confidential to help you form your decision as a Board. But it's not something that's available to be disseminated to all the school districts or used in your private employment. When we get to situations, hopefully they'll start to make more sense when we actually can see them in front of us and then we can talk about a specific example when it comes up.

Another example might be, the Health Care Authority has some contracts where a piece of the contract has been marked as proprietary. If there is a public records request or something for that piece of the contract, that would not be disclosed. Usually what the Health Care Authority would do is give that person an opportunity to object, but there's a process in place. The underlying assumption is that it would be kept confidential unless ordered otherwise. We can talk about it more when a real example comes up. Everything we talk about in a meeting like this is public, and everything that's in the materials that we provide is public. That part is not meant to be confidential. One of the core tenets of a Board like this where people are representing a constituency of

people is that you will go back and talk to your community of people that you're representing at your school or in your office. There's going to be a very small amount of information that's proprietary.

Lou McDermott: And I think when we do get to those pieces of information, we'll reiterate the nature.

Katy Hatfield: I think it will always be clear whether or not something is confidential. At least we'll always try to make it be clear. One thing about the Ethics in Public Service law is that the regulated entity is the state officer, the Board Member, not the agency. This is added not to be scary but to make you aware that ethics violations are considered to be personal in nature and you're personally responsible for violations. For that reason, I am providing you quite a bit of additional material that's online if you have additional questions.

One thing to also keep in mind is there's actually an ethics Board that does regulate only the Executive Branch of government. I'll go over that shortly. That Board is the one who brings actions against people for ethics violations. Members of the public do not. The public would file a complaint with the Board, the Board would do an investigation, and then bring action. There's a level of screening that happens rather than just someone filing a lawsuit.

Some of the potential penalties that the Ethics Board might impose include things like a letter of reprimand, a recommendation to the Governor to suspend or remove you from your current position. For situations where there was a finding of self-dealing, they can impose up to a $5,000 civil penalty or up to three times the economic value of the item that was received in violation of law.

The law is quite broad in terms of how it describes it but it talks about that you cannot do anything that's incompatible with the proper discharge of your official duties. That could mean things like outside employment, a volunteer activity, ownership in a private business, relationship, anything that would impair or conflict with your ability to make decisions on behalf of the state. I want to also emphasize that the Legislature recognizes that there's a lot of Boards like you where there are people who have businesses, companies and ownership of entities. That's not necessarily automatically a conflict. There's a recognition that people who are engaged in the private industry and other activities have a great service to provide to the state. The law allows for that. There are some parameters around it but they're quite reasonable when you look into them deeper. I want to make sure people recognize that.

Slide 11 is examples of possible conflicts of interest like:

- having a personal financial interest in a contract sale, lease, purchase, or grant that's under your specific authority or supervision in your role as a Board Member;

- acting in a state matter or transaction involving a business or organization in which you own, or in which you serve as an employee;
- assisting other persons in transactions involving the state in which you have a responsibility for these transactions as a state officer.

In the setting of this Board, that would be perhaps assisting a company in submitting a bid for a procurement in which this Board is going to be selecting the final entity that will be the apparent contract winner.

These are obviously very fact-specific considerations. I realize some of you may have to ask yourself some questions more times than others. If you think you might have a conflict of interest, some of the questions you might consider asking yourself is whether or not your outside interests will benefit as a result of your official action. And then also, whether or not a reasonable person would conclude that your private or personal interests impairs your independent and impartial judgment in the exercise of your official duties.

Dave Iseminger: Katy, I remember during the Open Public Meetings Act (OPMA), you talked about the difference between an actual fairness problem and an appearance of fairness, and you talked about newspaper headlines. Is there something comparable in the Ethics in Public Service Act or can you talk about whether that concept that you talked about in the OPMA is something that should be considered here?

Katy Hatfield: That's a good question. I think in the context of the Open Public Meetings Act, there is a concern for reputational issues because lawsuits are filed directly by members of the public. Whereas in this setting, complaints are filed with the Board and the Board investigates. So there is that level of scrutiny that's placed on complaints. So hopefully complaints that are retaliatory or totally without basis are screened out.

On the other hand, I think it is also important to remember that one of the purposes of the Act is to build public confidence. Even if there is not an actual conflict, if there is a concern about an appearance of conflict, that might be an opportunity that you would want to at least consider raising or recusing yourself. We're going to talk about some of the things to do if you think there is a conflict. But if you think there's even a possibility that a reasonable person would view it as a conflict, that might be one of the times to elevate the situation.

Slide 13: This statute regarding representing an identifiable group speaks to what I was trying to say earlier. Nothing in this chapter shall be interpreted to prevent a member of a board, committee, advisory commission, or other body required or permitted by statute to be appointed from any identifiable group or interest from serving on such body in accordance with the intent of the Legislature in establishing such a body.

In the case for the SEB Board, several of you are appointed to represent a specific constituency. It's not considered to be a conflict to be representing the ideas or the thoughts of that group in terms of the Act itself. Your alliance to that organization is not in conflict so long as you're there to represent them and people know that. Conflicts might happen and that's okay.

What do you do if you think you have a conflict? Most conflict of interest issues can be resolved without needing to resign from the Board. There are options and I'm happy to talk with you by phone or email if anyone thinks they have a conflict. One possible option is to abstain or recuse yourself from a specific vote or a specific deliberation if there's an idea that there might be a specific company that's going to be awarded a contract or something of that nature. Another option is to disclose the possible conflict to the Board Chair, Mr. McDermott, and let him decide whether or not to remove you from a particular vote or activity. Another option is to write a screening memo, which is something that I would help you with to inform other Board Members about a specific topic in which you should be screened. These are just a few of the options.

Slide 15 - Gifts: Reading this slide may sound very scary, but there are a lot of exceptions. The general rule is that no state officer or state employee may receive, accept, take, seek, solicit directly or indirectly, anything of economic value as a gift, a gratuity, or favor from a person if it could be reasonably expected that the gift, gratuity, or favor would influence the vote, action, or judgment of the officer or employee, or be considered as part of a reward for action or inaction.

People get nervous about what this means. On Slide 16 there are a lot of exceptions to the rule that really make sense in terms of items that you receive from bona fide friends and family members which are not part of the limitation on gifts. Also, if there are items that are related to an outside business that are customary and not related to the recipient's performance of official duties, those are also exempted from the gift rule. The gift rule is meant to be about bribery and an undo influence of people to misuse their official position. So the hard line rule that the Legislature has set is $50 as a source of a gift in a single calendar year. But again, the exceptions apply for family members and friends. Those don't count towards the $50.

Slide 17 - Section 4 Employees: In some of the other materials that the Executive Ethics Board has online, they have a lot of Q&As about Section 4 Employees. Section 4 refers to a specific provision of the Act which has to do with situations where your duties involve a specific decision about contracting or purchasing with a specific entity or vendor. In those situations where your decision that is before you has to do with contracting or purchasing from a specific vendor, the gift rules are more strict. That's the important takeaway. Even the $50 limit doesn't exist and is not allowed. There's a lot more information about gifts if you

go on the Executive Ethics Board's website. I did hyperlink everything on the online materials you got.

Slide 18 has information on Governor Inslee's website. These pages are also hyperlinked. Governor Inslee has training available online for all members of Boards and there is a specific training about Ethics and Government that's online for you to look at that goes into some of the things I talked about, some of it's a bit different, and some of it goes into the history of the ethics law.

Slide 19: The Executive Ethics Board is a five-member Board of persons appointed by the Governor and they enforce the Ethics in Public Service Act, but only for the Executive Branch. They don't enforce it for the Judicial Branch or the Legislative Branch, but they have jurisdiction over the statewide elected officials and state employees in all the Executive Branch agencies, including boards and commissions. They also have online materials that are very helpful.

One of the things that is nice about the Executive Ethics Board is that all line state employees are subject to the law so they have made the materials very accessible for all state employees to be able to read and understand the rules. They have online quizzes that make the rules understandable and easy to digest. And they also have some Washington Administrative Code citations that drill down into a lot more detail about some of the rules and penalties. They also have advisory opinions by subject matter. I really recommend that you go to this website. It's well done and helpful. Ethics may be a bit overwhelming, but again, all state employees and all Board Members are subject to it and it is accessible. It does have a logic to it when you get into the terms that people should not be personally gaining or benefitting from their position of trust and that the public should have confidence in state government and in state employees and their role.

Lou McDermott: If anyone has any questions, they you can ask Katy directly or you can communicate with Dave or me.

Proposed SEBB By-laws and Vice Chair Selection

Dave Iseminger: At our last Board meeting, Katy Henry had some questions related to including the ability to reimburse school districts for Board Member service time. We talked about how the authority for being able to spend that expenditure out of the Health Care Authority's budget has to be in statute. The agency can provide insight as to how that could be addressed in statute.

The By-laws before you are exactly what you had at the last meeting. The hope for today is to have a discussion, determine if there are changes you would like to make, and take action if there are not changes. You will be able to visit them at any point in the future as well. We went through the Ethics in Public Service Act training just before taking action on the By-laws to remind you about your obligations when taking votes. This is the one action item for today. The By-

laws is probably one of the less controversial things that you'll vote on in the next year and a half, but it does mark the first step in that voting journey as a Board.

Pete Cutler: Do I remember correctly that these draft By-laws closely reflect the By-laws that the Public Employees Benefits Board operates under?

Dave Iseminger: This draft was created from two sources. It was, in part, the Public Employees Benefits Board By-laws and a comparison of other educational entities like the State Board of Education to see if there were any relevant provisions. There are differences. For example, there is no Vice Chair in the PEBB By-laws. Those provisions are completely different. There are more granular details in some of the other By-laws about exactly the timeline for doing transcripts of meeting minutes. But the way that the law has developed around them, we wanted to make sure that there was as much flexibility to be able to get those done in the robust manner as possible. These By-laws are more aligned with the exact requirements with modern day law. That's the origin.

Pete Cutler: Thank you.

Lou McDermott: Do we have other questions or discussion from the Board on the By-laws?

Wayne Leonard: I just have one question. On Article 6 at the end, it says "two-thirds majority are required to amend the By-laws." Would that be two-thirds of those Board Members present or six out of the nine members?

Katy Hatfield: I would read that to mean that it's two-thirds of all of the whole body, regardless of how many people are present.

SEB Board By-laws

Moved. Seconded. Approved.
Voting to Approve: 8
Voting No: 0
Absent: Alison Carl White

Vice Chair

Dave Iseminger: Article 2, Section 2 of the newly enacted By-laws builds off of what the description is in statute. The vice chair serves as the presiding officer at a regular or special meeting of the Board if the regular or temporary chair can't serve. As a reminder, the regular or temporary chair that it is referring to is the Director of the Health Care Authority, or his or her designee, who serves on the Board. The regular chair would be the actual Director of the agency, the temporary would be their delegate, and then in the absence of either of those, then the vice chair would serve as the presiding officer. So that's the primary function of the vice chair. If the vice chair were in the position of serving as the

officer for the meeting, there would be administrative support from Connie and me. Lou has an annotated agenda to help make sure that we have the order. You'll certainly be provided the administrative support to serve in that function as well.

Lou McDermott: Is there a Board Member who's interested in serving as the vice chair? Is this the part where we encourage fellow members? Pete? You are very familiar with government process. I'm nominating you.

Pete Cutler: I'm willing to do it. Frankly, my thought was given that the purpose of this Board is to develop plans in eligibility criteria for school employees. I was inclined to hope that one of the four or five school employees would want to step forward.

Lou McDermott: Would you like to nominate one of them?

Pete Cutler: I would nominate Terri House because she's sitting right next to you!

Lou McDermott: Terri, what do you think about that?

Terri House: That would be fine.

Lou McDermott: Outstanding. Any other folks interested in taking this on? Ok, no other volunteers

Vice Chair

Moved. Seconded. Approved.
Voting to Approve: 8
Voting No: 0
Absent: Alison Carl White

Lou McDermott: Congratulations, Terri. Like I said, if you have to do it, Connie will take great, great care of you.

