Washington State Health Care Authority

# School Employees Benefits Board Meeting

**August 30, 2018**

Washington State Health Care Authority

# School Employees Benefits Board

**August 30, 2018**
**9:00 a.m. – 4:30 p.m.**

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

## Table of Contents

# TAB 1

Washington State Health Care Authority

# AGENDA

**School Employees Benefits Board**
**August 30, 2018**
**9:00 a.m. – 4:30 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

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| 9:00 a.m.* | **Welcome and Introductions** | | Lou McDermott, Chair | |
| 9:05 a.m. | **Meeting Overview** | | David Iseminger, Director Employees & Retirees Benefits (ERB) Division | Information |
| 9:10 a.m. | **Approval of Minutes for:**<br>**March 15, 2018 Meeting**<br>**April 30, 2018 Meeting** | TAB 3 | Lou McDermott, Chair | Action |
| 9:20 a.m. | **July 30 Board Meeting Follow-up** | TAB 4 | David Iseminger, Director Employees & Retirees Benefits (ERB) Division | Information/ Discussion |
| 9:25 a.m. | **K-12 Data Support for Decision Making** | TAB 5 | John Bowden, Manager SEB Section, ERB Division<br>Kayla Hammer, Fiscal Information and Data Analyst Financial Services Division | Information/ Discussion |
| 9:50 a.m. | **Centers of Excellence Program** | TAB 6 | Marty Thies Portfolio Management & Monitoring Section, ERB Division<br>Emily Transue, Associate Medical Director, Clinical Quality & Care Transformation (CQCT) Division | Information/ Discussion |
| 10:20 a.m. | **Break** | | | |
| 10:30 a.m. | **Policy Resolutions** | TAB 7 | Barb Scott, Manager Policy, Rules, & Compliance Section, ERB Division | Action |
| 11:00 a.m. | **Ethics Training** | TAB 8 | Kate Reynolds, Executive Director<br>Ethics, Attorney Generals Office | Information/ Discussion |
| 12:00 p.m. | **Executive Session & Lunch** | | | |
| 1:30 p.m. | **Group Vision Plan(s) Procurement Update** | TAB 9 | Lauren Johnston, Procurement and Account Manager<br>SEB Section, ERB Division | Information/ Discussion |

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|---|---|---|---|---|
| 2:00 p.m. | **Life and AD&D Insurance** | TAB 10 | Beth Heston, Contract Manager<br>Portfolio Management & Monitoring Section, ERB Division | Action |
| 2:30 p.m. | **Dental Benefits** | TAB 11 | Beth Heston, Contract Manager<br>Portfolio Management & Monitoring Section, ERB Division | Information/ Discussion |
| 3:15 p.m. | **Break** | | | |
| 3:25 p.m. | **Eligibility & Enrollment Policy Development** | TAB 12 | Barb Scott, Manager<br>Policy, Rules, and Compliance Section, ERB Division | Information/ Discussion |
| 3:45 p.m. | **SEBB Rule Development Plan & Process** | TAB 13 | Rob Parkman<br>Policy, Rules, and Compliance Section, ERB Division | Information/ Discussion |
| 4:05 p.m. | **Public Comment** | | | |
| 4:30 p.m. | **Adjourn** | | | |

***All Times Approximate**

The School Employees Benefits Board will meet Monday, August 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.

The Board will meet in Executive Session during the lunch period, pursuant to RCW 42.30.110(1)(d), to review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs; and pursuant to RCW 42.30.110(1)(l), to consider proprietary or confidential nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session will begin at noon on August 30, 2018 and conclude no later 1:30 p.m. The public portion of the meeting will resume no earlier than 1:30 p.m.

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

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

Direct e-mail to: SEBboard@hca.wa.gov. Materials posted at: https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program by close of business on August 28, 2018.

Washington State Health Care Authority

# SEB Board Members

| Name | Representing |
|---|---|
| Lou McDermott, Deputy Director<br>Health Care Authority<br>626 8th Ave SE<br>PO Box 42720<br>Olympia WA 98504-2720<br>V 360-725-0891<br>louis.mcdermott@hca.wa.gov | Chair |
| Sean Corry<br>Sprague Israel Giles, Inc.<br>1501 4th Ave, Suite 730<br>Seattle WA 98101<br>V 206-623-7035<br>sean.corry@siginsures.com | Employee Health Benefits Policy and Administration |
| Pete Cutler<br>7605 Ostrich DR SE<br>Olympia WA 98513<br>C 360-789-2787<br>p.cutler@comcast.net | Employee Health Benefits Policy and Administration |
| Patty Estes<br>7904 155th Street CT E<br>Puyallup WA 98375<br>C 360-621-9610<br>p.estes.sebb@gmail.com | Classified Employees |
| Dan Gossett<br>603 Veralene Way SW<br>Everett WA 98203<br>C 425-737-2983<br>dan.gossett@comcast.net | Certificated Employees |

## SEB Board Members

| Name | Representing |
|---|---|
| Katy Henry<br>Spokane Public Schools<br>200 North Bernard<br>Spokane WA 99201<br>V 509-325-4503<br>khenry@washingtonea.org | Certificated Employees |
| Terri House<br>Marysville School District<br>4220 80th ST NE<br>Marysville WA 98270<br>V 360-965-1610<br>Terri_house@msd25.org | Classified Employees |
| Wayne Leonard<br>Assistant Superintendent of Business Services<br>Mead School District<br>608 E 19th Ave<br>Spokane WA 99203<br>V 509-465-6017<br>wayne.leonard@mead354.org | Employee Health Benefits Policy and Administration (WASBO) |
| Alison Poulsen<br>12515 South Hangman Valley RD<br>Valleyford WA 99036<br>C 509-499-0482<br>alison@betterhealthtogether.org | Employee Health Benefits Policy and Administration |

**Legal Counsel**
Katy Hatfield, Assistant Attorney General
7141 Cleanwater Dr SW
PO Box 40124
Olympia WA 98504-0124
V 360-586-6561
KatyK1@atg.wa.gov

8/27/18

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

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

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

March 7, 2019 - 9:00 a.m. – 5:00 p.m.

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

May 16, 2019 - 9:00 a.m. – 5:00 p.m.

June 12, 2019 - 9:00 a.m. – 5:00 p.m.

July 18, 2019 - 9:00 a.m. – 5:00 p.m.

July 25, 2019 - 9:00 a.m. – 5:00 p.m.

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

August 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 8/12/18

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DATE: August 13, 2018
TIME: 8:07 AM

WSR 18-17-075

# 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**

March 15, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 4:00 p.m.

TVW was present and did a live stream of the meeting. The meeting can be found on the TVW website in their archives folder.
https://www.tvw.org/watch/?eventID=2018031122

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

**SEB Board Legal Counsel**:
Katy Hatfield

## Call to Order
**Lou McDermott, Chair**, called the meeting to order at 9:03 a.m. Sufficient members were present to allow a quorum. Board introductions followed.

## Meeting Overview
**Dave Iseminger**, Director of the Employees and Retiree Benefits (ERB) Division provided an overview of the agenda.

## Approval of October 23, 2017 SEB Board Meeting Minutes
**Pete Cutler:** I was going to make a comment. I appreciate that they are very complete minutes. I feel like I just re-experienced the meeting a second time. It was good. Just to prove that I read them carefully, on Page 2 under my comments, the last sentence says "working with the Health Care Authority in the Insurance Commissioner's Office." That should read "and the Insurance Commissioner's Office."

**Lou McDermott**: Pete Cutler moved, and Terri House seconded the motion to approve the October 23, 2018 SEB Board Meeting minutes as amended. Minutes approved by unanimous vote.

**Legislative Update:**

**Dave Iseminger**: The Legislature did leave on time, but there was a lot of activity. They passed over 300 bills in addition to the budget bills, and many of those are still at the Governor's Office for his consideration and action. Slide 2 is a reminder of the level of work involved. There's a lot of work that happens at the agencies across the state when a bill is dropped. The Employees and Retirees Benefits Division completed 200 separate analyses on a variety of different bills.

I will focus on the areas where the ERB Division was lead on high impact bills. High impact means a policy decision that might require rule making or has a fiscal impact.

Slide 3 is my inverted funnel. The funnel shows how bills die in the Legislature as they're not passing different cut-off and hurdles that the Legislature has set in its timeline. The division is heavily monitoring nine bills that are in the Governor's office. The Governor has signed one of them so far. The Governor has roughly 20 days after session, excluding Sundays, to act on bills. That's approximately Saturday, March 31. About 60 of the bills that passed the Legislature have been acted on and there's roughly 45 more to be acted on today alone. They are about one-third of the way through reviewing bills. A lot of the bills in that green part of the funnel were concepts related to other bills that passed. One of the topics in that area passed, which I'll speak about later.

There are two primary bills that impact this program I'll discuss today. Again, neither of these bills has been signed by the Governor at this time. The first bill is Engrossed Substitute House Bill 2408 (ESHB 2408). This bill has a variety of different features to it. It's primarily focused on stabilizing the individual market through the Health Benefit Exchange. Last year in the news, Klickitat County and Grays Harbor County were at risk for not having any offerings on the individual market to residents of those counties. Ultimately, some carriers went into those counties and we didn't have what were called "bare counties." Out of concern that there would be bare counties, there were ideas being tossed around in the Legislature of how to address that situation. ESHB 2408 is related to that concept.

How this relates to the SEBB Program is in Section 2 of the bill. Beginning January 1, 2020, which aligns with the launch of the SEBB Program Benefits, any health carrier that has fully insured plans approved by you or your colleagues on the PEB Board, must have a carrier within that insurance carrier's holding company that offers individual plans on the Health Benefit Exchange. They must have both a Silver Plan and a Gold Plan on the Exchange. If a carrier of a fully insured plan is approved for having coverage and offerings to the SEBB Program population, some part of their insurance holding company would also have to offer plans on the individual market. The Exchange offerings would have to match the same service areas that are covered in the SEBB Program.

Early in the session, a version of the bill was if you're offering on the SEBB Program population, you have to offer statewide coverage on the individual market. The ultimate bill that passed was the service area on the individual market would have to align with the service area for the School Employees Benefits Board Program or Public Employees Benefits Board Program. There's no requirement in the bill of statewide

coverage by a single carrier on either the Exchange or in the SEBB or PEBB Programs. The health carriers will have a choice whenever they're responding to procurements as to where they would like to offer coverage in counties in the SEBB Program; and thus, have this qualified health plan offering requirement on the Exchange. The other part of Section 2 is the health plans in the SEBB or PEBB Program may not include administrative or actuarial risks associated with the individual market exchange offerings. The agency is charged with, during the annual rate setting process, to monitor and ensure the risk for the SEBB Program rates are solely the risk associated with the SEBB Program population. That is part of the legislation and would be part of the procurement process. We would make sure that the carriers who are considering responding would be aware of this requirement.

**Lou McDermott**: Is this applicable only to the fully insured or the self-insured as well?

**Dave Iseminger**: This is applicable only to fully insured.

**Pete Cutler**: Has the Health Care Authority had its actuaries, or whoever would do the analysis, look at whether they think this bill or requirement may have the effect of reducing the geographic area that some of the insurers would be willing to offer fully insured plans? In other words, it's one thing to say you don't have to offer them statewide, you just have to have the same coverage. But if they fear they'd have adverse claims expense or losses in the individual market in certain counties, in certain parts where they thought they could operate profitably with the School Employees Benefits Board Program, then the result might be that they would choose to limit their willingness to offer to school employees only to those areas where they thought they could at least break even for both markets. So, has there been any analysis of that type done by the agency so far?

**Dave Iseminger**: Pete, we have not had our actuaries do that type of review. In part, we do not have the full claims data to be able to do that yet, which is part of the next bill that I'll talk about. So we haven't been able to do that actuarial piece to really analyze the potential impact on that. But, you have articulated some of the points that were raised during the policy debate in the Legislature. That is one of the concerns raised.