Terri House: Thank you. Thanks, Connie.

Dave Iseminger: I know that the Board's come to appreciate having a sense of what's on the next meeting's agenda. In January, we'll discuss medical and dental benefit structures. There will be quite robust comparison charts because the variability that exists with the medical and dental is pretty significant.

We'll also be presenting some draft resolutions for your consideration on benefit structure before we ask you to vote. We don't want to surprise you with the vote on the same day they are presented to you. We like to present to you and give you enough information and very specific things to be able to critique, discuss,

and debate, and then give you time to go back to constituencies and think about those pieces, and then vote at a subsequent meeting.

I'll provide an update on the first ten days of the short session of the Legislature. If there's anything that the Board is wanting us to look at specifically, now would be the time to help tee up topics for us to prepare for the two January meetings. Somewhere between those two meetings will also be information about the enrollment data that John referenced. I'm not quite sure exactly how that's going to land and having meeting materials ready, so It might not be until the end of January.

Meeting Adjourned

TAB 4

Washington State Health Care Authority

Uniform Medical Plan (UMP) Follow-Up

Shawna Lang, Senior Account Manager
Portfolio Management and Monitoring
Employees and Retirees Benefits Division
May 30, 2018

Utilization Follow-up on Selected Services

PEBB UMP Utilization

2017 Plan Year					
Service	Total Number of Unique Members	Total Visits	Max Number of Visits	Unique Members who Exceeded Max (Exceptions)	Total Number Visits Exceeding Max Limit
Chiropractic	24,573	125,785	10	3	10
Massage	19,628	141,847	16	2	6
Acupuncture	5,951	39,039	16	7	37
Therapies (NT, PT, OT, ST)	29,947	277,937	60	0	0

- Prevents prior authorization for all services, reducing administrative costs on the provider.
- Limiting some services contains plan costs, which impacts member premiums
  - Remember higher benefit levels in one area may require constraining benefits in another.

Process for Extending Services

- Group Level Exception (GLE):
  - GLE's are initiated by the Health Care Authority (HCA) or the Third Party Administrator (TPA) Account Team (Regence) requesting an exception; some instances are due to escalated member complaints. HCA approves and makes the determination for any exception.

Washington State Health Care Authority

Preventive Services

Washington State Health Care Authority

General Preventive Services

The following are services covered by the plan at 100%:

- Annual physical exam
- Routine vision exams
- Vision hardware, children age 18 and under only
- Routine hearing exams
- Well Baby/Child exams
- Colonoscopy performed to diagnose or treat disease or illness
- Routine screenings for women
- Screening mammograms
- Hearing tests as part of a newborn screening
- Fluoride for prevention of dental decay when prescribed by primary care provider to children 6 months and older
- Certain screening tests performed during pregnancy

Washington State Health Care Authority

Preventive Services (Women)

- HPV testing (ages 30 and over, once every 3 years)
- Chlamydia and gonorrhea testing in sexually active women age 24 and younger, and women age 25 and older who are at increased risk
- Education and counseling regarding contraception
- Counseling and screening for HIV, interpersonal and domestic violence, and sexually transmitted infections
- Birth Control
  - All barrier devices requiring a prescription or fitting
  - Over the counter female condoms (and male condoms as of CY 2019)
  - Contraceptive drugs are covered under the prescription drug benefit. Those not covered as preventive are subject to the prescription drug deductible and coinsurance as described in the Certificate of Coverage. Coinsurance is determined by the drug's tier level on the UMP Preferred Drug List.
  - Members may have up to a 12-month supply for contraceptive drugs

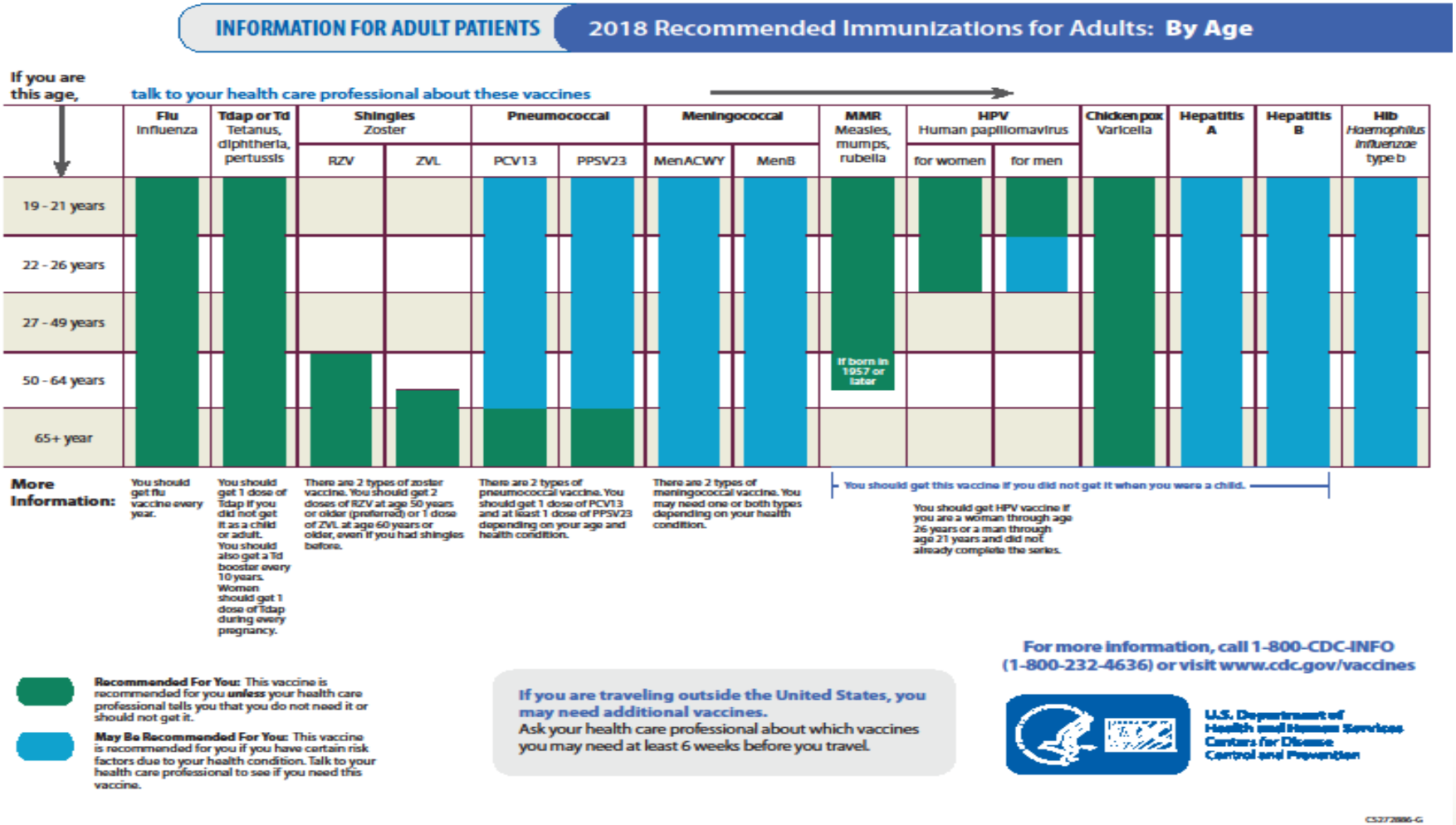
Washington State Health Care Authority

Other Plan Services Covered at 100%

- Diabetes control program
- Diabetes prevention program
- Intensive behavioral counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors
- Screening for hepatitis B for non-pregnant adolescents and high risk adults
- One-time screening by ultrasound for abdominal aortic aneurysm, for men 65-75 who have ever smoked
- Respite care
- Hospice care
- Sterilization

Washington State Health Care Authority

Immunization covered at 100%



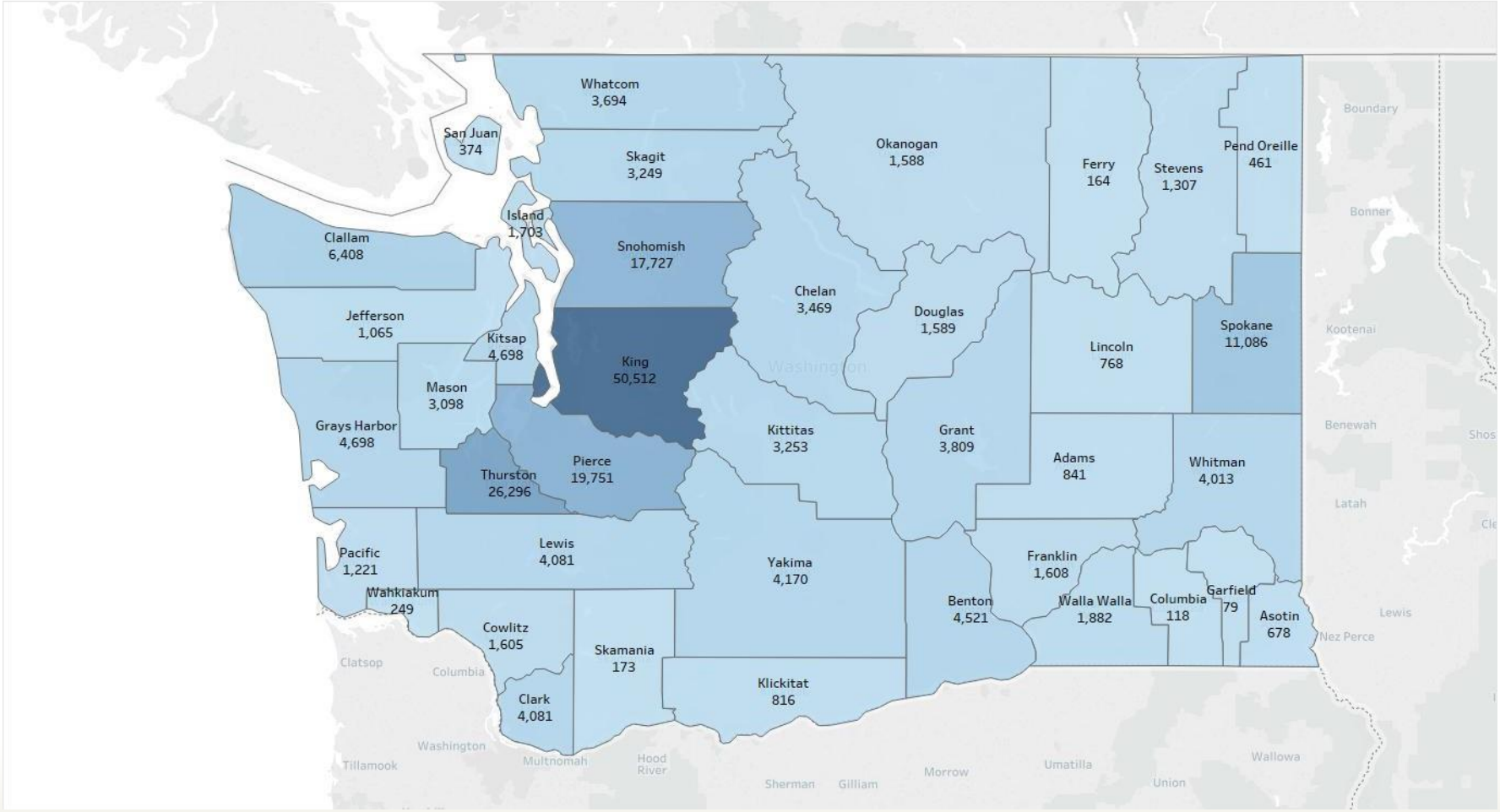
UMP Enrollment Maps

April 2018 UMP Enrollment

- Total population of UMP - 255,799
- Total population of UMP Classic in Washington State – 200,903
- Total population of UMP CDHP in Washington State – 19,022
- Total population of UMP Plus in Washington State - 26,181
- Total population of UMP outside of Washington State – 9,693

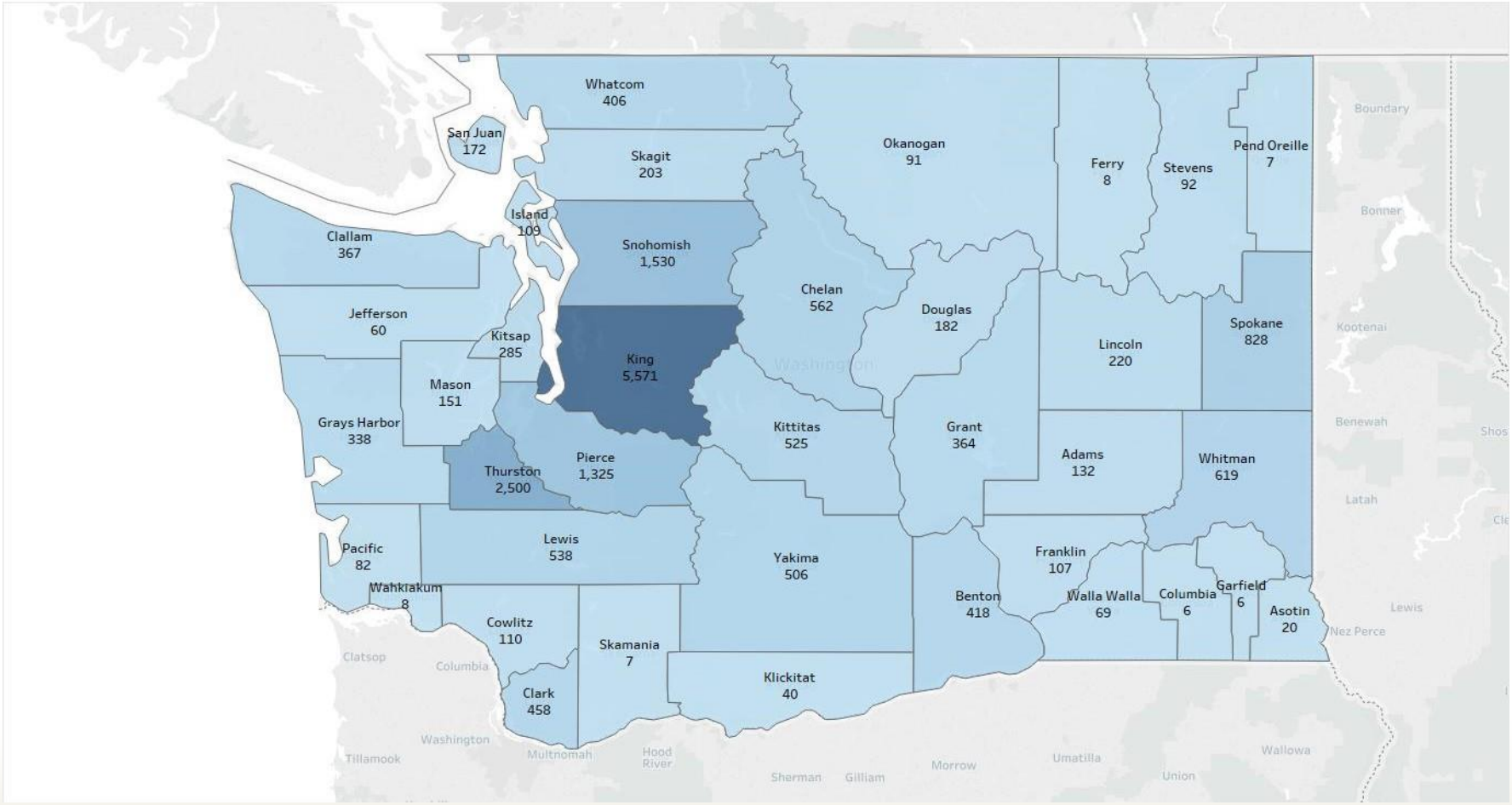
Washington State Health Care Authority

UMP Classic Population in Washington State
200,903 Members (April 2018)



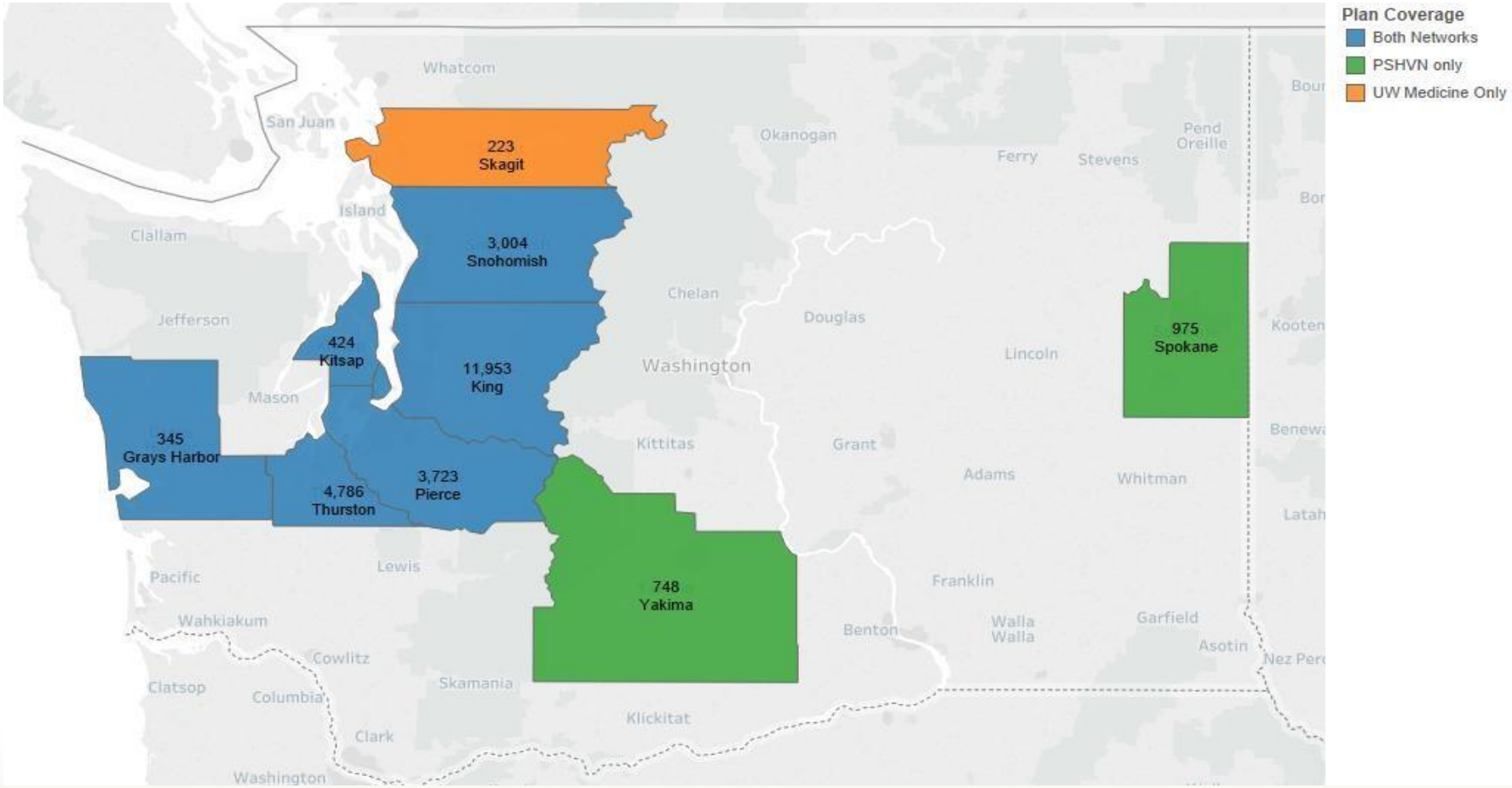
Washington State Health Care Authority

UMP CDHP Population in Washington State 19,022 Members (April 2018)



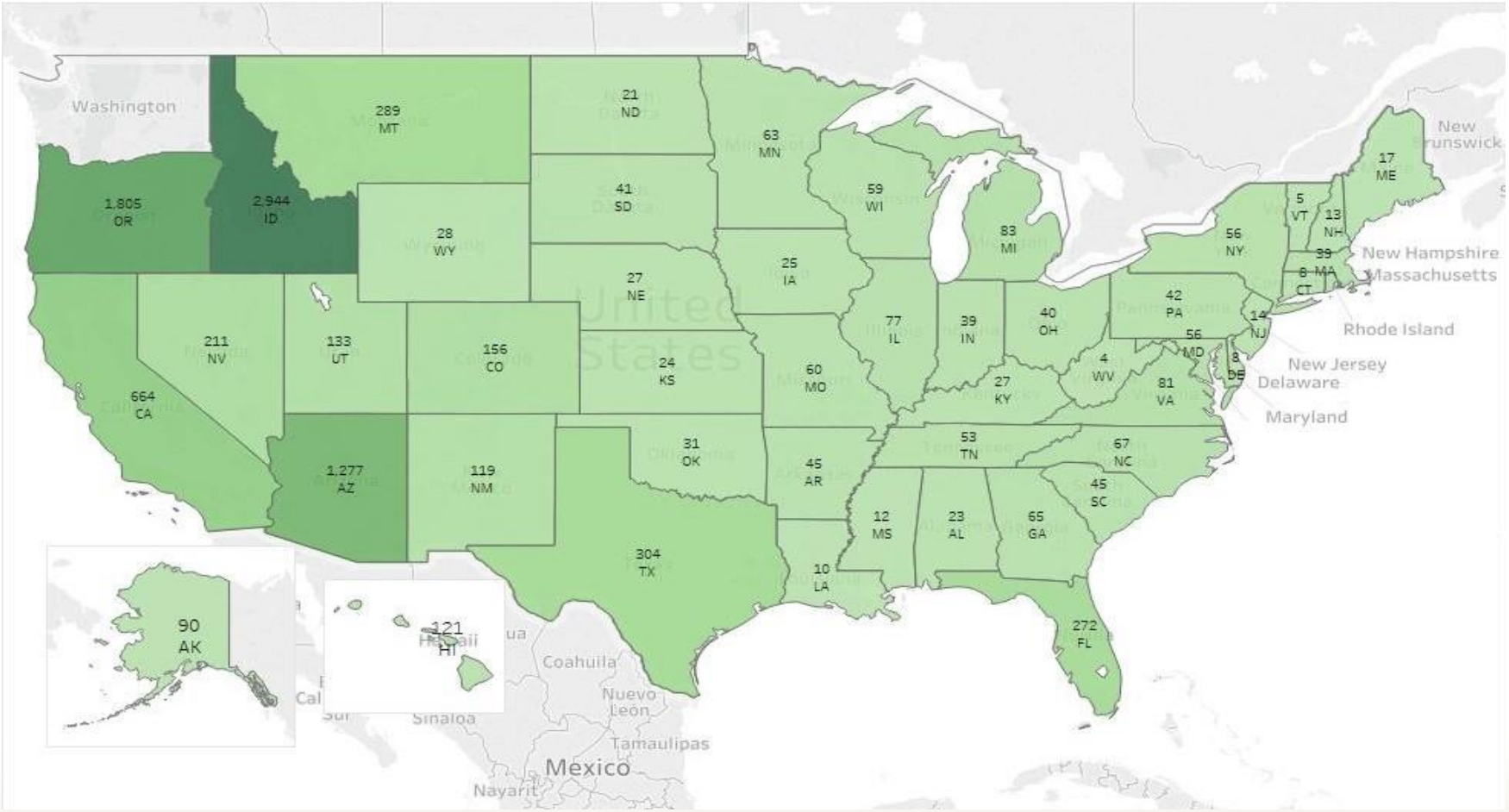
Washington State Health Care Authority

UMP Plus Population in Washington Counties 26,181 Members (April 2018)



Washington State Health Care Authority

UMP Population Nationwide 9,693 Members (April 2018)



Questions?