The second bill is Engrossed Substitute Senate Bill (ESSB) 6241. We have provided a one-page bulleted summary, and then a complete copy of the legislation. As you go through and look at the one-page summary, the top area is all the things I presented in the December and January meetings. Those clarify the intent and the technical changes to align different parts with what the agency understood was the Legislature's intent last year when passing 2242 and enacting the SEBB Program. All of those concepts I presented were in the final legislation and unchanged as it went through the process. To highlight a couple of them, the data collection requirements deadline moved up. The carriers are to respond to the data request we sent today by April 1. Fortunately, much of the data requested is similar to the data carriers are used to providing to the Office of the Insurance Commissioner (OIC) for their historical data reports.

We do have the provision that the agency has the authority to reimburse school districts for time related to your service when they have a substitute teacher. There are a lot of

clarifications about being able to utilize the state's Cafeteria Plan; to be able to do premium payment with pre-tax dollars for their medical premiums, as well as access to a medical flexible spending arrangement, a dependent care assistance program, and health savings accounts, if the Board authorizes a high-deductible health plan. There are pages related to cleanup of fiscal accounts, the right names, and exactly when interest accrues. There is clarity on the definition of school employees, clean up related to the Board roles and responsibilities, as our understanding is that the Boards were generally envisioned by the Legislature – between PEBB and SEBB – to have very similar powers, responsibilities, and roles.

The 3:1 ratio for full family coverage versus single subscriber coverage is in the bill. The definition of school year and eligibility requirements now include anticipated to work versus actually having to work 630 hours.

There were references missed in the original legislation to make sure that it was systemically referencing charter school employees, as the Legislature's intent was charter school employees will be part of the SEBB Program. Also a clear indication that if the IRS comes out with information that would subject the plan to ERISA, that there would be the discretion for the agency to work through any issues to maintain the ERISA exemption of the state's plan.

There's also the piece in the legislation that requires local school districts to have their local benefit contracts for the 2018-19 school year to exceed the one-year maximum that currently exists in law to bridge to the launch of January 1, 2020. Many school districts have benefit years that would end on Halloween. For November and December there was a question as to who would do the benefits piece. This legislation clarifies that the contracts negotiated for next year's school year would be extended by the number of months necessary to get to 12/31/2019.

The last part of the initial agency proposal was clarifying the waiver provisions for benefits. There was the understanding that the Legislature intended that individual employees would have the ability to waive benefits. That's different than the concept of a school district being exempted from the program. Individual employees, for a variety of circumstances, may want to waive benefits. They may have a spouse's plan that's cheaper for them, has better coverage, or has a specific provider. They may want to waive and be on Tricare or some other federal insurance program. This clarifies authority for the Board to be able to set up the parameters around waiver. The bill also clarifies that the funding mechanism envisioned, similar to the Public Employees Benefits Board Program, where agencies send the state portion to HCA, school districts, and if an individual waives benefits the state portion must still come to the Health Care Authority. A lot of that is related to the concept of having a single rate, which takes into account that individuals will waive benefits. This ensures all funding that's supposed to be allocated for health benefits on the average employee, versus an individual employee, makes it to the Health Care Authority for administrating claims for the medical plans. Those were the core pieces in the initial legislation.

You may remember in January I talked about several other proposed bills. Some of the concepts in those bills included the authority or the ability for a school district to be exempt from the SEBB Program. That concept did not make it through the Legislature.

There were ideas for changing the composition of the Board and adding additional members to this Board. That concept did not make it through the Legislature. But some of the pieces that did get added into ESSB 6241 are the last five bullets on this page.

Bullet 1: School districts are able to bargain for and provide SEBB-Program authorized benefits to employees who work less than 630 hours using local funds. The starting point for eligibility for SEBB benefits is anticipated to work 630 hours or more. This would now allow school districts, on their own dollars, to offer benefits to individuals who do not meet the core eligibility requirements for SEBB benefits. At the same time, those employees would receive SEBB benefits. There was a discussion about whether the benefits below 630 hours would be SEBB benefits or other benefits, but to make sure the transition as somebody crossed over the threshold was not as clunky as it could be. SEBB benefits must be the offerings for anybody under 630 hours. For reference, this is in Section 1, Page 4 of the bill.

**Pete Cutler**: This really doesn't go to our responsibilities as a Board, but I'm curious. If these people are working less than 630 hours, but they're delivering their part of basic education services, do we end up with another McCleary issue down the road? I guess that's just something for other policy makers and decision makers to ruminate on. I assume it would not. At this point, this would assume that you'd have your PEBB Program rules for eligibility, but they would include a caveat that in addition to the standard rules for those districts that collectively bargain for broader eligibility, there would be provision for that.

**Dave Iseminger**: Actually, Pete, the legislation requires this Board to set up a core framework for this situation as well.

**Pete Cutler**: Okay. Great. Because I think administratively I imagine it could bring up new questions. Thanks.

**Dave Iseminger**: Reading from the bill, Pete, the provision of the bill on Page 4 says that SEBB shall establish terms and conditions for School Employees Benefits Board organizations - that term means school districts, educational service districts, and charter schools - to have the ability to negotiate local eligibility criteria for a school employee anticipated to work less than 630 hours in a school year. The Board has a role in providing guidance.

**Wayne Leonard**: To clarify, and I think I know the answer to this because it always ends up going back on the local school district, but on the bullet point above where an employee may waive state coverage, you said that it says the state contribution must be sent to the HCA. I'm assuming whether the employee is in a locally-funded position or a federally-funded position, the contribution for health care needs to be paid to HCA whether the funding source is state, federal, or local funds.

**Dave Iseminger**: I'm going to make sure we get back to you with a little more clarity on that particular point. I'm just not comfortable answering that today, Wayne. I will clarify that we do know in the provision with local dollars being used for individuals under 630 hours, if an eligible individual below 630 hours waives, those dollars do not need to

come to the Health Care Authority because all of that is local funding for a local decision on under 630 hours. There's nothing that would need to be forwarded in a waiver situation for those individuals. That's at least a piece of the puzzle, Wayne.

Bullet 2: Section 29 of the bill is again about using local funds. The school districts have the ability to offer optional benefits described within the bill as outside the authority of this Board. That means the districts cannot offer benefits competing with those that this Board has jurisdiction over. To be clear, we understand the bill to say that, if for some reason this Board decided not to offer short-term disability coverage, short-term disability is the purview and authority of this Board. Just because this Board would not authorize that benefit does not grant power back to the districts to offer that benefit. It has to be something outside of your authority, not dependent on what your actions are.

This bill sets up a reporting requirement to the agency and the Board, beginning in 2019, for those optional benefits that school districts are offering. We can analyze that information and determine whether what's being offered as an optional benefit is within the Board's authority, thus something the Board should be taking on? Or is the Board interested in discussing with the Legislature about additional authority to offer that type of benefit? Again, this provision with optional benefits is funded by all local dollars.

**Alison**: Could you give us an example of what that might be?

**Dave Iseminger**: The most prominent example that has come up is supplemental cancer insurance. Some school districts have this as a benefit some people believe may fit the purview of this optional offering authority.

**Wayne Leonard**: Just for clarification, the way we currently operate, those are not locally funded by the district. They're employee-paid benefits. Are you making a distinction between those?

**Dave Iseminger**: I was not, Wayne. But we will work on the question as to whether the optional provision includes employee-paid abilities.

Bullet 3: Sections 31 and 32 requires data historically collected by the OIC, especially medical claims data, for roughly a five-year period, must be transmitted to the Health Care Authority. That sets up the Public Records Exemption to ensure the information received is protected from public disclosure. So that data will be forthcoming once the bill is signed.

Bullets 4 and 5: Sections 33 and 34 relate to concepts of funding benefits. I encourage you to read both of those sections on Page 59. Section 33 says the state funding for the 2019-21 biennium, the first cycle of benefits, will be at a rate that is no less than the per-employee per-month funding rate used in the PEBB Program. That's a window into the Legislature's intent with regards to funding of benefits. Section 34 is declaring an intent to review the state funded staffing assumptions in the K-12 funding model.

So you can easily find concepts in the bill, here are some crosswalks. School district reimbursement for your Board service is on Page 2 of the bill. The 3:1 ratio is on Page 3. The concept of waiving, Wayne, with the contribution coming to the Health Care

Authority, that straddles Pages 20 and 21. For anyone interested in the data provisions and the data deadline, that's Page 30 of the bill. For school districts that want to hone in on the requirement to extend their contract or agreement for 2018-19 until December 31, 2019, that's Page 39 of the bill.

Bills 2408 and 6241 were the two core bills that impact the SEBB Program.

Slide 5: Several other benefit bills passed the Legislature. 2SSB 5179 is related to hearing instruments and hearing aids. It expressly references the PEBB Program and Medicaid. It uses the language "employees," and at the same time ESSB 6241 uses the words "school employees." We believe the intent is that this would also apply to the SEBB Program. We would encourage general compliance for the benefits in the SEBB Program on this piece as well. It describes the minimum level of benefit coverage in the budget for hearing instruments, at least every five years.

**Sean Corry**: The coverage itself is subject to funding. Could you tell us whether it was put into the budget that was just passed so that there can be coverage available?

**Dave Iseminger**: In regards to the SEBB Program, there's no specific benefits funding pieces in the current biennial budget because the benefits go live in the next budget cycle. There was a specific amount in Medicaid. The PEBB Program funding model used to create the funding rate is based on assumptions of the coverage levels. I believe there is some aspect of that accounted for with the PEBB Program as well. There's nothing in there about the SEBB Program yet because there's nothing about the specific funding of SEBB Program benefits in this biennial budget.

ESSB 5518 is related to chiropractic reimbursement fees. This bill describes the provider payments and sets up equivalency and similarity to other codes for physical medicine and rehab, or spinal manipulation. It's a provider payment reimbursement bill.

SB 5912 is about 3D mammography or tomosynthesis. It expressly directs health plans to cover 3D mammography at a zero dollar cost-share. It specifically applies to the Uniform Medical Plan. Many times the Legislature will put a bill in the OIC's Chapter 48-43 with crosswalks that specifically identify and include the self-insured Uniform Medical Plan because the OIC does not directly regulate self-insured plans. The Legislature will describe when certain bills impact the UMP and this bill directly impacts the Uniform Medical Plan. The UMP already covers 3D mammography at a 15% member cost-share. Under this bill, the cost-share would go away.

SSB 6219 relates to reproductive health care. This bill has a variety of impacts. It requires plans to cover all contraceptive drugs, devices, and other FDA-approved products, voluntary sterilization, consultations, and exams - at no cost-share - except for high-deductible health plans. In that instance, cost-shares can be applied only at the minimum level to maintain the plan as a qualifying vehicle for health savings account contributions and reimbursements, which conveniently, the IRS issued a long-awaited ruling about three days before the end of session declaring that was something necessary to keep plans as qualifying high-deductible health plans. A second piece is there cannot be medical management techniques implemented by a plan to limit enrollee choice for these services. A third part of the bill is if maternity care is covered

in a plan, then voluntary termination must also be covered. This bill will impact the fully insured plans, as well as the self-insured plans. It does not directly impact the Uniform Medical Plan, but often what is done to ensure adverse selection doesn't occur between plans is the Uniform Medical Plan implements core pieces when things are legislated for the fully insured plans.

**Pete Cutler**: I wanted to make sure I understood the last point about the scope of coverage for Senate Bill 6219. If I understand correctly, the bill provisions actually only amend the law that applied to health carriers in the private sector. What you're anticipating is that the UMP would make changes to be parallel for the reasons you mentioned. Did I understand correctly that this would be presented as benefit design choices for the Public Employees Benefits Board to endorse or approve? Is this something that requires Board action, and then by extension, would require action by this Board as well? Or is that something that the agency can do without Board action?

**Dave Iseminger**: It depends on the exact wording of the bill. Sometimes it's to inform rather than required. I need to have staff see what it says exactly. There were a lot of permutations of the reproductive bill and I do not remember exactly how it's written. The answer is it could be either way. It depends exactly on how the bill is written and then whether it's a mandate or whether there is some discretion.