Shawna Lang, Senior Account Manager
Portfolio Management and Monitoring Section
Employees and Retirees Benefits Division
Shawna.lang@hca.wa.gov

Appendix:

UMP Exclusions

Washington State Health Care Authority

UMP Exclusions

Examples of UMP exclusions are listed below. Some come from mandated exclusions or limitations such as Health Technology Clinical Committee determinations. A list of these determinations are included within the UMP Certificates of Coverage (COC). This list comes from the UMP Classic COC.

Here are some examples of common services and conditions that are not covered. Many others are also not covered—these are examples only, not a complete list. These examples are called exclusions, meaning these services are **not** covered, **even if the services are medically necessary.**

1. Air ambulance, if ground ambulance would serve the same purpose.
2. Autologous blood and platelet-rich plasma injections.
3. Bariatric surgery under the following circumstances:
   - BMI 30 to 34 without Type II Diabetes Mellitus.
   - BMI less than 30.
   - Patients younger than 18 years of age.
4. Bone growth stimulators for:
   - Nonunion of skull, vertebrae, or tumor related.
   - Ultrasonic stimulator – delayed fractures and concurrent use with other noninvasive stimulator.
5. Bone morphogenetic protein-7 (rhBMP-7) for use in lumbar fusion.
6. Bronchial thermoplasty for asthma.

Washington State Health Care Authority

UMP Exclusions, (*cont.*)

7. Cardiac nuclear imaging for:
   - Asymptomatic patients: Does not apply to pre-operative evaluation of patients undergoing high-risk non-cardiac surgery or patients who have undergone cardiac transplant.
   - Patients with known coronary artery disease and no changes in symptoms.
8. Carotid artery stenting of intracranial arteries.
9. Carotid intima media thickness testing.
10. Complications arising directly from services that would not be covered by the plan during the current plan year. The plan will, however, cover complications arising directly from services that a PEBB plan paid for you in the past.
11. Computed tomographic colonography (CTC), also called a virtual colonoscopy, for routine colorectal cancer screening.
12. Corneal refractive therapy (CRT), also called orthokeratology.
13. Coronary or cardiac artery calcium scoring.
14. Coronary artery tomographic angiography for:
    - Patients who are asymptomatic or at high risk of coronary artery disease;
    - CCTA used for coronary artery disease investigation outside of the emergency department or hospital setting; and
    - CT scanners that use lower than 64-slice technology.
15. Cosmetic services or supplies, including drugs and pharmaceuticals. However, the plan does cover:
    - Reconstructive breast surgery following a mastectomy necessitated by disease, illness, or injury.
    - Reconstructive surgery of a congenital anomaly, such as cleft lip or palate, to improve or restore function.
16. Court-ordered care, unless determined by the plan to be medically necessary and otherwise covered.
17. Custodial care (see definition on page 176).

UMP Exclusions, (*cont.*)

18. Deep brain stimulation and transcranial direct current stimulation when used as nonpharmacological treatments for treatment-resistant depression.
19. Dental care for the treatment of problems with teeth or gums, other than the specific covered dental services listed on pages 43–45.
20. Dietary or food supplements, including but not limited to:
    - Herbal supplements, dietary supplements, medical foods, and homeopathic drugs.
    - Infant or adult dietary formulas (see "Exceptions covered" by the plan on page 88).
    - Medical foods.
    - Minerals.
    - Prescription or over-the-counter vitamins (see exceptions on page 88).
21. Dietary programs.
22. Discography for patients with chronic low back pain and lumbar degenerative disc disease. This does not apply to patients with the following conditions:
    - Radiculopathy
    - Functional neurologic deficits (motor weakness or EMG findings of radiculopathy)
    - Spondylolisthesis greater than Grade 1
    - Isthmic spondylolysis
    - Primary neurogenic claudication associated with stenosis
    - Fracture, tumor, infection, inflammatory disease
    - Degenerative disease associated with significant deformity

Washington State Health Care Authority

UMP Exclusions, (*cont.*)

23. Drugs or medicines not covered by the plan as described in the "Your prescription drug benefit" section, pages 76–97.
24. Drugs or medicines obtained through mail-order pharmacies located outside the U.S.
25. Educational programs, except as described under:
    - "Diabetes Control Program" on page 46.
    - "Diabetes education" on page 46.
    - "Diabetes Prevention Program" on page 46.
    - "Tobacco cessation services" on page 72.
26. Electrical Neural Stimulation (ENS), which includes Transcutaneous Electrical Nerve Stimulation (TENS) Units.
27. Email consultations or e-visits.
28. Equipment not primarily intended to improve a medical condition or injury, including but not limited to:
    - Air conditioners or air purifying systems
    - Arch supports
    - Communication aids
    - Elevators
    - Exercise equipment
    - Massage devices
    - Overbed tables
    - Residential accessibility modifications
    - Sanitary supplies
    - Telephone alert systems
    - Vision aids
    - Whirlpools, portable whirlpool pumps, or sauna baths

Washington State Health Care Authority

UMP Exclusions, (*cont.*)

29. Erectile or sexual dysfunction treatment with drugs or pharmaceuticals.
30. Experimental or investigational services, supplies, or drugs.
31. Extracorporeal shock wave therapy for musculoskeletal conditions.
32. Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, photokeratectomy, or LASIK surgery.
33. Facet neurotomy for the thoracic spine or headache.
34. Fecal microbiota transplantation for treatment of inflammatory bowel disease.
35. Foot care not related to diabetes: cutting of toenails; treatment for diagnosed corns and calluses; or any other maintenance-related foot care.
36. Functional neuroimaging for primary degenerative dementia or mild cognitive impairment.
37. Headaches (for chronic migraines and tension-type headaches) (see page 52): Treatment of chronic tension-type headache with Botox. Treatment of chronic migraine or chronic tension-type headache with acupuncture, massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy (example: chiropractic services).
38. Hip resurfacing.
39. Hip surgery for treatment of Femoroacetabular Impingement (FAI) Syndrome.
40. Home health care, except as described on page 54. The plan does not cover the following services:
    - Private duty or continuous care in the member's home.
    - Housekeeping or meal services.
    - Care in any nursing home or convalescent facility.
    - Care provided by or for a member of the patient's family.
    - Any other services provided in the home that do not meet the definition of skilled home health care as described on page 54 or not specifically listed as covered in this certificate of coverage.

Washington State Health Care Authority

UMP Exclusions, (*cont.*)

41. Hospital inpatient charges for non-essential services or features such as:
    - Admissions solely for diagnostic procedures that could be performed on an outpatient basis.
    - Reserved beds.
    - Services and devices that are not medically necessary (see definition on page 182).
    - Personal or convenience items.
42. Hyaluronic acid injections (viscosupplementation) for treatment of pain in any joint other than the knee.
43. Hyperbaric oxygen therapy treatment for:
    - Brain injury including traumatic (TBI) and chronic brain injury
    - Cerebral palsy
    - Multiple sclerosis
    - Migraine or cluster headaches
    - Acute and chronic sensorineural hearing loss
    - Thermal burns
    - Non-healing venous, arterial and pressure ulcers
44. Imaging of the sinus for rhinosinusitis using X-ray or ultrasound.
45. Immunizations for the purpose of travel or employment, even if recommended by the Centers for Disease Control and Prevention.
46. Implantable drug delivery systems (infusion pumps or IDDS) for chronic non-cancer pain.
47. In vitro fertilization and all related services and supplies, including all procedures involving selection of embryo for implantation.
48. Incarceration: Services and supplies provided while confined in a prison or jail.

UMP Exclusions, (*cont.*)

49. Infertility or fertility testing or treatment after initial diagnosis, including drugs, pharmaceuticals, artificial insemination, and any other type of testing, treatment, complications resulting from such treatment (e.g., selective fetal reduction), or visits for infertility.
50. Knee arthroscopy for osteoarthritis of the knee.
51. Late fees, finance charges, or collections charges.
52. Learning disabilities treatment after diagnosis, except as covered under the following benefits:
    - "Applied Behavior Analysis (ABA) Therapy" on page 40.
    - "Physical, occupational, speech, and neurodevelopmental therapy" on page 65; or
    - When part of treating a mental health disorder as described on page 61.
53. Lumbar artificial disc replacement.
54. Lumbar fusion for degenerative disc disease.
55. Magnetic resonance imaging, upright (uMRI), also known as "positional," "weight-bearing" (partial or full), or "axial loading."
56. Maintenance care (see definition on page 181).
57. Manipulations of the spine or extremities, except as described under "Spinal and extremity manipulations" on page 69.
58. Marriage, family, or other counseling or training services, except as provided to treat an individual member's neuropsychiatric, mental, or personality disorder.
59. Massage therapy services when the massage therapist is not a preferred provider.
60. Medicare-covered services or supplies delivered by a provider who does not offer services through Medicare, when Medicare is the patient's primary coverage (see page 123).
61. Microprocessor-controlled lower limb prostheses (MCP) for the feet and ankle.

Washington State Health Care Authority

UMP Exclusions, (*cont.*)

62. Migraine headaches (chronic migraines and tension) (see page 52): Treatment of chronic tension-type headache with Botox. Treatment of chronic migraine or chronic tension-type headache with acupuncture, massage, trigger point injections, transcranial magnetic stimulation, or manipulation/manual therapy (example: chiropractic services).
63. Missed appointment charges.
64. Noncovered provider types: Services delivered by providers not listed as a covered provider type (see page 13).
65. Novocure (tumor treating fields).
66. Orthoptic therapy except for the diagnosis of strabismus, a muscle disorder of the eye.
67. Orthotics, foot or shoe: Items such as shoe inserts and other shoe modifications, except as specified on page 48.
68. Osteochondral allograft/autograft transplantation for joints other than the knee.
69. Out-of-network provider charges that are above the allowed amount.
70. Over-the-counter contraceptive supplies intended for use by males.
71. Pharmacogenomics testing for depression, mood disorders, psychosis, anxiety, ADHD, and substance use disorder.
72. Positron Emission Tomography (PET) scans for routine surveillance of lymphoma.
73. Postage and handling related to medical services and supplies.
74. Prescription drug charges over the allowed amount, regardless of where purchased.
75. Prescription drugs that require preauthorization unless the request is:
    - Supported by medical justification from a clinician other than the patient or member of the patient's family.
    - Approved by the plan.

Washington State Health Care Authority

UMP Exclusions, (*cont.*)

76. Proton beam therapy for conditions other than:
    - Ocular cancers.
    - Pediatric cancers (e.g., medulloblastoma, retinoblastoma, Ewing's sarcoma).
    - Central nervous system tumors.
    - Other non-metastatic cancers with the following conditions: patient has had prior radiation in the expected treatment field with contraindication to all other forms of therapy, and at agency discretion.
77. Provider administrative fees—Any charges for completing forms, copying records, or finance charges, except for records requested by the plan to perform retrospective (postpayment) review.
78. Recreation therapy.
79. Replacement of lost, stolen, or damaged durable medical equipment.
80. Replacement of medications that are any of the following:
    - Confiscated or seized by Customs or other authorities
    - Contaminated
    - Damaged
    - Expired
    - Lost or stolen
    - Ruined
81. Residential treatment programs that are not licensed to provide residential treatment, solely to persons: Requiring residential chemical dependency treatment, or diagnosed with a mental health condition and requiring residential treatment.
82. Reversal of voluntary sterilization (vasectomy, tubal ligation, or similar procedures).

Washington State Health Care Authority

UMP Exclusions, (*cont.*)

83. Riot, rebellion, and illegal acts: Services and supplies for treatment of an illness, injury, or condition caused by a member's voluntary participation in a riot, armed invasion or aggression, insurrection or rebellion, or sustained by a member arising directly from an act deemed illegal by a court of law.
84. Separate charges for records or reports.
85. Service animals: Any expenses related to a service animal.
86. Services covered by other insurance, including but not limited to motor vehicle, homeowner's, renter's, commercial premises, personal injury protection (PIP), medical payments (Med-Pay), automobile no-fault, general no-fault, underinsured or uninsured motorist coverage. See page 116 for more about how this works.
87. Services delivered by providers or facilities delivering services outside the scope of their licenses.
88. Services or supplies:
    - That are not medically necessary for the diagnosis and treatment of injury or illness or restoration of physiological functions, and are not covered as preventive care. This applies even if services are prescribed, recommended, or approved by your provider.
    - For which no charge is made, or for which a charge would not have been made if you had no health care coverage.
    - Provided by a family member or any household member.
    - Provided by a resident physician or intern acting in that capacity.
    - That are solely for comfort.
    - For which you are not obligated to pay.
89. Services performed during a noncovered service.
90. Services performed primarily to ensure the success of a noncovered service, including but not limited to a hiatal hernia repair done to ensure the success of a noncovered laparoscopic adjustable gastric banding surgery.

Washington State Health Care Authority

UMP Exclusions, (*cont.*)

91. Services supplemental to digital mammography. When performed supplementary to digital mammography for screening purposes for women with or without dense breasts, the following procedures are not covered:
    - Non-high-risk patients:
        - Magnetic resonance imaging (MRI)
        - Hand held ultrasound (HHUS)
        - Automated breast ultrasound (ABUS)
    - High-risk patients:
        - Hand held ultrasound (HHUS)
        - Automated breast ultrasound (ABUS)
92. Services, supplies, or drugs related to occupational injury or illness (see page 185).
93. Services, supplies, or items that require preauthorization unless the request is:
    - Supported by medical justification from a clinician other than the patient or member of the patient's family.
    - Approved by the plan.
94. Skilled nursing facility services or confinement:
    - When primary use of the facility is as a place of residence.
    - When treatment is primarily custodial.
95. Sleep apnea diagnosis and treatment as indicated in referenced Medicare national and local coverage determinations.
96. Spinal cord stimulation for chronic neuropathic pain.

Washington State Health Care Authority

UMP Exclusions, (*cont.*)

97. Spinal injections, therapeutic (except as described under "Spinal injections" on page 69) of the following types:
    - Medial branch nerve block
    - Intradiscal
    - Facet injections
98. Spinal surgical procedures known as vertebroplasty, kyphoplasty, and sacroplasty.
99. Stereotactic radiation surgery and stereotactic body radiation therapy.
100. Telephone or virtual consultations or appointments, except as described under "Telemedicine services" on page 70.
101. Travel, transportation, and lodging expenses, except as specified for ambulance services covered by the plan (see page 39), or approved travel and lodging costs related to the Center of Excellence (COE) Program for knee and hip replacement (see page 56).
102. Ultrasounds during pregnancy, except as described on page 64.
103. Upright magnetic resonance imaging (uMRI), also known as "positional," "weight-bearing" (partial or full), or "axial loading."
104. Vagal nerve stimulation for the treatment of depression.
105. Vitamin D screening and testing is not covered as part of routine screening.

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UMP Exclusions, (*cont.*)

106. Weight control, weight loss, and obesity treatment:
    - Non-surgical: Any program, drugs, services, or supplies for weight control, weight loss, or obesity treatment. Exercise or diet programs (formal or informal), exercise equipment, or travel expenses associated with non-surgical or surgical services are not covered. Such treatment is not covered even if prescribed by a provider, except as covered under "Diabetes Control Program (see page 46)," "Diabetes Prevention Program" (see page 46), "Nutrition counseling and therapy" (see page 63), or "Preventive care" on page 66.
    - Surgical: Any bariatric surgery procedure, any other surgery for obesity or morbid obesity, and any related medical services, drugs, or supplies, except when approved by preauthorization review.
107. Workers' compensation: When a claim for workers' compensation is accepted as being caused by a work-related injury or illness, all services related to that injury or illness are not covered, even if some services are denied by workers' compensation.

If you have questions about whether a certain service or supply is covered, call Customer Service at 1-888-849-3681.

TAB 5

Washington State Health Care Authority

Uniform Medical Plan (UMP) Plus

Barb Lantz, MN, RN
Manager, Clinical Policy Development, Implementation and Oversight
Clinical Quality and Care Transformation

May 30, 2018

Michael Arnis
Account Manager, UMP Plus
Portfolio Management and Monitoring
Employees and Retirees Benefits Division

Washington State Health Care Authority

Presentation Overview

1. Where did UMP Plus come from?

2. What is UMP Plus?

3. How does UMP Plus work?

Washington State Health Care Authority

Where did UMP Plus come from?

Accountable Care Network Plans
Washington State

The Boeing Company

Washington State Health Insurers

Washington State Health Care Authority

Value-Based Purchasing

High value, Low cost

Network of providers accountable for their performance

- Quality of care
- Financial

UMP Plus: two accountable care provider networks

- UMP Plus – Puget Sound High Value Network (PSHVN)
- UMP Plus – UW Medicine Accountable Care Network (UW Medicine)

What is UMP Plus?

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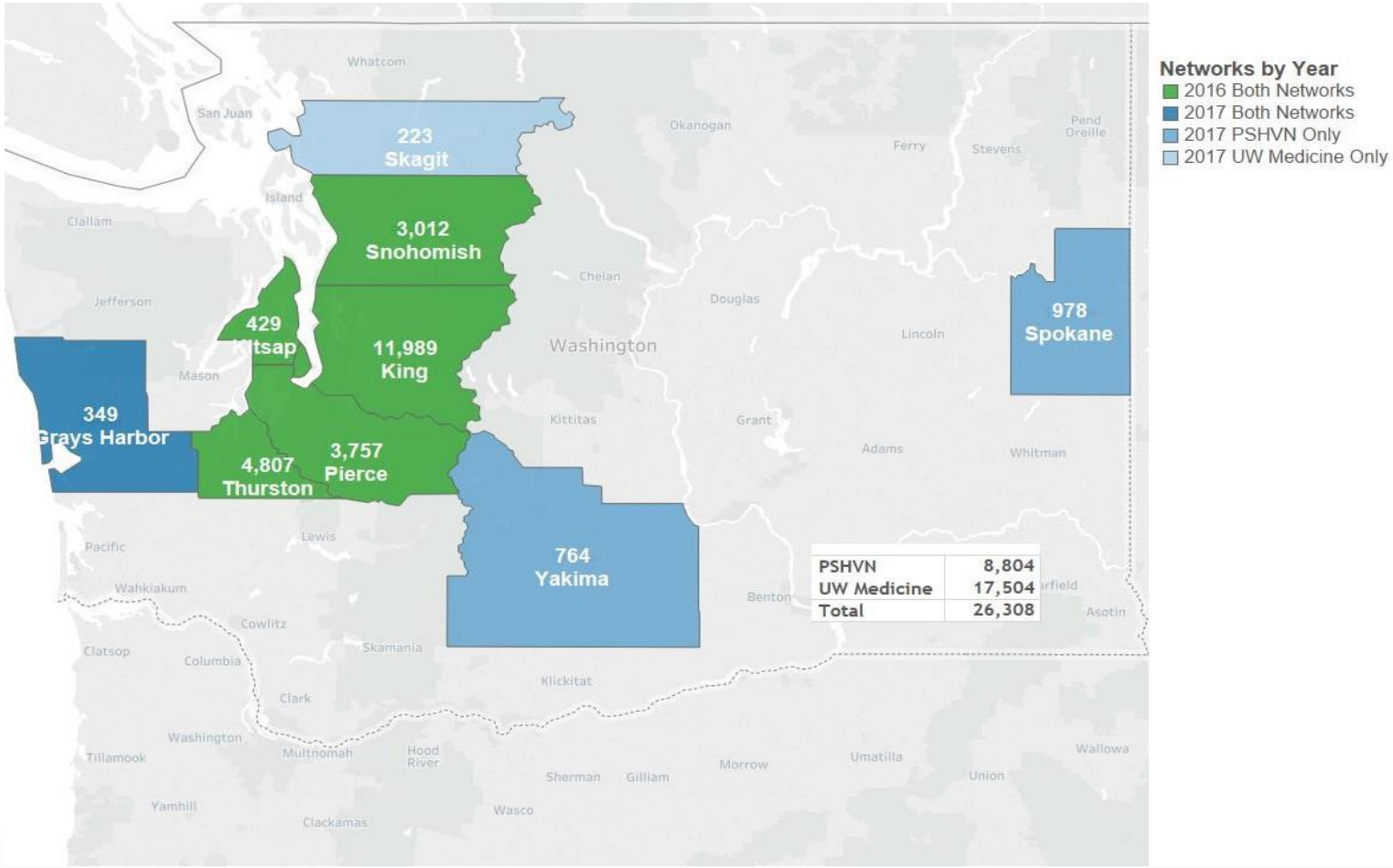
UMP Plus Currently Offered in Nine Counties

May 2018 Enrollment



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Annual Increases in UMP Plus Enrollment

Enrollment	January 2016	January 2017	January 2018	Percent change 2016-2017	Percent change 2017-2018
PSHVN	3,173	4,935	8,545	55%	73%
UW Medicine	7,398	11,192	17,172	51%	53%
Total	**10,571**	**16,127**	**25,717**	**52%**	**59%**

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UMP Plus vs. UMP Classic

Benefits

They cover the same

health care services

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UMP Plus vs. UMP Classic

Cost Sharing

	UMP Classic	UMP Plus
Services	**What a member pays preferred providers**	**What a member pays network providers**
Office visits	15%	0% primary care 15% non-primary care
Naturopathic physician services	15%	0% for office visits (no deductible) 15% for related services (subject to deductible)
Emergency room	15% after $75 copay	15% after $75 copay
Most other services	Typically 15%	Typically 15%

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UMP Plus vs. UMP Classic

Lower Deductible in UMP Plus

	UMP Classic	UMP Plus
Annual Member Costs	**What a member pays preferred providers**	**What a member pays network providers[1]**
Medical deductible *(applies to medical out-of-pocket limit)*	$250 per person (up to $750 for a family of **three** or more)	$125 per person (up to $375 for a family of **three** or more)
Out-of-pocket limit	**Medical**: $2,000 per person, $4,000 maximum for family **Prescription drug**: $2,000 per member, no family maximum	**Medical**: $2,000 per member, $4,000 maximum for family **Prescription drug**: $2,000 per member, no family maximum

[1]*See the network's UMP Plus 2018 Certificate of Coverage for a definition of network providers.*

Washington State Health Care Authority

UMP Plus vs. UMP Premiums

(2020 premiums will be Different for SEBB and PEBB)

UMP Plus has a lower deductible and a lower premium

Tier	2018 Premium UMP Plus	2018 Premium UMP Classic	Annual Savings In UMP Plus Premium
Subscriber Only	$45	$102	$684
Subscriber and Spouse/SRDP*	$100	$214	$1,368
Subscriber and Children	$79	$179	$1,200
Subscriber, Spouse/SRDP*, and Children	$134	$291	$1,884

* State-registered domestic partner

In the PEBB Program, the ratio between the “subscriber only” and “subscriber, spouse/SRDP, and children” tiers is 1 to 2.75.

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UMP Plus vs. UMP Classic

Provider Network

- UMP Classic has tens of thousands of providers throughout 39 counties
- Emergency services covered by the same worldwide network
- UMP Plus has thousands of providers throughout nine counties

Providers	PSHVN	UW Medicine
Primary care providers	1,200	1,200
Specialists	5,500+	7,400+
Hospitals	16	17
Clinics	1,200+	1,400+

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How does UMP Plus Work?

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UMP Plus
Quality and Cost

Quality is the Roadmap to Better Costs

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UMP Plus
Quality of Care Emphasis

1. Improve both Primary and Specialty Care
2. Looked to both national and local organizations to adopt standards for quality:
   - National Committee for Quality Assurance
   - Bree Collaborative

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Patient Centered Medical Home

1. Certification as a Patient Centered Medical Home
2. Patient Centered Medical Home standards
   - Offer flexible access and scheduling
   - Provides health care advice electronically
   - Delivers team-based care
   - Uses clinical practice guidelines

Questions?