**Pete Cutler**: I would be curious to find out which category this particular bill lands in. Thanks.

**Dave Iseminger**: We'll follow up on that.

At this point, the budget has nothing related to SEBB Program benefits because there are no benefits until the next biennial budget. What is in the budget are things related to administrative costs. At one of the first meetings I described that in the original operating budget passed by the Legislature last year, $8 million was allocated in the PEBB account as a startup for administrative costs for the SEBB Program. The agency released its fiscal note after session was over that indicated roughly $10 million *a year* was needed. That was about a $12-$13 million dollar biennial shortfall from what was projected to be necessary. The agency put forward a decision package. The Governor's Office and the proposed Governor's Supplemental Budget supported that. The Legislature fully funded that as well so all the funds the agency requested for administrative purposes were fully funded in the budget. In addition, the original fiscal note had earmarked a request for IT dollars for system of record improvements. It originally had slated that for the next biennium, but it was moved up and we have an initial allocation of between $7-$8 million for the IT infrastructure piece to have a system of record for the SEBB Program.

From an administrative standpoint, everything requested to fully endorse and go forward with this program was in the budget. The other part included in the budget, in Section 504 of the budget bill related to collective bargaining indicates that a tobacco surcharge and a spousal coverage surcharge are to be implemented and applied in the SEBB Program. The surcharges were required by the Legislature for the agency to implement approximately two or three years ago in the PEBB Program. There are identical surcharges that exist in the PEBB Program. We'll begin working on the implementation

of those surcharges and present the Board information about how those could be implemented. The tobacco surcharge is $25 a month per account. If there is a family of four on an account and one person smokes, that account is charged $25. If four people smoke, the account is charged $25. It's not a per smoker surcharge, it's a per account surcharge per month. That is in addition to any monthly premium of the employee.

The spousal coverage surcharge relates to circumstances where a spouse or a state-registered domestic partner has access to health insurance through their own employer that is actuarially similar and with a similar premium, within a 95% band, to the benchmark plan in the program. The benchmark is defined as the plan that has the highest enrollment. On the PEBB side that is the Uniform Medical Plan Classic. If we're on the PEBB side, it's any plan that is within a 95% actuarial equivalency to the Uniform Medical Plan Classic and the employee premium cost-share for the UMP Classic. We still have to identify what the benchmark is on the SEBB side, but that's at least a way to understand what that surcharge is. That surcharge is $50 per month for the account.

**Pete Cutler**: I'm curious, where in the budget is this language found?

**Dave Iseminger**: It's in Section 504 of the budget. That is the Collective Bargaining Section for K-12. If you want to see the similar PEBB language, it's in the 900 series, which is in the miscellaneous section at the end of the budget bill.

**Pete Cutler**: Oh, that's K-12. Right and those sections are based on the actual - that current biennium. I was curious what could they be applied to, but it was in Section 504 dealing with K-12 funding. Thank you.

**Dave Iseminger**: It's in the Collective Bargaining piece – foreshadowing that this needs to be addressed in collective bargaining and signaling to the agency that we should begin implementation of those for the launch of the program. Otherwise it wouldn't be in until the next biennial budget and the agency would have 90 days to implement them.

**Follow-up Board Questions**

**Scott Palafox**, Acting Deputy Director, Employees and Retirees Benefits Division. Before I get started, I want to take this time to give Dave and others a plug as he provided you a very high-level summary of this legislative session. Legislative session is a very busy time for all agencies. This isn't a time when we get additional resources to do the work that we need to do. We do it with the existing staff. The numbers may not indicate the amount of hours and work that's put into it, but in particular, for ESSB 6241, I just have to say Dave and some of the staff from Barb's section spent hours in meetings at the hill providing clarifying information for legislative staff. Although Dave doesn't want to receive that recognition, I think it's important for me to share that. We're glad this session got done on time. But, sometimes it means when you have a short session and you have a short amount of days to get it done, there's a lot of work that needs to be done in that short period of time. I just wanted to recognize Dave for that accomplishment.

In the last Board Meeting, one of the first questions Pete had was about whether or not he was paying the correct amount for his frames and lenses. I'm here to confirm, Pete, yes, you are; the $150 covers the combined.

Slide 1: This is a correction to the slide that was behind Tab 4 at the January 29, 2018 Board Meeting. This shows there is statewide coverage for the Willamette Dental coverages.

Slide 2: Terri asked about orthodontia coverage for PEBB Program plans. The slide shows the Uniform Dental Plan, a PPO plan, and the two-managed care dental plans regarding orthodontia. As you can see, the member for our PPO plan pays 50% of the cost until the plan has paid $1,750. Anything over the $1,750, the member is responsible. For the managed care plans, the member pays up to $1,500 per case.

**Sean Corry**: Just for framing question for the Board. When we talk about coverage that's already provided through the PEBB, we have discretion. I'm not arguing for any changes here in orthodontia coverage, but with respect to the orthodontia coverage, because the PEBB does it this way, we have choices as we move forward on how we want to do it for SEBB. Within limits, of course.

**Dave Iseminger**: Yes, Sean, you do have that discretion. There are guardrails. There's a finite amount of resources. You'll hear that a lot from Megan shortly. At the same time, there is the ability to do trade-offs. If you wanted a smaller orthodontia benefit in order to fund a higher plan cost-share, there would be the ability for trade-offs. A potential limiting aspect to think about is the extent of the agency contracts with vendors or administrators, there may be some need to have things pretty substantially similar in order to access the same contracts. At what point variation starts to not be very similar is a question we would make sure to advise the Board about, so you know how that would impact our contracting abilities and the timeline for launching benefits. Discretion with guardrails as you've noted.

**Medical Services Comparisons**

**Scott Palafox**: This presentation came from a question. We've been doing a lot of comparisons with the Health Care Authority PEBB Program benefits and other districts. Our comparisons thus far have been at a very high level regarding cost-sharing and plan offerings. Slide 2 I presented at a previous Board Meeting. It lays out the different non-Medicare plan offerings that we compared. The next few slides address the request to look at specific services the plans offer and how they compare. When we selected the services, we looked at our Uniform Medical Plan, some of the top utilized services for this comparison, and added additional services for comparison that seemed to have been of much interest for Board Members.

Slide 3 - Medical Services Comparison: The first comparison is chiropractic care and spinal manipulation. From the business perspective there's an array of how that compares across the board. There are 10-12 visits per year under the PEBB Program benefits, up to unlimited visits in the Seattle Public School District. Regarding copays, the PEBB Program is within the range of the others, as well as the cost-sharing coinsurance split with the plan and the member. Looking at Primary Care Office Visit, again, looking across the board with the copays, the PEBB Program is within a relative

range. Laboratory/Diagnostic Services is interesting as you look at the school districts. There are qualifiers of how much needs to be paid before the coinsurance applies. The Health Care Authority has a copay and then into the cost-sharing coinsurance split, which is relatively similar across the board.

Slide 4 – Medical Services Comparison (*cont.*): Outpatient Psychiatric/Mental Health comparisons. Again, looking at the copays, relatively similar within a range, as well for those that offer a coinsurance split within the same comparable range. For Outpatient Physical Therapy, the ranges for visits are a little different across the board – as low as 25, 15 in some, up to unlimited in others, in comparison to the 60 visits per calendar year for the PEBB Program benefits. Those that have copay within a relative range were similar as those that offer the coinsurance split.

**Pete Cutler**: On the Outpatient Physical Therapy, the WEA Select Plans it says "15 unlimited visits." I'm not catching what that means.

**Scott Palafox**: I think there is a dash missing between there. So as low as 15 up to as high as unlimited visits.

**Pete Cutler**: Okay, thank you.

**Scott Palafox**: Massage Services. The PEBB Program benefits. I need to explain the dash on this one. It's as low as 16 or up to 60. It doesn't mean there are 60 visits in PEBB Program plans that you can go for massage services. Within the rehab and rehabilitative services there is a 60-limit combined for all of those services, in which massage therapy is part of the occupational therapy, speech therapy, and physical therapy rehab services. There are 16 unique massage therapy visits completely separate from physical therapy, occupational therapy, speech therapy, and neurodevelopmental therapy 60-visit limit. Copays, again, similar across the board. For those that offer a coinsurance split, we seem to be within the range.

Looking at all these services in comparison, it seems like there's not much difference across the board for what PEBB Program benefits offer in comparison to what's being offered in some of the school districts.

**Pete Cutler**: On Slide 2, just an acronym question on WEA Select Plans United Health Care 6 - HPN Plans – can you help me out?

**Scott Palafox**: Those are high performance networks (HPN). It's a network defined by the physician's grouping that's part of that. It's nothing similar to what is in the PEBB Program.

**Pete Cutler**: So not an ACN – what is ACN?

**Scott Palafox**: Accountable Care Network.

**Pete Cutler**: It's not the same as the UMP's ACN, but is a different kind of specialized more limited network?

**Scott Palafox**: Yes.
**Pete Cutler**: Okay. Is it true, it seems to indicate that Seattle Public School District offers seven plans and they're all offered through Kaiser Permanente? Is that accurate? Great. Thank you.

**Dave Iseminger**: For the record Sean nodded his head and said "yes."

The other thing I want to highlight is there are many service categories. We took the top five utilizations from UMP. We know that's not perfect data. There are differences in populations for PEBB and SEBB; but unfortunately, we don't yet have the SEBB data to do utilization across the SEBB population so we used the best proxy to give you a snapshot into some of the higher utilized categories, plus massage. Everyone always asks about massage.

**BREAK**

**Dave Iseminger**: I want to add one thing for everyone who is participating or watching in the audience. If you ever see a potential mistake on one of our slides, something is inaccurate, or we haven't gotten it quite right on doing a benefit comparison, for example, email the person whose slide deck it is. Presenter information is at the end of all our slide decks. We're doing the best we can with the information we have at hand, but we're certainly not perfect. Contact the presenter and let us know. We'll bring any refinements to the Board.

I believe Scott Palafox got an update potentially for one of the medical comparators during our break. Just want to make sure everyone knows that for the record. When you see something, say something.

**Pete Cutler**: I had a question related to the bill that passed. I was wondering if I could slip that in before we move on. On the list of bullet points, there's one about clarifying and ensuring alignment of the Board roles and responsibilities. When I went through the bill, I realized there was language about the Board being – it makes some reference to being involved with certain decisions and activities – that would be the SEB Board. That language is different than what was in the language that's parallel for this Public Employees Benefit Board. It appears to be a substantive change. Is that something that was discussed in terms of what the intent was in terms of pulling that language out?

**Dave Iseminger**: Pete, let me get everyone to the right page of the bill. I think I know what you're talking about. Correct me if I'm wrong, in Section 14 of the bill, Page 30, this is the provision that talks about the contracting and procurement process?

**Pete Cutler**: Yes, that's one of them, correct.

**Dave Iseminger**: Our understanding from the Legislature was that, generally speaking, the powers, roles, and responsibilities of the two Boards were intended to be very similar. When you look at this with regards to the contracting and procurement aspects of the agency, you'll see especially in Section 1, where that word oversight is changed to insight. That is functionally what has happened with the Public Employees Benefits Board, even though it has not been in statute. We always talk, inform, discuss, and get

feedback on that process. But there was a discussion about what it meant to actually have oversight and how often the Board meets versus how that would impact the procurement process. There was that discussion about functionally. What was really meant by oversight was what has happened in the PEB Board world, which is a conversation about what's going on, getting direction. But not necessarily – oversight implied something much more granular than really would be realistic and feasible for the amount of time that the Board gets together and the role that the agency has. Even though it wasn't added for PEBB, it was maintained to be clear that is a role of the Board. Does that help?

**Pete Cutler**: Yes. I'm curious as to who was involved in those discussions and was it just legislators and the HCA? Were there any employee organizations or anybody else involved in those discussions?

**Dave Iseminger**: It was primarily the agency with legislative staff.

**Pete Cutler**: Legislative staff, okay, great, thank you very much.

**School Employees Benefits Enrollment Data**

**John Bowden**, Manager, School Employees Benefits Section. My role when I make presentations seems to be on who the K-12 employees are, who their employers are, demographics about the employees, and what kinds of benefits they enroll in. Today we're going to discuss school employee counts, enrollment for elected entities, medical enrollment, and statewide school employee non-medical enrollment.

Slide 3 – Different School Employees Counts. I'm going to start out with the statewide headcount according to the S275 report and the Legislative Evaluation and Accountability Program (LEAP). LEAP looked at the information contained in the S275 report. In the past, I've presented 144,000 employees. LEAPs official number, and therefore the Legislature and OFM number, is just under 134,000. Within the S275 there are some substitute teachers, contractors, and employees that don't work the full year and they either resign, terminate, or move on. The official number used for budget purposes and headcount is more like 134,000.