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TAB 6

Washington State Health Care Authority

Uniform Medical Plan (UMP) Pharmacy Benefits

Ryan Pistoresi, PharmD, MS
Assistant Chief Pharmacy Officer
Clinical Quality and Care Transformation
May 30, 2018

Washington State Health Care Authority

Formulary Models

Formulary Type	Description
Open	Non-preferred drugs still available at a higher member cost share.
Closed	No coverage for non-formulary drugs. Drugs are blocked for rebate purposes. A smaller, limited formulary.
Hybrid	A formulary where a select mix of drugs in drug classes are identified as warranting exclusion for clinical or financial reasons.
Value-based	Emphasizes the clinical effectiveness of a drug rather than cost. Non-preferred are covered only when medically necessary and clinically appropriate after review of the individual clinical circumstances.

Washington State Health Care Authority

Other Pharmacy Terms

- **Multi-Source Brand (MSB):** The originator drug that originally held the patent for the drug but the patent has expired and now has generic alternatives.
- **Preferred:** First-line medications, placed at low member cost-share to encourage use and adherence. Typically the most cost-effective, high-value medications.
- **Non-preferred:** Second-line medications, placed at higher member cost-share. Often have utilization management strategies to ensure that the medications are being used appropriately.
- **Not covered:** Medications that the health plan does not pay for unless it is determined to be medically necessary, clinically appropriate, and other covered therapies are ineffective.

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Overview of UMP Pharmacy Benefit

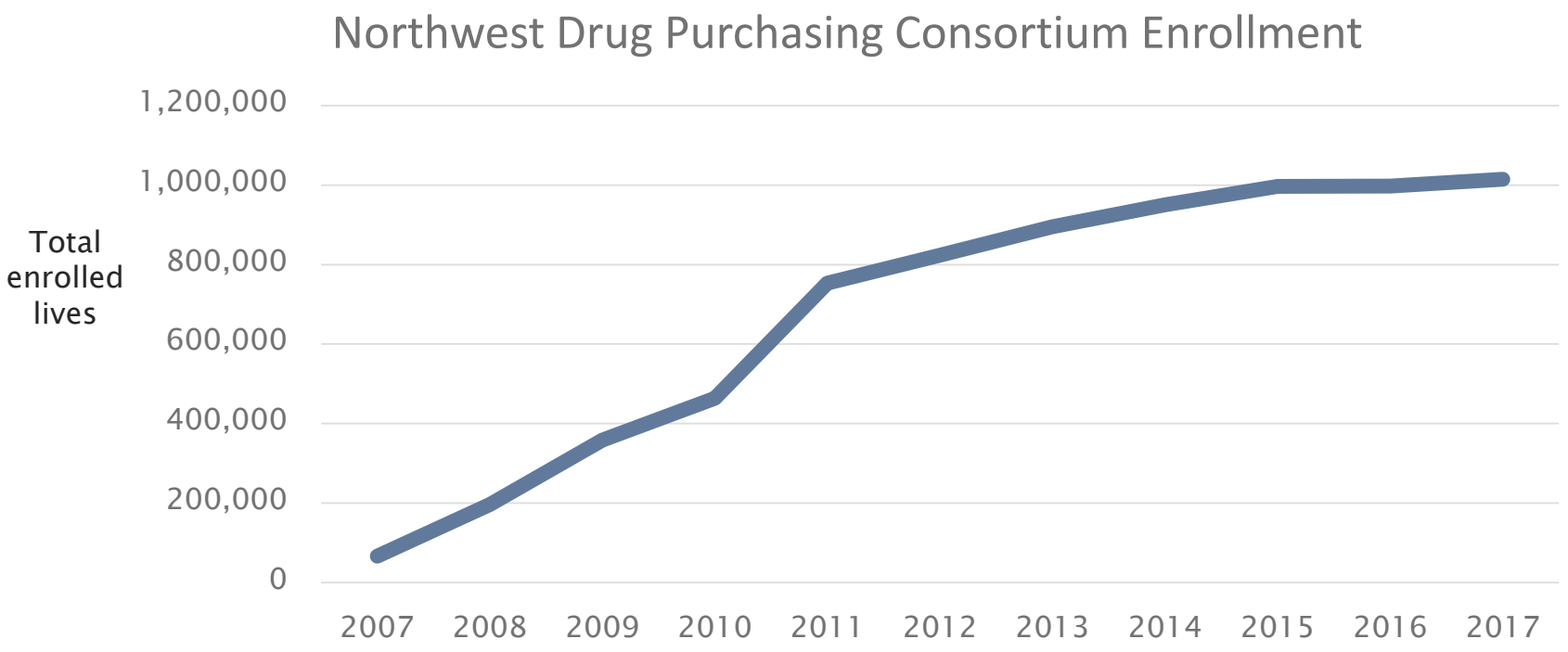
- In 2005, the state legislature created the Washington Prescription Drug Program (WPDP) to administer the state prescription drug purchasing consortium.
  - RCW 70.14.060 requires that state purchased health care programs (defined in 41.05.011) must purchase through the prescription drug purchasing consortium.
  - Programs can be exempt if they can demonstrate greater discounts and cost savings through other mechanisms.

- In 2006, Washington Prescription Drug Program (WPDP) joined with Oregon Prescription Drug Program (OPDP) to create Northwest Drug Consortium to pool purchasing power and to reduce drug purchasing costs.

- In 2007, the Consortium selected Moda Health to administer the program. That year, the Consortium bid for UMP business.
  - Moda Health has administered this contract since 2008

Washington State Health Care Authority

NW Drug Consortium Growth



Overview of UMP Pharmacy Benefit

- UMP pharmacy services are administered under the Consortium by Washington State Prescription Services (WSRxS). WSRxS is made up of four partners:
  - **Moda Health**: Administration and customer service
  - **MedImpact Healthcare Systems, Inc**: Pharmacy network management and prescription drug claims processing
  - **Ardon Health**: Network specialty pharmacy services
  - **Postal Prescription Services**: Network mail-order pharmacy

Overview of UMP Pharmacy Benefit

- UMP formulary is structured with 5 different tiers for drug coverage:
  - **Preventive Tier**: drugs required under the Affordable Care Act or recommended by the US Preventive Services Task Force
  - **Value Tier**: specific high-value medications to treat certain chronic conditions
  - **Tier 1**: primarily low-cost generic drugs
  - **Tier 2**: preferred brand-name drugs and high-cost generics
  - **Tier 3**: non-preferred drugs

Washington State Health Care Authority

UMP Plans Pharmacy Comparison

	UMP Classic	UMP Plus	UMP CDHP
Annual costs *(you pay)*	**What a member pays preferred providers**	**What a member pays network providers[1]**	**What a member pays preferred providers**
Prescription drug deductible	Preventive, Value Tier, and Tier 1 are not subject to Rx deductible. $100 for Tier 2 and Tier 3 (brand-name) drugs. $300 maximum for a family of three or more.	$0	Prescription drug deductible is combined with the medical deductible. **One person covered:** $1,400 **Two or more persons covered:** $2,800
Prescription drugs	**No deductible:** Preventive 0%, Value Tier: 5% (max $10), Tier 1: 10% (max $25) **Subject to Rx Deductible:** Tier 2: 30% (max $75 after), Tier 3: 50% (SP max $150)	**No deductible:** Value Tier: 5% (max $10), Tier 1: 10% (max $25), Tier 2: 30% (max $75), Tier 3: 50% (SP max $150)	**No deductible:** Preventive 0% **After meeting deductible:** All drugs 15%
Out-of-pocket Maximum	$2,000 per person (no family maximum)	$2,000 per person (no family maximum)	**One person covered:** $4,200 **Two or more persons covered:** $8,400 (once an individual meets $6,850, then the plan will pay 100% for that individual)

[1]*See the network's UMP Plus 2018 Certificate of Coverage for a definition of network providers.*

Value Formulary Component

Washington State Health Care Authority

Principles of a Value Formulary

- Focus on drug classes with potential for cost savings without reducing quality of care to members
- Make a difference to premiums without sacrificing care
- Transition members who have used these medications for a long time or who are in refill-protected drug classes

Washington State Health Care Authority

Implementing a Value Formulary

- A value formulary for some drug classes, such as diabetes, cholesterol, beta blockers, androgens, antidepressants, blood pressure, psychotherapeutic/neurological, and Parkinson's disease
  - Other drug classes would be structured with preferred and non-preferred
    - There would be some inequity issues because some members could pay different amounts for the same non-preferred drugs
  - Transition period allows members to continue on their medications
  - New users would be directed to preferred or be transitioned if stable on non-preferred medications

- A value formulary for multi-source brands (MSB)
  - All MSB in all drug classes would be covered only when medically necessary and clinically appropriate
  - There would be some inequity issues because some members could pay different amounts for single-source brands

Member Transition Examples (T2DM)

- Scott is a school employee whose district currently contracts with HCA for medical benefits. Scott has been a UMP member and continues to enroll in UMP in January 2020. He uses the GLP-1 agonist, Victoza, for type 2 diabetes mellitus. As an existing UMP member, Scott can continue taking Victoza.

- Lou is a school employee new to UMP as of January 2020, but he was diagnosed with type 2 diabetes mellitus years ago and has been stable on Victoza for 5 years. Lou's provider can request Victoza and Lou can continue taking Victoza.

- Dave is a school employee new to UMP in January 2020 and was recently diagnosed with type 2 diabetes mellitus. Dave would be directed to preferred antidiabetic medications first. If the preferred drugs are not effective for Dave, he can then try non-formulary drugs.

Questions?

Ryan Pistoresi, PharmD, MS
Assistant Chief Pharmacy Officer
Clinical Quality and Care Transformation

TAB 7

Washington State Health Care Authority

Proposed Self-Insured Medical Plan Resolutions

Dave Iseminger, Director
Employees and Retirees Benefits Division
May 30, 2018

Proposed Resolution SEBB 2018-20 Self-Insured Plan Offering

Beginning January 1, 2020, and subject to financing decisions, the SEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks, and same clinical policies as the Uniform Medical Plan Classic in place for plan year 2020 under the PEBB Program. The cost shares (deductible, out-of-pocket maximums, coinsurance for services, etc.) will be the same as the UMP Classic under the PEBB Program.

Proposed Resolution SEBB 2018-21 Second Self-Insured Plan Offering

Beginning January 1, 2020, and subject to final financing decisions, the SEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks, and same clinical policies as the Uniform Medical Plan Classic in place for plan year 2020 under the PEBB Program. The cost shares (deductible, out-of-pocket maximums, coinsurance for services, etc.) will be the same as the UMP Classic under the PEBB Program, except for the following:

Proposed Resolution SEBB 2018-21 Second Self-Insured Plan Offering (*cont.*)

- Annual Deductible (medical): $750/$2,250 (single/family)
- Annual Deductible (drug): $250/$750 (single/family)
- Out-of-Pocket Maximum (medical): $3,500/$7,000 (single/family)
- Coinsurances: 20%/80% (member/plan)

Proposed Resolution SEBB 2018-22 Third Self-Insured Plan Offering

Beginning January 1, 2020, and subject to financing decisions, the SEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks, and same clinical policies as the Uniform Medical Plan Consumer-Directed Health Plan in place for plan year 2020 under the PEBB Program. The cost shares (deductible, out-of-pocket maximums, coinsurance for services, etc.) will be the same as the UMP CDHP under the PEBB Program.

Proposed Resolution SEBB 2018-23 Fourth Self-Insured Plan Offering

- Beginning January 1, 2020, and subject to final financing decisions, the SEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks (either or both of the PSHVN and UW ACN), and same clinical policies as the Uniform Medical Plan Plus in place for plan year 2020 under the PEBB Program. The cost shares (deductible, out-of-pocket maximums, coinsurance for services, etc.) will be the same as the UMP Plus.