The statewide FTE number, the full-time equivalent, is just under 110,000. About 60% of employees are full-time, about 40% are less than 1.0 FTE. When you add those part-timers all together you come up with about 110,000 full-time equivalent employees. Of that 109,900, the state, through the prototypical school funding model - the mega model - funds about 94,400 FTE. The difference between 109,900 and the 94,400 means that locally about 15,500 employees, or FTEs, are locally funded. The funding for employees can be split through many sources – state, local, federal dollars.

**Sean Corry**: Quick question about the local funding. Whatever that total number is it's not apportioned equally across districts. It actually varies quite a bit with respect to relative percentages of employees at a particular district that are locally funded or not. Is that right?

**John Bowden:** Yes.

**Dan Gossett**: This is just a question because there are employees that are federally funded. Where do they fall?

**John Bowden**: The portion of it, it's labeled as locally funded, but that does include some special education federal dollars as well as some vocational pieces. So yes, there are federal dollars.

Slide 4 – Where School Employees Live. When we conducted the focus groups, they wanted the Board and HCA to recognize east, west, urban, and rural. This map shows you where the school employees live and if it's urban or rural where they work. About three-fourths of all employees are on the west side of the state. If you look at the map there's a line going down slightly to the left. That's the mountain range. Anything east of that we're calling east. About three-quarters on the west side, but one-fourth on the east side. Breaking down each of those sides between urban and rural you can see that about 64% on the west side are urban and on the east side about 15% are urban. The rural on both east and west is fairly similar. Approximately one-fifth of all school employees live in urban areas.

Slide 5 – School Employee Enrollments for Selected Entities. I'm going to talk about the enrollment coverage tiers and actuarial values of the plans employees are enrolled in for medical benefits.

Slide 6 – School Employee Enrollment by Coverage Tier. The green band at the top is for employee, spouse or state-registered domestic partner, and children. The red band is employee and spouse or state-registered domestic partner. The yellow/orange band is employee and child or children. The blue band is the largest and is employee only. You can see that most school districts in the WEA have a higher percentage of employees enrolled in employee only than there are in the state Public Employees Benefits Board Program. The last column on the far right is K-12 employees enrolled in the PEBB Program. If you look at the PEBB Program in total, or you look at K-12 employees, the percentages are similar. The K-12 employee enrolled PEBB Program population is about 4,500, which is equivalent to Spokane, but smaller than Seattle. It's more than in Lynden because Lynden is a small district, but all of them combined are less than the enrollment in WEA. There are different enrollments in each column.

**Patty Estes**: I have one question and one comment. Is this just medical enrollment?

**John Bowden**: Yes.

**Patty Estes**: Then just a reminder for the PEBB Program. We had 29 school districts. Is that correct still or has it increased since then?

**Dave Iseminger**: The number of school districts, I believe, is 75 – about 25% of the school districts. The whole number, I believe we're at 79 and now I can't remember if that's inclusive or exclusive of ESDs. But it's about 25% of school districts – it's in the high 70s.

**John Bowden**: Of those school districts, some are fully enrolled and some are only partially. One bargaining unit or the administrators might be enrolled.

**Patty Estes**: Okay. Thank you.

**Dave Iseminger**: Before we move on from this slide, I want to foreshadow a couple things because they relate to concepts coming up this afternoon and this slide epitomizes several of them.

There is a proposed resolution related to the tier structure that Barb Scott will present this afternoon. All of the comparators have four tiers. Four tiers is not a mandatory tier structure. Yet, Lynden, Seattle, Spokane, the WEA, and the state through HCA all have a four-tiered rate structure that is employee only, employee children, employee spouse or state-registered domestic partner, and employee spouse or state-registered domestic partner plus children.

The other piece to highlight is the 3:1 ratio under the legislation is the green tier versus the blue tier on Slide 6. Currently, the tiered structure is different across all of the districts. When you look at the two columns on the far right, "state PEB" and "K12 PEB," the tier structure for the PEBB Program has been 2.75 for that green column versus one, for decades. This data in real time is an acknowledgment of what the dependent enrollment may look like in a tiered structure that is close to the 3:1 ratio. We don't have the current ratios for Lynden, Seattle, Spokane, and the WEA. John's and my understanding has been that the school districts, through their local bargaining, may have different tiered structures at the individual level, so there's not a WEA tier structure to report on. Under a JLARC report for 2013-14, the ratios were: Lynden 10.8:1; Seattle 15.8:1; and Spokane 5.5:1. That data is four years old. We'll be able to provide more insight about that when we get the OIC data because that's where those numbers were born from, the JLARC report.

When you look at the left side of Slide 6, you see a tiered rate structure that has a higher compression than a 3:1 ratio. Whereas looking at the right side of the slide, you see a tiered rate structure that's close, but actually more compressed than a 3:1 ratio. You can see what impact that probably has on employees adding dependents to their plans. I wanted to talk through some of the inferences. One might be able to look at this seemingly simple slide and see different factors regarding dependent enrollment, especially as we move forward later this afternoon with the tiered rate structure resolution.

**John Bowden**: When JLARC did the study, the statewide ratio full family or employee spouse/state-registered domestic partner and children, was 7.6:1 compared to the individual tier. The Legislature had instructed districts to work toward a 3:1 ratio on every plan. Not an aggregate. Even the ratios that Dave just mentioned were across all plans within those districts. For individual plans, what JLARC found was a tremendous range. In one sample district, it was almost 300:1 in terms of the employee paying 300 times as much for full family coverage as for individual.

**Dave Iseminger**: John happens to have that knowledge readily available because he was at JLARC doing that report.

**Wayne Leonard**: I have a comment on Slide 3. I have written comments on slides coming up in the next section. I think it's important to point out as we go forward that one of the reasons why there has been so much discussion about the cost of things, or who is going to pay for what, is that currently the way most school districts fund their benefit pools is on an FTE basis. Under these plans, we're moving closer to a headcount basis, so when we see a difference of 24,000 employees, between the headcount and the FTE, essentially what we're talking about is the locally funded insurance, or locally funded employees, going from 15,000 up to 39,000 people.

The Legislature, I think in the slide coming up, has said they're not going to fund that. They're just going to fund their formulas based on the FTEs that a school district generates. That's going to be a significant impact on local school districts financially. I know based on the bill, I think it's the correct interpretation, it's of great concern to my constituents, to the business officials, of how we're going to pay for that because that's going to mean cuts to other programs as we go forward. I wanted to make sure I got that on the record more than anything else.

**John Bowden**: A quick follow up to a question Wayne had asked at the last meeting about work FTE versus benefit FTE, and I responded that I thought I could get you some information. I was thinking it was contained within the S275 report. I was remembering data that OIC had collected that actually had information comparing work FTE and benefit FTE. When we get the data from OIC, I think we'll be able to answer that. I know there's a significant number of employees whose benefit FTE is greater than their work FTE through various kinds of collective bargaining arrangements. We'll try to do some analysis and bring it to an upcoming meeting.

**Pete Cutler**: Following up on Wayne's question and concern, it strikes me that the data point important to have is the headcount of individuals who are above the 630 hours per year employment at the school districts, and whatever FTE that turns into, because I guess that depends on whether you use 1,440 hours, 2,000 hours, or whatever. That's really the gap Wayne refers to. If the assumption is that benefits will be provided and paid by somebody for everybody working over 630 hours in a year, how that number compares to the FTE number that's funded in the budget models is an important data point to have.

**John Bowden**: Slide 7 – School Employee Enrollment by Actuarial Value. This slide shows 2018 enrollment and actuarial values. The left side of the pair of bars is for the individual employee tier and on the right side is for the employee, spouse or state-registered domestic partner, and children tier. You can see the actuarial values we're showing, basically three ranges: 66%-75% show in blue, and the 76%-85%, is the orange, and then 86% and above is the green. There's a lot of green for most of the entities that we're looking at on the K-12 PEBB Program and the entire PEBB Program. The far right pairs of bars have the actuarial values of plans offered either in the 76%-85% or in the 86% to higher. It's the same for Lynden and Seattle. In Spokane and WEA some are in the 66%-75% range. Some of this comes back to the cost to the employee and they make decisions about what plan to enroll in based on what share of the cost they have to pay. Enrollments are based largely on employee cost.

**Dave Iseminger**: I was thinking more about the family columns across the slide, there is another indicator pointing to the relationship of the 3:1 tier ratio. If you look at the right family columns, you see more people are enrolling dependents in the two far right columns compared to other situations. Remember a 2.75:1 ratio exists for the far two right sets of bars, but the ratio is higher than 3:1 on the other family columns. This is another piece that ties to the proposal you'll see this afternoon when Barb does her presentation about a tiered rate structure.

**John Bowden**: Slide 8 – Statewide School Employee Enrollment, looks at more of a statewide basis. Here we'll be looking at some coverage tiers and plan types, information about looking at east/west, urban/rural, and work hours.

Slide 9 – School Employee Count by Coverage Tier. This slide shows numbers of employees by the tier coverage level they enrolled in. This is for all school districts we had information on. The majority of employees, about 44%, are enrolled in employee only coverage. To the far right of the slide you see 28,700 employees with no medical coverage, about 22% of all employees. Basically, there's about 105,000 employees enrolled in some kind of coverage, almost 134,000 total. This gets closer to that OFM number I said we'd be using. Here again you can see that the majority of employees select employee only coverage.

**Dave Iseminger**: John, will you confirm? My understanding of that 28,700 number, although we can't break it down, it includes both people who may have waived as well as those individuals who aren't eligible for benefits. Is that a correct understanding?

**John Bowden**: Yes, that is correct. Slide 10 – School Employee Count by Plan Type, looks at what types of coverage they enroll in. The preferred provider organizations (PPO), the health maintenance organizations (HMO), or the consumer directed health plan (CDHP). The majority of all employees are enrolled in PPOs, approximately 77%, about 18% in the HMOs, some in CDHPs, and about 4% we're not sure what they're enrolled in.

Slide 11 – Distribution of School Employees by Plan Type shows the same types of coverage plans divided between east and west. We see a little more PPO enrollment on the east side, a little less HMO because the HMOs tend to be located in urban areas. You'll see a sliver of CDHPs on the west side in red. I do know from past work that there are some CDHPs on the east side of the state, but they didn't show up. Enrollment in CDHPs has been very low historically, but gaining somewhat. When we get the most current OIC data and then get claims data from carriers, we'll know a bit more about these types of enrollments.

**Dave Iseminger**: Will you provide more context based on your experience as to why CDHP enrollment might be lower in school districts compared to the state population?

**John Bowden**: There's a difference of opinion within school districts about whether they can contribute to an employee's HSA, which goes with the CDHP. Some school districts believed they could not put money into an HSA for an employee. Other districts believed they could. This is around whether an employee can take the contribution for

the HSA with them when they move to a different job. Difference of opinion contributed to some districts either going with CDHPs or not.

The second piece is, if there was an individual within the district that took the time to explain to employees about a CDHP. When there wasn't anyone who understood CDHPs within the district, or there wasn't a broker or someone working with the district, the enrollment was low. When we get the OIC data and the claims data, we'll have a better understanding about enrollment trends in CDHPs.

Slide 12 specifically looks at the types of plans employees in rural school districts enroll in. Castle Rock is the only rural district with a CDHP. The other takeaway from this slide I already alluded to on the differences between PPOs and HMOs. In the rural districts where you see the green section of HMOs, most of those districts are fairly close to urban areas where the HMOs are offered.

Slide 13 looks at a geographic distribution by the coverage tier. There is not much difference between the tier level that employees enroll in on the east side versus the west side. There is a little more of the family or children, spouse/state-registered domestic partner enrollment on the east side. There are no major differences between them. This also holds true for the urban/rural breakdown as well. The percentages are fairly similar on the coverage tier level.

**Sean Corry**: Did you cross that with the geographic differences in family size and other circumstances that might inform some of these percentages?