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Proposed Resolution SEBB 2018-24 Self-Insured Value-Based Formulary

Beginning January 1, 2020, the pharmacy benefit for all SEBB self-insured plans will be a value-based formulary with:

- a select mix of drugs within a drug class that are covered only when medically necessary and all preferred products have been ineffective or are not clinically appropriate, and
- multi-source brand drugs being covered only when medically necessary and clinically appropriate, and

Proposed Resolution SEBB 2018-24 Self-Insured Value-Based Formulary (*cont.*)

- members who have been taking a non-preferred drug be able to receive their current medications during a transition period, and

- the transition period for brand name drugs ends when a generic equivalent or interchangeable biologic becomes available, unless the transitioned multi-source brand name drug is medically necessary and clinically appropriate.

Washington State Health Care Authority

Questions?

David Iseminger, Director

Employees and Retiree Benefits Division

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TAB 8

Washington State Health Care Authority

Fully Insured Medical Plan(s) Procurement Update

Lauren Johnston
SEBB Procurement and Account Manager
Employees and Retirees Benefits Division
May 30, 2018

Washington State Health Care Authority

RFI Summary

- March 15, 2018 the Board adopted resolutions to procure for fully insured group medical plan(s).
- A request for information (RFI) was released.

Benefit Type	Release Date	Responses Due
Fully Insured Group Medical Plans	April 2, 2018	April 27, 2018

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RFI Objectives

- Get an idea of plan designs and costs
- Inform creation of competitive solicitation for benefits
- Learn current and proposed geographic coverage areas
- Make market aware of the intent to procure benefits

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Respondents

- Aetna
- Kaiser Permanente Northwest
- Kaiser Permanente Washington (HMO)
- Kaiser Permanente Washington – Options (PPO)
- Premera Blue Cross
- Providence
- UnitedHealthcare

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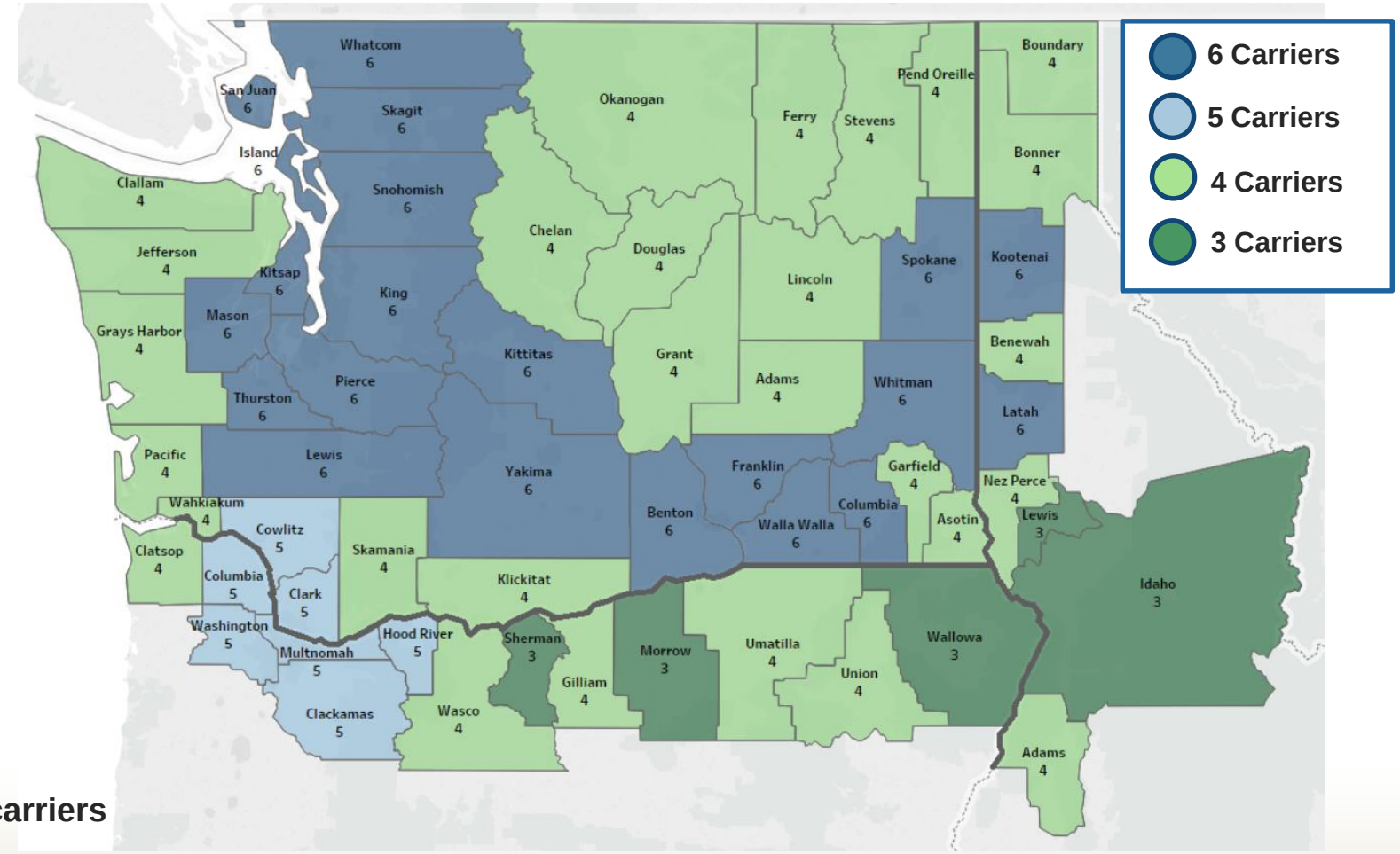
RFI Highlights

- All respondents are accredited by one or both of:
  - National Committee for Quality Assurance (NCQA)
  - Utilization Review Accreditation Commission (URAC)
- **Fully insured HMO vs. PPO offerings:** 2 HMO/5 PPO preferred network types
- **AV Range:** mid 70s to low 90s
- **AV Median:** low 80s
- All responses suggested they can add providers to their network throughout the year. However, there is an application and contracting process new providers will need to go through.

Washington State Health Care Authority

Potential 2020 County Coverage

Carrier WA/OR/ID Glance



7 total carriers

Washington State Health Care Authority

Potential 2020 County Coverage

By Carrier and County

Carrier Name	# of WA Counties Potentially Covered	
Aetna	39	All counties
Kaiser Permanente NW	2	Clark and Cowlitz
Kaiser Permanente of WA	19	Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, Thurston, San Juan, Skagit, Snohomish, Spokane, Walla Walla, Whatcom, Whitman, and Yakima
Kaiser Permanente of WA – Options	19	Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, Thurston, San Juan, Skagit, Snohomish, Spokane, Walla Walla, Whatcom, Whitman, and Yakima
Premera	39	All counties
Providence	39	All counties
United Healthcare	39	All counties

Washington State Health Care Authority

RFP Summary

- Estimated release: Early June 2018
- RFP Highlights:
  - Compliance with the OIC's regulations for transitioning care of members between existing and receiving carriers.
  - Alignment with the Triple Aim (better health, better care, lower cost): A provider network that is cost effective and delivers high quality services to members.
  - Carriers engage their membership through a number of different communication channels, resources, and tools.

RFP Summary, (*cont.*)

- RFP Highlights, (*cont.*):
  - Online self-service tools: provider search, cost transparency, communicating with providers, etc.
  - Performance Guarantees:
    - ✓ Implementation
    - ✓ Customer Service: answering time, abandoned calls, etc.
    - ✓ Reporting delivery
    - ✓ Account management
    - ✓ Quality Metrics
  - Compliance with ESHB 2408

RFP Summary, (*cont.*)

- Benefit Design:
  - Bidders will be asked to propose plans with specified AV limits.
  - RFP will provide the UMP Classic list of covered services and exclusions as a base from which the Bidder's will highlight any variations within their proposed plans.
  - Bidders will be asked to propose by plan: deductibles, co-pays/coinsurance, and out-of-pocket maximums.

Follow up to KPNW's Dental Presentation

- The dental plan itself is a separate line of business, (aka stand alone group dental benefit) with separate rates, separate plan selection, separate explanations of coverage. Although care is coordinated in the KPNW system, the medical and dental plans are separate benefits.
- The Board voted to leverage the PEBB dental plans for 1/1/2020 and would need to vote to procure for fully insured dental plans in order to potentially include KPNW's dental plan.

Washington State Health Care Authority

Questions?

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TAB 9

Washington State Health Care Authority

Policy Resolutions

Barb Scott, Manager
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
May 30, 2018

Washington State Health Care Authority

SEB Board Policy Resolutions

Information on policy resolutions to establish the following:

- Dual enrollment in SEBB benefits is prohibited
- Definitions for the following:
    - Tobacco products
    - Tobacco use
- Surcharge attestation default:
    - Tobacco surcharge
    - Spousal surcharge

RCW 41.05.740(6)(d) As Amended by ESSB 6241

(6) The school employees' benefits board shall […]

(c) Authorize premium contributions for a school employee and the employee's dependents in a manner that encourages the use of cost-efficient health care systems. For participating school employees, the required school employee share of the cost for family coverage premiums may not exceed three times the premiums for a school employee purchasing single coverage for the same coverage plan;

(d) Determine the terms and conditions of school employee and dependent eligibility criteria, enrollment policies, and scope of coverage. **At a minimum**, the eligibility criteria established by the school employees' benefits board shall address the following:

(i) The effective date of coverage following hire;

(ii) The benefits eligibility criteria, but the school employees' benefits board's criteria shall be no more restrictive than requiring that a school employee be anticipated to work at least six hundred thirty hours per school year to be benefits eligible; and

(iii) Coverage for dependents, including criteria for legal spouses; children up to age twenty-six; children of any age with disabilities, mental illness, or intellectual or other developmental disabilities; and state registered domestic partners, as defined in RCW 26.60.020, and others authorized by the legislature;

Policy Resolution SEBB 2018-15

Dual enrollment in SEBB Benefits is prohibited

Resolved that, School Employees Benefits Board (SEBB) medical, dental, and vision coverage is limited to a single enrollment per individual.

Washington State Health Care Authority

ESSB 6032
Budget Bill for 2018 Session

Section 504 - FOR THE SUPERINTENDENT OF PUBLIC INSTRUCTION—FOR SCHOOL EMPLOYEE COMPENSATION ADJUSTMENTS

(3) - The maintenance rate for insurance benefit allocations is $780.00 per month for the 2017-18 and 2018-19 school years. The appropriations in this section reflect the incremental change in cost of allocating rates of $820.00 per month for the 2017-18 school year and $843.97 per month for the 2018-19 school year. When bargaining for health benefits funding for the school employees' benefits board during the 2017-2019 biennium, any proposal agreed upon must assume the imposition of a twenty-five dollar per month surcharge payment from members who use tobacco products and a surcharge payment of not less than fifty dollars per month from members who cover a spouse or domestic partner where the spouse or domestic partner has chosen not to enroll in another employer-based group health insurance that has benefits and premiums with an actuarial value of not less than ninety-five percent of the actuarial value of the public employees' benefits board plan with the largest enrollment. The surcharge payments shall be collected in addition to the member premium payment.

Policy Resolution SEBB 2018-16
Definition of "tobacco products"

Resolved that, "tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

Washington State Health Care Authority

Policy Resolution SEBB 2018-17
Definition of "tobacco use"

Resolved that, "tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include religious or ceremonial use of tobacco.

- "Religious use of tobacco" means the use of tobacco products as part of a formal tradition, rite, or ritual.
- "Ceremonial use of tobacco" means the use of tobacco products for ceremonial purposes in connections with the practice of a traditional ceremony or ritual.

Policy Resolution SEBB 2018-18
Tobacco surcharge attestation default

Resolved that, a subscriber's account will incur a $25 monthly premium surcharge if he or she fails to attest that any member, age 13 years or older, enrolled in medical on his or her account does or does not engage in tobacco use within the HCA's enrollment timeframe.