**John Bowden**: No. We could look at census data along those lines in terms of information we either get from the OIC data or the S275 Report. We only know if dependents are enrolled. If they are not enrolling dependents, we don't know about them. There may be family composition differences, east/west, urban/rural. There are also differences based on enrollment and decisions employees make. We don't have a good way of getting at what some of the reasons might be behind it. Another comparison that I hesitate to talk about might be looking more closely at the employee's share of the benefits to see if there are differences east/west, urban/rural in the cost of the plans and if that makes any difference.

**Lou McDermott**: To Sean's point, the slide where we show the school districts in PEBB, have we ever sliced that information into those components: east/west, rural/urban, just to see? That might be a good avenue.

**John Bowden**: Right. Slide 14 looks at the coverage tier level based on employees full-time versus part-time. Full-time is a 1.0 FTE or above. In some cases, part-time is anything less than a 1.0 FTE. If somebody works 99% time, here they're considered part-time. It's important to note that as you go down in FTE, the coverage tiers start changing. The less of an FTE an employee has, the more likely they are to enroll in employee only. This is only for the enrolled employees. One of the things you'll see as you go down to part-time is more waiving or not being eligible. You can see a difference between part-time, full-time, and enrolling dependents versus employee only.

**Dave Iseminger**: This slide and the prior slide helps give insight on future proposed resolutions. The tier structures in orange/yellow and red are those extra tiers that can exist within a four-tier rate structure. What I wanted to highlight is both on this slide and on Slide 6. You'll see that when school employees, regardless of their full- or part-time status, regardless of whether they're east or west, and regardless of which school district they're in or in PEBB, there are more enrollments of children on a plan than there are of just a spouse or state-registered domestic partner. That factor influenced the agency's recommendation in the proposed resolution about the tiered rate structure. We saw more information suggesting school employees tend to add more children as dependents rather than spouses. We're seeing more of that in the tier structure in all of these slides.

**Patty Estes**: With the change in pooling, which school districts still do, and taking that out of their options, do you foresee any changes in enrollment because I know that is a factor. In my school district, we recently went to PEBB. It was a definite factor in selecting just an employee only or an employee and their family. Have you looked into that at all?

**Dave Iseminger**: Part of the grand debate on this statewide consolidation has centered around the 3:1 ratio, access and dependent affordability, and equity of benefits across the state. What we're expecting, or hypothesizing is going to happen, is exactly what we're seeing in this data, which is with a compressed ratio there may be many more dependents that enroll in benefits, I believe is what you're saying was your experience, Patty, in Eatonville.

**Patty Estes**: Yes. Personally, I went from paying $120 per month just for myself to paying $44 for my daughter and myself. It's a huge difference for somebody who is that 630-hour employee. It was way better for me.

**Dave Iseminger**: We'll see what the hypothesis is when it's all 295 school districts, 9 ESDs, and 10 charter schools. That's the grand hypothesis around the mandatory 3:1 ratio and pooling at the statewide level, instead of pooling at the individual district level.

**Patty Estes**: Okay.

**John Bowden**: Slide 15 – Statewide School Employee Enrollment Non-Medical. This slide has information based on data received from the Washington School Information Processing Cooperative (WSIPC), and from other districts not using the WSIPC insurance module. We will look at non-medical benefits – dental, vision, life, long-term, and short-term disability.

Slide 16 – Statewide School Employee Enrollment Non-Medical by Eligibility Threshold. We were able to separate this information between the employees that work less than 630 hours and the employees that work 630 or more hours. This information is from the 2016-17 school year, but we recently collected it, so in terms of vision, 11% of employees under 630 hours had enrolled in vision benefits; 79% of those above 630 hours or more had enrolled in vision. For dental, 11% of employees under 630 hours, 85% had enrolled in the dental if they worked 630 hours or more. Dental and vision are often considered mandatory, so waiving or not being covered would get you down to

less than 100% in these two categories. The 11% and 79% get you to 90%. The 11% and 85% for dental get you to 96%.

In terms of life insurance, 7% of those working less than 630 hours enrolled, 57% who worked 630 hours or more enrolled. Life is one of those basic benefits that statute says should be offered. In most districts, I understand it's offered but employees often pass on the life to get better coverage for the medical in particular. They bargain to have any available dollars going to medical as opposed to things like life, long-term, or short-term disability. On long-term disability, 8% who worked under 630 hours enrolled; 60% of the employees working 630 or more hours enrolled. What's interesting to me is comparing the short-term disability enrollments to information that I presented several meetings ago. I forget the exact number but it was close to 90% of all school districts were offering short-term disability, but you see the enrollment in short-term disability is very low.

**Pete Cutler**: John, it occurred to me going back to, I guess it was Table 3 about FTEs and employee counts. The state retirement systems provide eligibility, I think, for employees that work more than 70 hours a month. I'm not quite sure exactly where that threshold is. I'd be curious to know what their enrollment is for the school employee retirement system and for the teacher retirement systems for school districts and ESDs. That would seem to give a benchmark, in a sense, of who all school districts are reporting to Department of Retirement Systems as employees meeting that threshold. I'd be curious to see those numbers in the future. Thank you.

**SEBB Financial Considerations and Fully Insured Medical Benefits Procurement**

**Megan Atkinson**, Health Care Authority Chief Financial Officer. I am a relatively recent hire. I look forward to working with you over the next few months and through the summer as we support the work of collective bargaining this fall and a year from now when we're doing final bid rates and procurements. Kim Wallace and I are dividing this presentation. The first series of slides are intended to be global in nature and starting to set the framework for a longer financial conversation that we'll have over the next 12 months. I anticipate taking pieces of this conversation to the next few Board Meetings. We'll keep building our way through until a year from now when we get to final rates.

**Dave Iseminger**: Megan, I do want to make sure the Board knows even though you're new to the agency this is not your first tour of duty with the Health Care Authority, nor your first tour of duty with regards to employee benefits and compensation. Megan has a lot of experience for those Board Members who are not familiar with Megan and her past experiences and iterations.

**Megan Atkinson**: To that point, Pete hired me at the Health Care Authority thirteen years ago in 2005 and then Pete and I were colleagues on the Senate Ways and Means Committee for a few years, as well. Now I'm back and having to refresh my understanding. Many years ago I worked for then-Superintendent Terry Bergeson at OSPI, but my K-12 knowledge is very old, so also having to refresh that.

Slide 2, again thinking globally, is helpful when we start talking about funding mechanisms and funding amounts for a large program, which SEBB is. We ground ourselves in a basic construct - we have finite resources. It's easy to lose sight of that.

We'll be having a 12-month conversation talking about per member amounts, per employee amounts, per subscriber amounts, per adult unit, per FTE. You've already started having those conversations today around headcount versus FTE. There will be times we bring you those amounts and it will be $200 or $800 or even $5.67 for the xyz benefit on a per member, per month basis.

Parallel to that, what we have to keep track of is the overall size of the SEBB Program and funding benefits for a population of this size. We're talking hundreds of millions of dollars into the billions of dollars, to operate a program of this size. Even though that's a huge amount of money, it is still finite. Health care is an expensive benefit to provide for employees. There is a large number of employees bringing their dependents into SEBB. It would be easy to spend twice or three times that amount. Some of the conversations we'll have with you as we work over the next few months is really understanding some of those tradeoffs, because we do constantly have to balance back to a finite budget constraint. That's true on the state level, but it's especially true that we be cognizant of the district costs that we're pushing out to the districts. They too have very real budget constraints. Wayne, you alluded to the tradeoffs that the districts have to make in terms of funding employee cost, funding classroom cost, funding other student supports. We will be very cognizant of that and we'll be talking a lot about those tradeoffs and thinking that through as we go on this 12-month financial journey together.

Slide 2 – SEBB Financial Considerations. There are two benefit cost drivers, generosity of benefits and generosity of eligibility. When we prepared this slide, our actuary cringed a little because these technically aren't really the ways we talk about costs and health care benefits. But I think they're a real way that we, as people who use health care and get that for our families, can think about it. For you as Board Members, the reality is the more generous the benefit packages are, the greater the cost. The larger the number of people you bring into your benefit pool, the larger the total cost is because even insuring children, while they are cheap, they still cost. As your benefit generosity increases, your costs rise. As your eligibility generosity increases, your costs rise. There's a basic calculation in your package: cost times your members equals your total costs.

Slide 4. Something for you to keep in mind is the elementary concept that overall our plan funding must cover our cost. As we mature the SEBB Program, and if we do a self-insured product, then there are complicating factors around looking at reserves and covering a shortfall in one year with reserves, spending down a surplus in the following year, etc. That's the timing of the issue, but the principle remains the same. Over all, we have to pay the cost with the three funding streams we're bringing into the SEBB Program. There is the state allocation, money the local districts put on the table, and the employee monthly premium share. In terms of scale, the state contribution is the largest, the majority of the funding stream. Local districts the next largest and then the employee the smallest.

Benefit eligibility decisions impacting both our cost and revenue sources are in three buckets. There are legislative decisions the Legislature will make. There are some the Legislature has already made in the implementing legislation and the legislation that Dave walked you through earlier. There are implementation decisions, many of which will be made by this SEB Board and some made within the agency. Finally, decisions

about procurement this Board will make as we walk you through the procurement process.

Slide 5 – Headcount vs FTE. Wayne, both you and Pete talked about this earlier in terms of headcount versus full-time equivalent. Headcount is your actual number of employees regardless of the hours worked and you in K-12 are well aware of this because you have these considerations constantly. There are two bullets for full-time equivalent defining how I was looking at certificated staff and classified staff. You have your SEBB benefit requirement and your minimum of 630 hours. There's a significant difference. I'll illustrate this on Slide 6.

Slide 6 – Headcount vs FTE Illustrated. In K-12 you deal with partial FTEs all the time. If you look at the bottom of the slide, each employee is working 520 hours in a year so you have two employees each working 520 hours in a year. Added together, they're only half an FTE. In that scenario, neither one of those meets the benchmark for benefits. In the upper two scenarios, it's one to one. In the second one, it's two employees each working half time. Both are qualified for benefits, but together they total a single FTE, yet there are two benefit allocations.

Slide 7 – Headcount vs FTE Funding. It's the same concept illustrating the differences between headcount, FTE, and adding dollars. I made up district scenarios using a base $780 maintenance level state funding rate that's in the K-12 section of the budget now. That's not the actual amount that's being driven out per FTE. I used a simple straightforward comparison that the state funding's driving out $780 per state allocated FTE per month. That's in the current world of per FTE. Health care costs being $780 per employee per month. Even with those being the same, the state funding per FTE and the health care costs per employee being equal at $780, the difference between moving headcount to FTE drives cost. In district A where you have 2,000 employees, 1,000 FTEs, the additional cost would be about $780,000. The dollars really aren't important here because they're all made up. It's the issue I'm trying to underscore, explain, and illustrate.

On Slide 8 we start talking about money. School employees are SEBB Program eligible at 630 hours. Wayne, you had a comment about this in John's presentation. This issue of funding on a per FTE basis versus per employee, which currently happens in K-12, is a legislative decision that's already been made. If you look at Section 33 of the SEBB bill from this year, the requirement placed on the Legislature is that the monthly insurance benefit allocated to school districts for state funded staffing assumptions must be funded at a rate that is no less than the per employee per month funding rate provided to state agencies. That decision of funding at the state level for state recognized staff, at a per FTE or per headcount basis, is in this bill. We are working with OFM on developing the costing models. Kim will talk about our next steps on that. We'll be supporting OFM labor relations in the collective bargaining this summer. The result of that collective bargaining will be fed into the legislative cycle through the Governor's budget this winter, into the legislative session next year.

While that decision of funding per FTE versus per headcount for the state recognized staff has been made, the amount of money implicit in that decision is in the hundreds of millions of dollars on the state side. We have a statewide headcount and statewide FTE

count. John walked you through a state funded FTE count of about 94,000 employees. If you assume state funded, statewide headcount, and statewide FTE, that ratio between the 109,000 and the 133,000, if you assume that same ratio exists for the state funded FTE to headcount, and again we don't know state funded headcount, we know state funded FTE is about 94,000. Using that ratio, doing the calculation, you have an additional push on the state funding side of around $200 million.

**Dave Iseminger**: Per year, right Megan?

**Megan Atkinson**: Yes, per year, thank you. We believe the state funded staff comprise about 84%-85% of the total staff. Just doing simple math, assuming all the comparisons and ratios stay the same, that's an additional $30-$40 million on the district for the district funded staff. That's just getting in the door, the initial decision to go from FTE to headcount. Probably everyone in the room would say this is a foundational decision to go to the SEBB Program and away from the way the K-12 benefits are being funded and procured currently. Doing that is driving hundreds of millions of dollars of increased cost. The entire reason I'm here is to set that up for you. You will have that information as we walk through decisions that you'll make in the next 12 months around eligibility, benefit design, benefit richness, actuarial value, etc., because again we're talking about large sums of money and a significant sum must already have been spent.

**Sean Corry**: Megan, switching to headcount apparently drives the cost about an additional $200 million per year. What's missing for me is the funding amount per FTE. Is that calculated at the current $780 or --?

**Megan Atkinson**: I did calculate at the current $780. I costed this out to give you the magnitude of it. This is not an exact cost because the $780 may not be the figure used. Maybe we'll be super successful in procurement, but $780 is a couple hundred dollars less than what we're paying at PEBB now, assuming the demographics are the same. Assuming we get similar rates. The $780 is low. Again, I'm just trying to get you into the magnitude of the cost associated with moving from the per FTE to the per headcount. We won't know the real cost until a year from now when we get to the final rates.

**Sean Corry**: To follow up, the $200 million had to have some multiplier. You have a headcount number. What was the multiplier? Was it $780 or was it the current PEBB?

**Megan Atkinson**: It was the $780.

**Sean Corry**: It was the $780. If we were to add the extra $200 per head –

**Megan Atkinson**: Then, yes, it would be significantly more. You are correct. Let me walk you through how I did this. I didn't know all the items I had to know to do the calculation. I knew statewide headcount and statewide FTE count and that ratio, the 109,000 to the 133,000. I knew that state funded FTE is 94,000. From those then I could calculate the number of state funded headcount. The difference between the two was around 20,000. Essentially, I added an additional 20,000 people times the $780 times 12 months. I set it up using different amounts to see how much it had to increase

to get me over roughly $200 million. That's why roughly $200 million for the $780 per month. I also calculated at $900 per month, which is currently the funding for PEBB. I think $900 brought the calculation to around $300 million. Again, talking big numbers, $200-$300 million per year, to make this change from FTE to headcount on the state side. Then there's also the locally funded staff.

**Wayne Leonard**: I noticed on this slide, for the first time, a number on there -- $200 million estimate and it's frustrating since the state Legislature made a policy decision to mandate this but chose not to fund it. They're only funding what they consider, I guess, the basic education part of this. We don't treat people differently depending on the funding source of their salary. This would apply to all of our employees. So really, the $200 million cost, the way our benefits are set up now, that's actually shared between the local, the employer, and the employee. I went back and tried to figure out from the 15-16 years in my own district, how much additional I would have spent for medical insurance based on a headcount and it was in excess of $725,000 per year. As I go forward and bargain with my own employee groups, recognizing the fact that as the employer we're going to be funding a lot more in terms of medical benefits, it is going to impact the levels of employment, most likely. To Patty's point it is good for most of our employees. Most of our employees will be paying less money out of pocket, but from a policy perspective there will also be fewer employees most likely.

I don't think a lot of school districts are paying attention to this right now because the legislative session just wrapped up, and from a legislative point of view, they were hitting up the Legislature for staff mix and levy elections. They're not really paying attention to these policy level decisions that are driving costs higher. I'm sure now that the legislative session is completed they will probably start paying more attention to this. That's a big increase. It's not an insignificant increase, obviously.

**Megan Atkinson**: To your point, Wayne, I had a similar aha moment when I first tried to get to this calculation. I was concerned about the impact on the districts. Again, if you assume state funded staff are around 85%, then you've got about 15% of staff that are locally funded. That drives out, in my rough calculations if we stay in this world, $30-$40 million of additional district costs per year. That's hugely significant.

I think you are correct that as we move toward the next legislative session that would be the next decision point for funding. The cost of the SEBB Program, the impact on the individual districts, because obviously it varies widely, will be a significant topic of conversation. That's one of the reasons why we understand when we bring you decisions that have a financial impact, we bring you as much information as we can. Not just on the state funded piece, but how it would play out for districts. We will not immediately be as robust as some of the conversations that I know currently happened within the legislative cycle around K-12, where K-12 staff are able to break down impacts by district, because we will be somewhat limited initially by the data we have around enrollment by district. Initially we won't have that information. It's not until we run the program for a few years that our data stores will build up and we'll have better information and better able to give you that information. We do understand the need, at the aggregate level, to at least bring you the impact pushing out to district, even if we can't break it out for you by district. We do understand that's a significant consideration for you as you make decisions.

**Sean Corry**: In our last conversation about the multiplier, the $780 versus the funding for the current PEBB enrollees being a significant difference of roughly $100 million, rounding as you did. Knowing that it is up in the air, I'm wondering about the chicken and egg question as we develop our models for benefits that we might want to consider for offering to SEBB employees and the costs associated with providing money for these things. Dave, maybe you can help me understand, when are we going to have to make benefit decisions, or the range of benefit choices that we'll be making later, relative to knowing what kind of money is available to districts for benefits?

**Dave Iseminger**: You are right. There are many chickens and eggs in the launching of this program. What we've found in many instances, and this is partly the model for how the agency is going forward with recommendations on policy resolutions, is put a stake in the ground to talk about and figure out what we know.

In this instance, Sean, over the next nine months, before the next legislative session, the agency is going to need to do procurements informed by this Board's insight. We're going to bring you ideas about what a more granular benefit design could look like, ask you to be the first ones out of the gate because right now the Legislature isn't in town. We'll build towards potential budget models. We're going to ask you as a Board to make decisions with the best information we have to craft what those financial costs are so we can say this is what the Board has been proposing and is thinking about doing. Then we can plug it into the financial models and see how it works.

If, during the legislative session, it comes back that the funding doesn't support the created benefit package, we'll come back to the Board to make refinements to fit the funding model. The Legislature is going to need, and the funding mechanism is going to need, ideas around what the benefit structure looks like for collective bargaining to identify what payment will be negotiated in a collective bargaining agreement, and then plug it in a financial model. We need to build the benefit package with the best information we can, and give you an order of magnitude of the possible impacts, and then come back to refine different parts based on what happens during the next legislative session.

**Megan Atkinson**: I agree with Dave in the interests of what we're trying to set up, but the next big significant step is collective bargaining this summer. The intention of collective bargaining is to end up with an agreement that will be around benefit funding levels. The collective bargaining agreement will essentially be an indicator of the state's funding level. That bargaining agreement has to come to the Legislature next year for funding. This summer we should have a number that would allow districts to quantify the impact to them. Collective bargaining, for those of you who may not understand why I think that is so significant, will result in an agreement this summer of a funding amount. It will be per employee. We would have that amount and could estimate cost. To Dave's point, we don't have that information yet because collective bargaining happens this summer. We don't do procurement for the benefit plan until next winter.

**Dave Iseminger**: Rates procurement, right?

**Megan Atkinson**: Rates. Thank you. We don't do the procurement for the rates until next winter, early spring. That's when we would know, based on the benefit plan design, enrollment, and demographic assumptions how the carriers are bidding back our population, and are we or are we not within the amount that was collectively bargained? Either one of those outcomes has a different impact, a different next step. Next session, the Legislature has to fund a certain amount.

**Lou McDermott**: One of the things Megan's trying not to say is that we're going to guess wrong. There's no way we can guess right. It's going to take every single assumption and our best guess using our actuaries, our finance people and their experience, the PEBB experience, looking at the demographics, OIC information, the results of collective bargaining, and adding layers, and layers onto a model, which will give a number. This is what we think is going to happen. It's probably not going to happen. It's going to be wrong.

But back to Megan's point of collecting information over a period of time within the second year, the third year, and the fourth year, it will settle down. We will know what our premium stabilization rate needs to be. We will know what the monthly cost is for members. We will understand what the demographic is. There will be switching assumptions. There will be things that happen every year. But even in that first year when we take a look at the suite of plans we're offering, those plans will cost different amounts, which means we have to guess how many people will pick each plan. Sometimes we guess pretty close and sometimes we're not close at all. There's a lot of guesswork that takes place in this process and it's just going to unfold over a period of time.

**Dave Iseminger**: Some people may wonder why we can't procure rates earlier than next winter or spring. The further the rate setting from the benefits going live, the more risk there is from a carrier's perspective and so that is calculated and included in the rates. It's to everyone's interest to have the rate set closer to the beginning of the plan year, aka January 1, 2020, than it is *this* summer. That's why we need to balance the layers of information that we're getting with how much risk we want to be able to minimize fully insured carriers having to account for in their rate setting process.

**Sean Corry**: For those of us who pencil these things out, especially those of us who are from or work with larger districts, given that the funding for SEBB is to be no less than PEBB, it would be prudent for us to use the higher number, which in this previous conversation pushes it up to $300 million-ish then, too.

**Megan Atkinson**: That's a very good point and I'll take that away so whenever we bring this back, I'll use a higher number that is more in line with where we are in PEBB because you are correct, the legislation does direct that it would be no less than.

**Alison Poulsen**: Can you talk a little bit about what the implication is from our decisions on local districts? I'm imagining that's part of what we're trying to balance here – don't be too generous so that our local districts are like "Whoa! We can't do that!" We create some level of chaos whether it's less employment or it's just putting districts financially at risk. Can you give me a little bit more information?

**Megan Atkinson**: Every time I talk about this, and try to peel the onion, there is no one experience for districts. There's too much variability across the districts in terms of how they currently have benefits procured, funded, and offered. There is no one scenario for the districts and that adds to everyone feeling a little bit at sea. If you think in terms of the most significant places where we're changing the experience, one of the most significant is the funding change. The eligibility change being on the employee basis and the minimum of 630 hours. That alone drives a significantly different eligibility calculation. Thus, that drives a significantly different funding situation. That's what I've been trying to talk about here. The tiering could be the next biggest significant difference or the standardization of the benefits. Dave, what would you say is the next biggest place that drives differences?

**Dave Iseminger**: I think the tier, the compression to 3:1, can't be understated as a big impact. Then benefits standardization.

**Megan Atkinson**: Those decisions are the foundational pillars of putting together the SEBB Program. Those decisions are significant factors that drive cost.

**Lou McDermott**: I've thought about this program, the districts, and the sophistication levels at the districts to do some modeling so they can understand their impact. I would hope as the program evolves and the modeling on our end evolves, we would have tools the districts could use to try to understand their net impact. I don't know exactly what that looks like. But I think it's fair to try and provide them with some sort of snapshot into what the future may look like, depending on their circumstances, giving them an opportunity to adjust some dials on the model so it fits more in line with their circumstances, and then being able to predict the impact for them. Like I said, I don't know what that looks like. I don't know if that's just an FAQ, which communicates the changes or an actual model. I think it would be fair to try and help the districts with something like that. This is off the cuff! I haven't had a chance to talk to staff about that, but it seems like it would be in order.

**Wayne Leonard**: From my analysis in my district, the primary driver of that extra cost was not really the eligibility because our staff are eligible right now at 720 hours. There's not a huge difference between 630 hours and 720 hours. The big difference from our current world is someone that's half time at 720 hours would only get a half-time allocation and under the SEBB Program they get a full-time allocation.

**Dave Iseminger**: So the FTE/headcount full benefit versus no proration.

**Wayne Leonard**: Correct. If someone is eligible and opts out of benefits, that did not make a significant difference because under our collective bargaining agreements, we would still put that into the employee pool and other employees would use those funds for their own medical insurance. The FTE/headcount difference was the big cost driver.

**Megan Atkinson**: In terms of the calendar for the next 12 months, we need to get information from the carrier community around how they're seeing the cost of this population. That is significant because the carriers are the ones with the inside information. They are the ones providing the benefits now. We're setting up a procurement calendar that includes a Request for Information (RFI). We definitely want

to structure that for the fully insured medical plans and there are certain reasons and certain philosophies why we want to do that through an RFI. We want to structure it in a way that gets us the best information the quickest. We can then continue informing the discussion here with you and use it to inform the modeling that we need collective bargaining work this summer. Kim's going to talk about that.