Policy Resolution SEBB 2018-19
Spousal surcharge attestation default

Resolved that, when a subscriber has a spouse or state-registered domestic partner enrolled in medical on his or her account, the subscriber will incur a $50 monthly premium surcharge if he or she fails to attest to the applicability of the spousal surcharge within the HCA's enrollment timeframe.

Washington State Health Care Authority

Next Steps

Incorporate the policy resolutions into SEBB Program rules.

Washington State Health Care Authority

Questions?

Barbara Scott, Manager

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Employees and Retirees Benefits Division

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SEBB Policy Resolutions

Policy Resolution SEBB 2018–15 – Dual enrollment in SEBB Benefits is prohibited: Resolved that, School Employees Benefits Board (SEBB) medical, dental, and vision coverage is limited to a single enrollment per individual.

Policy Resolution SEBB 2018–16 – Definition of "tobacco products": Resolved that, "tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

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  "Ceremonial use of tobacco" means the use of tobacco products for ceremonial purposes in connections with the practice of a traditional ceremony or ritual.

Policy Resolution SEBB 2018–18 – Tobacco surcharge attestation default: Resolved that, a subscriber's account will incur a $25 monthly premium surcharge if he or she fails to attest that any member, age 13 years or older, enrolled in medical on his or her account does or does not engage in tobacco use within the HCA's enrollment timeframe.

Policy Resolution SEBB 2018–19 – Spousal surcharge attestation default: Resolved that, when a subscriber has a spouse or state-registered domestic partner enrolled in medical on his or her account, the subscriber will incur a $50 monthly premium surcharge if he or she fails to attest to the applicability of the spousal surcharge within the HCA's enrollment timeframe.

TAB 10

Washington State Health Care Authority

Eligibility & Enrollment Policy Development

Barb Scott, Manager
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
May 30, 2018

Introduction of Policy Resolutions

- SEBB 2018-12 Effective Date of Coverage for School Employees Eligible for the Employer Contribution
- SEBB 2018-25 When the Employer Contribution for SEBB Benefits End
- SEBB 2018-26 SEBB Eligibility for Employer Contribution Based on a Revision to the School Employee's Anticipated Work Pattern
- SEBB 2018-27 SEBB Eligibility for Employer Contribution Based on Actual Hours Worked
- SEBB 2018-28 SEBB Eligibility for the Employer Contribution Based on Stacking of Hours
- SEBB 2018-29 School Employees are Required to Provide Evidence of a Dependent's Eligibility to Enroll the Dependent

RCW 41.05.740(6)(c) & (d)

(6) The school employees' benefits board shall […]

(c) Authorize premium contributions for a school employee and the employee's dependents in a manner that encourages the use of cost-efficient health care systems. For participating school employees, the required school employee share of the cost for family coverage premiums may not exceed three times the premiums for a school employee purchasing single coverage for the same coverage plan;

(d) Determine the terms and conditions of school employee and dependent eligibility criteria, enrollment policies, and scope of coverage. **At a minimum**, the eligibility criteria established by the school employees' benefits board shall address the following:

(i) The effective date of coverage following hire;

(ii) The benefits eligibility criteria, but the school employees' benefits board's criteria shall be no more restrictive than requiring that a school employee be anticipated to work at least six hundred thirty hours per school year to be benefits eligible; and

(iii) Coverage for dependents, including criteria for legal spouses; children up to age twenty-six; children of any age with disabilities, mental illness, or intellectual or other developmental disabilities; and state registered domestic partners, as defined in RCW 26.60.020, and others authorized by the legislature;

Washington State Health Care Authority

Proposed Policy SEBB 2018-12
Effective Date of Coverage for School Employees Eligible for the Employer Contribution

For September each year, a school employee who is establishing eligibility for the employer contribution towards SEBB benefits, and whose first day of work is on or after September 1 but not later than the first day of school for the current school year as established by the SEBB organization, the effective date of coverage is the first day of work.

For a school employee who is establishing eligibility and whose first day of work is at any other time during the school year, the effective date of coverage is the first day of the month following the day the school employee establishes eligibility for the employer contribution toward SEBB benefits.

Effective Date of Coverage for School Employees Eligible for the Employer Contribution Example #1

Example: Classified employee (bus driver)

This is a new employee who is **anticipated** to work 630 hours or more during the school year. His **first working day will be the first day of school**. For his district that is **September 9, 2020.**

- When does he establish eligibility for the employer contribution for SEBB benefits? September 9, 2020.
- When does SEBB coverage begin? September 9, 2020.

Effective Date of Coverage for School Employees Eligible for the Employer Contribution Example #2

Example: Classified employee (bus driver)

This is a new employee who is **anticipated** to work 630 hours or more during the school year. Her **first working day will be September 15, 2020**, although for her district the first day of school is **September 9, 2020.**

- When does she establish eligibility for the employer contribution for SEBB benefits? September 15, 2020.
- When does SEBB coverage begin? October 1, 2020.

Effective Date of Coverage for School Employees Eligible for the Employer Contribution Example #3

Example: Certificated employee (teacher)

This is an employee who is **anticipated to work greater than 630 hours during the school year**. Her **first working day will be August 27, 2020,** so she can get her classroom ready for the new school year. The district's first day of school is **September 9, 2020**.

- When does she establish eligibility for the employer contribution for SEBB benefits? August 27, 2020.
- When does SEBB coverage begin? September 1, 2020.

Washington State Health Care Authority

Proposed Policy SEBB 2018-25

When the Employer Contribution for SEBB Benefits End

The employer contribution toward SEBB benefits ends the last day of the month in which the school year ends. The employer contribution toward SEBB benefits will end earlier than the end of the school year if one of the following occurs:

- The SEBB organization terminates the employment relationship. In this case eligibility for the employer contribution ends the last day of the month in which the employer-initiated termination notice is effective;
- The school employee terminates the employment relationship. In this case, eligibility for the employer contribution ends the last day of the month in which the school employee's resignation is effective; or
- The school employee's work pattern is revised such that the school employee is no longer anticipated to work 630 hours during the school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which it is determined that the school employee is no longer anticipated to work 630 hours during the school year.

When Employer Contribution for SEBB Benefits End Example #1

Example: Classified school employee (bus driver) who receives an employer-initiated termination

This school employee was **anticipated** to work 630 hours or more during the school year and has been receiving SEBB benefits. On **November 13, 2020**, this school employee received an **employer-initiated termination notice** effective immediately.

- When does the employer contribution for SEBB benefits end? November 30, 2020.

When Employer Contribution for SEBB Benefits End Example #2

Example: Classified school employee (bus driver) who quits working in the middle of the school year

This school employee was **anticipated** to and actually did work more than 630 hours during the school year and has been receiving SEBB benefits. On **April 13, 2021**, this school employee turns in a **resignation letter** effective immediately so he can work for another employer.

- When does the employer contribution for SEBB benefits end? April 30, 2021.

When Employer Contribution for SEBB Benefits End Example #3

Example: Classified school employee (bus driver) work pattern is revised such that the school employee is no longer anticipated to work 630 hours during the school year

This school employee was **anticipated** to work 630 hours or more during the school year and has been receiving SEBB benefits. On **October 13, 2020**, this school employee's work pattern is revised such that the school employee is **no longer anticipated** to work 630 hours during the school year.

- When does the employer contribution for SEBB benefits end? October 31, 2020.

When Employer Contribution for SEBB Benefits End Example #4

Example: Classified school employee's (paraeducator) work pattern will be revised such that he is no longer anticipated to work 630 hours during the school year.

This school employee was **anticipated** to work 630 hours or more during the school year and has been receiving SEBB benefits. On **October 13, 2020**, he is notified that he is **no longer anticipated** to work 630 hours during the school year because one of the students he is supporting is leaving the district over Winter break resulting in a drastic cut in hours effective in January 2021.

- When does the employer contribution for SEBB benefits end? October 31, 2020.

When Employer Contribution for SEBB Benefits End Example #5

Example: Certificated school employee (teachers) who turns in a resignation letter in early summer that is effective August 15, 2020.

This school employee was **anticipated** to work 630 hours or more during the school year and has been receiving SEBB benefits. On **June 13, 2020**, in order to help her district plan for the next school year, she turns in a **resignation later** indicating she will not be returning to the district for the next school year. **The effective date of the resignation letter is August 15, 2020.**

- When does the employer contribution for SEBB benefits end? August 31, 2020.

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Proposed Policy SEBB 2018-26

SEBB Eligibility for the Employer Contribution Based on a Revision to the School Employee's Anticipated Work Pattern

If a school employee's work pattern is or will be revised such that he or she is now anticipated to work 630 hours for the school year, the school employee establishes eligibility for the employer contribution toward SEBB benefits as of the date the school employee is anticipated to work 630 hours for the school year.

SEBB Eligibility for the Employer Contribution Based on a Revision to the School Employee's Anticipated Work Pattern Example #1

Example: Substitute bus driver hired (as a school employee) at the beginning of the school year

This is a school employee who is **not anticipated** to work 630 hours within the school year, so the district does not offer SEBB benefits to her at the start of the school year (September 9, 2020). On **January 22, 2021,** the employee's **work schedule is updated** and the district now anticipates that she will work 630 hours within the school year.

- When does she establish eligibility for the employer contribution for SEBB benefits? January 22, 2021.
- When does SEBB coverage begin? February 1, 2021. (See SEBB 2018-12)

SEBB Eligibility for the Employer Contribution Based on a Revision to the School Employee's Anticipated Work Pattern Example #2

Example: Classified school employee's (paraeducator) work pattern will be revised such that he is now anticipated to work 630 hours during the school year

This school employee was **not anticipated** to work 630 hours or more during the school year and has not been receiving SEBB benefits. On **October 13, 2020**, he is notified that he is **now anticipated** to work 630 hours during the school year because he is being assigned a new student starting in January 2021.

- When does he establish eligibility for the employer contribution for SEBB benefits? October 13, 2020.
- When does SEBB coverage begin? November 1, 2020. (See SEBB 2018-12)

Proposed Policy SEBB 2018-27
SEBB Eligibility for the Employer Contribution Based on Actual Hours Worked

A school employee who is not anticipated to work 630 hours in the school year, but actually does work 630 hours, establishes eligibility for the employer contribution for SEBB benefits as of the date the school employee worked 630 hours.

SEBB Eligibility for the Employer Contribution Based on Actual Hours Worked Example

Example: Substitute teacher hired (as an employee) at the beginning of the school year

This is an employee who is **not anticipated** to work 630 hours within the school year, so the district does not offer SEBB benefits at the start of the school year (September 9, 2020). On **February 9, 2021,** the employee has **actually worked** 630 hours within a single school district.

- When does he establish eligibility for the employer contribution for SEBB benefits? February 9, 2021.
- When does SEBB coverage begin? March 1, 2021. (See SEBB 2018-12)

Proposed Policy SEBB 2018-28
SEBB Eligibility for the Employer Contribution Based on Stacking of Hours

School employees benefits board (SEBB) eligibility may be established based on stacking of hours within only one SEBB organization.

Proposed Policy SEBB 2018-29
School Employees are Required to Provide Evidence of a Dependent's Eligibility to Enroll the Dependent

- A school employee who wants to enroll his or her dependent is required to provide evidence of the dependent's eligibility. If the school employee does not submit the required evidence to verify his or her dependent's eligibility within the HCA's required timeframe, the dependent will not be enrolled.
- The school employee's next opportunity to enroll the dependent, if eligible, would be the next eligible open enrollment.

Next Steps

- Incorporate Board feedback in the proposed policies
- Send the proposed policies to stakeholders *(after today's meeting)*
- Bring a recommended policy resolution to the Board to take action on:
  - *June 13, 2018 (SEBB 2018-12)*
  - *July 30, 2018 (SEBB 2018-25 through SEBB 2018-29)*

Washington State Health Care Authority

Questions?

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Employees and Retirees Benefits Division

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