**Kim Wallace**: This obviously is a very important and impactful conversation that we are having now at this stage. On the next few slides is information about what actions we're taking to gain the information that Megan alluded to. It will help us understand when we will know more. How confident can we be in the information that's coming? How are these financial models going to start coming together so we can see the impact whether it's on an individual district level or in the aggregate for the SEBB Program? What I'd like to share now is about some important activity that we have planned at the HCA that will be helpful in providing some reassurance in terms of the way forward.

Slide 10 – The Purpose of Sample Plans. The reason we're going to talk about sample plans is that these are some high-level plan designs for fully insured medical benefits for which we'll be asking carriers for quotes. We're going to say, "Dear Carrier Community, the SEBB Program is interested in understanding "non-binding" quotes. We're interested in describing for you a few sample plans that we would like you to cost out and provide us with quotes." I'm going to describe that process. Very soon we will start the conversation with the medical carriers about the SEBB Program. This will enable us to start costing out high-level plan options. We are hopeful that we will start to have a shared understanding about the plan designs that make sense for SEBB Program members.

There are two kinds of plans I'm going to describe. One is a set of sample plans the HCA will define, and the other, sample plans designed by the carriers. Some carriers know quite a lot about the plans they've been offering and the population they've been covering. We're going to give them flexibility in this RFI stage to tell us what kind of plan designs, what kind of cost-sharing, deductibles, etc., and what kinds of covered services make sense to them. We're asking for non-binding quotes on plan ideas they would like to propose.

We anticipate having responses back from a number of carriers by May. It's going to be very interesting to see the range of quotations that come back. We are also going to see the plan designs along with quotations the carriers are proposing we consider. I hope we all will feel we're starting to get some real information.

We're trying to support the decision making process with regard to the richness of plan benefits and coverage. That's already come up. It's going to be interesting conversation. We also need to better understand what the state's going to contribute and how much employees will contribute.

**Katy Henry**: How will the carriers receiving the RFIs be determined? Which carriers will receive them?

**Kim Wallace**: The state has a process of posting and informing, community-wide, all carriers licensed and registered to do business in Washington. They will all have an opportunity to respond. We don't pick and choose.

**Pete Cutler**: Will the data, like estimated costs or other information, the carriers submit be kept confidential? I imagine if I'm a carrier how I answer may vary depending on whether I think my competitors will see what I'm telling you.

**Kim Wallace**: Pete, absolutely. The state has very clear and strict guidelines about the types of information we keep confidential at various stages of procurement. We stay in close contact with our contract and legal folks. The rules do vary depending on what stage of procurement you're at. In an RFI situation, an early stage of the game with non-binding quotes, there are certain rules. Once we issue an RFP, which is our intention later summer 2018, the rules change a bit. We're very careful to allow carriers to designate what they consider to be confidential and proprietary, and then there are rules around how we protect and/or release, under what circumstances, that information.

**Dave Iseminger**: Pete, we'll make sure the RFI and RFP documents are as clear as possible about that. But inevitably during the procurement process, whatever stage it is, any of the carriers can submit questions to clarify what the expectations are for privacy. The extra layer is that we'll be able to talk with Katy Hatfield about what we could have as a more detailed discussion with the Board during different stages of procurement at an Executive Session as well. There may be a level of information during the procurement process that we're able to share with you as Board Members that we would need your confidence kept, under the Open Public Meetings Act, via a closed Executive Session.

**Kim Wallace**: Slide 11 is a bit more about sample plans. What are these? These are plan designs that the HCA will include in the upcoming RFI. I've already mentioned the carriers will be asked to provide non-binding quotes. They will propose additional plan designs and quotes they believe will meet the needs of the SEBB Program members. We will also have them tell us what counties they intend to serve and to describe their provider networks. There is a bit more information they will be responding with as well. We're trying to understand which carriers are interested in the SEBB Program, where they think they can provide coverage, what kinds of plan designs they think will meet the needs of the program members, and what their capacity is, what qualifications they bring specifically to the program.

The due date for this information is late April. That's why I said by May we're hoping to have a better picture of what might be happening. With regard to the sample plans, each plan design will have a different actuarial value. We've talked a lot about actuarial value (AV) in the past couple of meetings. Each sample plan design will have a different level of member cost-sharing for things like the deductible, the coinsurance, and the annual out-of-pocket maximum. We're anticipating that each one will have a different monthly premium cost. The sample plans we're setting up have the same covered services and the same exclusions. That's not because we're prescribing what exactly the covered services or exclusions will be. We want to have controls around the

sample plans so we can have apples to apples comparisons when we get the quotations back.

The guide we're using now for covered services and exclusions in the sample plans is the Uniform Medical Plan Classic in the PEBB Program. We're using this plan because it has a wide array of covered services and a pretty standard set of exclusions. We feel it's an appropriate level of breadth of covered services to initially ask for.

**Dave Iseminger**: This is not about being prescriptive. Basically, we're doing our scientific experiment. We're putting forward our hypothesis and trying to control as much as possible. This agency has a wide range of experience in understanding the nuances of the covered services and exclusions of the Uniform Medical Plan. That makes that part of the controlled experiment, for lack of a better description, much more understood by the agency so we have more variables taken out of the equation for that apples to apples comparison about the non-binding quotes. It's the reason we're focused on UMP Classic's covered services and exclusions. It is not meant in any way, shape, or form to indicate to the carrier community that this is or should be the benefit design. It's not the agency trying to identify a specific plan that has been endorsed by anyone. It's simply the scientific experiment exercise that we're going through.

**Sean Corry**: When this occurs will you be asking the respondents to quote both insured and self-funded arrangements?

**Kim Wallace**: This is for fully insured products. An additional point I want to make is we're telling the carriers to share back with us, to respond with alternative plan designs separate from the sample plans. Part of that is for them to tell us if there are suggested additional services they propose covering compared to the sample plans, or if there are one or two of those services that we've proposed in the sample plans they propose to exclude and give a quote for that. We will have apples to apples comparison with the sample plans that we are putting out to the carriers. We're also giving them the flexibility to share with us what they think would be the best plan design. I'm repeating myself, but trying to drive home the point we're trying to find the sweet spot between having the controls in place so we can understand enough and be on solid footing going into the summer of collective bargaining, putting all this information into our financial model, and understanding how much money we're talking about, while at the same time becoming more intelligent about the possibilities using the carrier information.

Slide 12 discusses what we mean by sample plan options. With respect to the actuarial value and member cost-sharing, this is what we intend at this time. On the left side you see the AVs. 76%, 82%, and 88%. You recall that actuarial value is a measure of benefit richness. It basically is saying how much a typical member can expect for their plan to cover when they go to get care. You can see that in the annual deductible, the coinsurance, and the annual out-of-pocket maximum columns. The lower AV plan has a higher deductible, higher coinsurance the member is responsible for at the time of service, and a higher annual out-of-pocket maximum that needs to be reached before benefits kick in 100%. One important note is that all of these dollar figures do not include the employee monthly premium contributions. Those amounts paid for premiums are in addition to these member cost-sharing amounts.

Slide 13 is a sample list of covered services. The actual document is 200 pages.

**Dave Iseminger**: Of that 200-page document, the summary of covered services is 14 pages.

**Kim Wallace**: I added Slide 13 so you would understand the breadth of covered services. Does anything on this list surprise you? If something is missing, it's not because we're specifically excluding it, it's because this is a broad brush.

**Patty Estes**: It seems pretty standard.

**Kim Wallace**: I mentioned standard exclusions, which are things like cosmetic surgery, dietary foods or dietary supplements, etc. There are exceptions to the cosmetic surgery of course, post-mastectomy, etc. I'm talking about for cosmetic purposes.

We are excited to continue to support you in designing this benefit program. We are seeking to balance the benefits offered, the members who are eligible, and the overall cost of program. We recognize there is a balancing act, a trade-off between what the employees will pay in monthly premiums versus what's paid during the year for the services they receive. We are hopeful the medical carrier quotes for the sample plans and the alternative plans will give us information about what can be provided and at what cost. We're excited and hopeful we'll be proceeding with a fully insured medical plan procurement that is ultimately going to result in a menu of offerings that give people options of benefit richness. You saw we're starting the sample plan options at 76% AV and our intention is to go up from there. We intend to give members options to pay more and get more. Or if they don't believe they will be using a lot of services, we want them to also have options to pay a relatively low amount in monthly premium.

**Dave Iseminger**: I want to clarify about the timeline we're envisioning. There are resolutions this afternoon that are procurement insight resolutions. It felt fairly straightforward to us that there is no option but to do a fully insured medical procurement, so we've been working under that assumption and building documentation in anticipation of today's vote on that particular resolution, as well as the other benefit resolutions. Anticipating a positive outcome on that particular resolution, we've been working under assumption of releasing the initial RFI around the first part of April and then asking for a four-week turnaround from the carrier community. Then we'll be working with you and using that information to inform further Board discussions in May, June, and July, as well as the collective bargaining process. Then we will work on an RFP for the second half of this year, for release sometime in late spring/early summer. The goal is to have final negotiated contracts by the end of the year as we move toward implementation because we have to get the eligibility and data stream feeds set up to carriers and finalize rates late winter/early spring of next year. That's just the fully insured medical. There are the other adjacent timelines for other procurements, but I'm just focusing on fully insured medical.

**BREAK**

**Dave Iseminger**: Amy Blondin, our Chief Communications Officer, will walk us through the website. At the last meeting there were public comments and questions about

where content really is on the website. Amy will share where we are, why we are where we are, and where we're going.

**Web Content Discussion**

**Amy Blondin**, HCA Chief Communications Officer: I want to give you a quick orientation to our website of where we currently have the SEB Board content and our future plans for integrating even more SEB Board content onto our site. Our goal is to make sure school employees have easy access to clear and plain talk information and they can easily find themselves on the website. We do have a very information-rich website, so that's always a challenge because we have so many populations and audiences, but we have a plan.

First, I want to orient you to what we currently have on our website. On the homepage we have our news carousel at the top and right now two out of the three stories on the carousel are SEBB Program related. The carousel is meant for timely top news stories. Just this morning we posted an item about the insurance carrier information that we're requesting.

**Dave Iseminger**: To add context, under the legislation I went over this morning, the carrier data deadline was originally set for January 1, 2019 and Engrossed Substitute Senate Bill 6241 moved that deadline up to April 1. Even though the Governor has not yet acted on ESSB 6241, we are sending information to the carriers saying that data provisions were part of the agency request legislation, which was supported by the Governor's Office. Considering that dynamic, for those specific provisions of the bill, even though the bill has not been acted on, we have every reason to believe those pieces would be acted on favorably and we want to give them as much notice as we can – two weeks – to pull together the carrier data that is requested. We just launched this piece today and we'll be sending out individual carrier notifications in the next couple of days. We have it as "Calling all carriers" because we're not quite sure we have the full comprehensive carrier list.

**Amy Blondin**: It is also posted under News. We have a newsfeed, so it's posted there as well.

**Dave Iseminger**: And I think we did a Facebook notification.

**Amy Blondin**: We're doing some social media this afternoon as well. Facebook and Twitter.

**Dave Iseminger**: So any carriers in the audience or on the phone could get it even faster by clicking on the carousel.

**Amy Blondin**: In general, School Employees Benefits Board (SEBB) Program information is under our Programs and Initiatives bucket. We have three main audience buckets on our website for your low-cost health care, which is Apple Health, Medicaid; Public Employees Benefits; and Billers and Providers information.

For the other programs and initiatives that we run, those have their own bucket and SEBB Program content lives there for now because it really is information just about

Board Meetings, Board votes, and Board materials, not so much about benefits and coverage information for actual members. We have general information about the Board and then we have links to the Board Meeting Materials, a way to sign up for SEBB rule making notices, a list of FAQs that our Employees and Retirees Benefits Division team have created, and a list of the SEB Board Members. That's where we're putting information related to the SEBB Program for now. If you click on News on the left-hand side, now we just have one announcement related to letting folks know that the bill passed this session. As we have new announcements and news, they will be posted here and also sent to those who signed up for the SEBB Program news alerts through our system.

**Dave Iseminger**: For example, after the Board hopefully takes actions on resolutions this afternoon, in the next day or two information would end up in this newsfeed as significant development of Board action that was taken. When the Governor takes action on the bill that would be another. We'll be incorporating the news link there about the carrier data request as well. That will be, for the short term at least, a place to go for the most recent information.

**Amy Blondin**: That's the current state for SEBB Program information on our website. Our web content team is working closely with Dave's communications team on the plan for integrating information for SEBB Program members onto our website. The middle bucket now says Public Employees Benefits – and that's information about the PEBB Program. We are going to rename this in the coming months to Employees and Retirees Benefits. That will be encompassing of both the PEBB and the SEBB Programs and then the sub-bullets underneath will also depict that we have PEBB, we have SEBB, and so forth. We're still working on the plan. As with any website, when you change one thing there are a lot of interdependencies, and a lot of dominoes and consequences. We're working really hard to make sure that SEBB Program content is as prevalent on our website for members as PEBB Program content – and really any content, because this is an audience who will have questions and need to be able to access quick and easy information. If you have any thoughts, recommendations, or things for consideration as we move forward with web content, let us know. We're absolutely all ears. We want to make sure we're doing the best we can for these new members as we start building this section of our website.

**Dave Iseminger**: In the carousel, we made sure that we elevated the main SEB Board page with meeting materials into the carousel so that it wasn't just part of the initiative list. In response to last month's public comment about content being buried, we made sure to incorporate the direct link to Board materials as high in the website as possible. As Amy said, we are working on the long-term plan to include more and robust information about plans, eligibility, about what exactly you need to do for open enrollment, and describing the benefits. That content doesn't currently exist. To just build the scaffolding and have links under an Employees and Retirees Benefits bucket that goes to "under construction pages," doesn't seem like a good customer service either. We went with elevating the content we do have to the highest level so people have easier access to getting those pieces as a direct response to the feedback that came up last meeting.

**Amy Blondin**: Obviously the website is an important tool for communication, but it's not the only tool. We're working with Michelle George, the Employees and Retirees Benefits Division Communications Manager and her team, to build a robust communication plan for SEBB Program outreach in the coming months and years. I would imagine at some point we will be bringing more details to the Board about that work for your input.

**Patty Estes**: I know we just approved the minutes from the October meeting. Are we going to post those with the meeting agendas, in an area?

**Amy Blondin**: Yes. So if you go to the Meetings and Materials section of the SEBB page and then click on Meeting Materials.

**Connie Bergener**: After the Board approves the minutes they will be posted to the website.

**Patty Estes**: For today's meeting or under the October meeting?

**Connie Bergener**: The approved amended minutes from the October 23 meeting will be posted with the October meeting materials on the website.

**Dave Iseminger**: Next to the meeting notice to which the minutes relate to.

**Patty Estes**: Perfect. That was my question, thank you.

**Dave Iseminger**: You'll be able to click on the agenda or the briefing book and then next to that will be the link to the approved minutes. We'll only post the minutes once they're approved. You just approved the October minutes. You see how detailed those minutes are and considering the volume of meetings we have, we did go forward in the administrative budget in procuring a transcription service so we don't fall significantly behind on minutes. The other piece I want Amy to highlight is how members of the public can sign up for GovDelivery.

**Amy Blondin**: If you see the green box, that's our call to action box that we use across our website. You can sign up to receive emails relating to meetings. We use a service called GovDelivery, but it's really just an email subscription service. That's one way to do it. From our home page, if you scroll down to "Connect With Us," there is an icon with an email image and you can sign up for SEBB Program notices, as well as a whole host of other information from HCA.

**Pete Cutler**: For the email subscription, is it possible to get updates or hear about new developments only for SEBB?

**Amy Blondin**: Yes.

**Pete Cutler**: Okay, so you're not forced to take everything from HCA.

**Amy Blondin**: We will not inundate you with messages.

**Pete Cutler**: Great. Speaking of the budget, what resources do you have for this biennium for communications.

**Dave Iseminger**: Pete, are you talking about staff or overall communication?

**Pete Cutler**: Overall communication. I'm just curious. I know the good news is that the budget includes funding at the request level for implementation generally. I hope a significant part of that is for communications, or outreach to the districts. I don't need specific numbers, but just a sense of order of magnitude of activities that are funded for at least the next 18 or however many months.

**Dave Iseminger**: Let's start with staffing assumptions. Within the ERB Division communications team essentially adding three additional staff, which is roughly doubling the staff, but not quite. Then in the central communications shop, adding in graphic design work. Usually when we send a mailing in the PEBB Program population, it's somewhere between $20,000 and $30,000 for a six- to eight-page glossy piece. When it's just mailing an individual letter it's a couple of thousand dollars. In the magnitude of our budget of $28 million, the bulk of that is staffing as well as consultation services, then IT dollars, and the rest of it is usually where we pick up additional costs within communications. I don't remember the number off the top of my head but the staffing assumptions was roughly three people in the ERB Division communications, a project position on graphic design, and a permanent graphic designer within central communications.

**Lou McDermott**: Pete, we have flexibility within the administrative budget to move money around and do what we need to do. There's been a high-level commitment to make sure that whatever communications plan, or costs associated with it, we're going to figure out a way to fund that.

**Pete Cutler**: It just seems to me that we state employees are used to getting our information directly. You know, website or through the HCA. But of course school employees are used to going to their districts, or to whatever other resource the district has set up. It seems like there is going to be a need for an initial push just to get people reoriented to, "here's where you can get your questions answered."

**SEBB Policy Resolutions: Eligibility**

**Barb Scott**, Employees and Retirees Benefits Division's Policy and Rules Section Manager. It's been a while since we've talked about the resolutions that were in draft form at our January meeting.

Slide 2 – Policy Resolution Process. Each meeting I'm going to repeat the process of what I'm going to walk you through this afternoon; probably at almost every meeting over this next year, in order for us to build the infrastructure of policy and rule that is necessary in order to run a program. You'll start to see a pattern. I want to revisit the process so I can orient you to where we're at today in each of the two presentations we'll walk through.

Each time we'll bring draft resolutions to the Board in order to have a discussion about them, get your insight, and your guidance. Bullet 1 is where we were at the January

meeting, and for those we'll walk through and vote on today. After we talk about draft resolutions, like in January we incorporate your insight into those resolutions and send them out to a set of stakeholders in order to get their insight and feedback as well. There's a lot that we don't know. We are learning from the stakeholders and we want to make sure we understand the issues as we move forward. We are committed to releasing proposals within a couple of business days of a Board Meeting. The turnaround time for the information we're getting back from them is fairly quick. That's necessary in order for us to continue to make progress forward through the decisions needing to be made. Once we receive insight and information back from the stakeholders, we develop a final agency recommended policy. The set you'll see shortly is from January with feedback incorporated. That is the agency's final recommendation.

Slide 3 is an excerpt from RCW 41.05.740, as passed by the Legislature, not yet signed by the Governor. This is included so you can refer back to it as we look at these policy resolutions today. The highlighted area is relevant to the policy resolutions you'll see shortly.

The three policy resolutions from January are:
SEBB 2018-01 – Legal Spouse and Domestic Partner Eligibility Criteria
SEBB 2018-02 – Dependent Eligibility Criteria
SEBB 2018-03 – Extended Dependent and Child Eligibility Criteria

Changes were made to the policy resolutions based on feedback received. I will summarize the changes for you as we look at each policy resolution.

SEBB 2018-01 – Legal Spouse and Domestic Partner Eligibility Criteria. We did receive feedback from stakeholders. One stakeholder recommended the eligibility for domestic partners be as broad as eligibility exists today under the WEA Select plans. That eligibility allows domestic partners that currently share the same regular and permanent residence, have a close personal relationship, are jointly responsible for basic living expenses as defined, not married to anyone, each are 18 years or older, not related by blood closer than would bar marriage in Washington State, mentally competent to consent to being in a domestic partnership, and each other's sole domestic partner. We received feedback that if the Board didn't go with eligibility that broad, they might consider grandfathering those domestic partnerships that were in place for the 2018-2019 and 2019-2020 school years.

We do not recommend the broader eligibility for the following reasons: the Legislature expressly mandated that this Board determine eligibility criteria for spouses and state-registered domestic partnerships. Although we do not believe the Board is statutorily prohibited from eligibility criteria that is broader, HCA's recommendation is to limit eligibility to spouses and state-registered domestic partners because of the way HCA anticipates funding will be allocated from the Legislature. As Megan explained earlier about the funding, the broader the eligibility established by the Board, the greater the cost to the overall program. There is a risk that the Legislature's contribution will not cover persons that the Legislature did not anticipate in its funding model. Costs of those additional members, because of the broader eligibility, would likely be borne by school employees. It is important to keep in mind that under the new SEBB system, it is

not likely that individual employees will bear the full cost of that specific person's dependents. Rather, the overall cost of dependents will spread across the entire population so each employee is impacted by a broader eligibility decision.

**Dave Iseminger**: One concept school employees are used to is pooling at the local level. In that model, many times – at least the way many districts are operating – an individual can add a dependent if they simply subsidize very heavily out of their own paycheck for that dependent. But when we're now pooling the entire state in a single system, the broader the eligibility requirement set by this Board the entire pool is subsidizing it now across the entire system. There's more impact across the entire pool, with broader eligibility requirements.

**Barb Scott**: As Patty described, the difference that she saw when the Eatonville School District moved from how they were purchasing to purchasing through the PEBB Program, she saw this very thing occur. That's what I was trying to explain in my slide. We really believe the funding is going to steer more that direction.

**Wayne Leonard**: You said the bill currently mandates –

**Barb Scott**: At a minimum.

**Wayne Leonard**: That it's a registered domestic partnership.

**Barb Scott**: At a minimum, the statute requires that this Board make a decision on eligibility at least for spouses and state-registered domestic partners. It doesn't make it so that you couldn't go broader than that. But it does make it that you have to set that at a minimum.

**Wayne Leonard**: With the WEA Select plans, I'm gathering the eligibility is a little looser than being a state-registered domestic partner.

**Barb Scott**: It is looser.

**Wayne Leonard**: Is it just a matter of doing paperwork or is there some requirement to being a state-registered domestic partner that makes it onerous to do that?

**Dave Iseminger**: This might seem like a long route to answering your question, but I think it's also relevant information. At the January Board Meeting we also had the concept that came up about discriminatory practices. I want to make sure we clarify that part on the record as well. Bear with me as I go through that journey and then I think it gets to your question. I'm going to be talking about the PEBB Program because that was the experience with the domestic partner registry and this aligns with how the domestic partner criteria is set up in the PEBB Program.

In this state, in the late '90s, there was a Defense of Marriage Act passed by the Legislature and signed by the Governor that prohibited legal statewide recognition of same-sex couples' relationships. In the PEBB Program population there were members of the public that brought to the PEBB Board a concern about equity and wanting to recognize same-sex relationships. The PEB Board at that time, against many wishes in

parts of government, put forth a domestic partnership declaration-based system somewhat similar in criteria to what the WEA Select has now. It was limited to just same-sex couples. The PEBB Board did that in the idea of generosity of benefits, generosity of eligibility. They did that partly out of a sense of equity, to be able to recognize just those same-sex relationships, but the PEB Board did not open the eligibility so wide (by including opposite-sex couples) that suddenly there was a very big broadening of the eligibility created significant pressure on the fiscal side.

Fast forward 20 years. The state passed a same-sex marriage recognition law and then federal marriage recognition occurred. Then the PEB Board faced having a declaration-based policy just for same-sex couples created when there was no way to recognize same-sex couples' relationships under state or federal law. Do we open eligibility and have a loose requirement for domestic partners for same- and opposite-sex couples, or do we retire that eligibility rule? In the concept of generosity of benefits, either make it nondiscriminatory by allowing everyone or close it down. The PEB Board closed down that eligibility requirement. I forget what your question was and how I connected this.

**Wayne Leonard**: I was wondering if it's just a matter of filing. Is it an onerous process to be a state-registered domestic partner?

**Dave Iseminger**: The state-registered domestic partnership has at least one key distinction that's different than the declaration-based process. At the state level, one or both individuals in the state-registered domestic partnership have to be 62 years or older. That is due, in part, because under federal law, domestic partners aren't recognized. Being in a state-registered domestic partnership allows people to maintain eligibility for social security pensions but still have many of the protections that are related to medical rights, burial rights, and other factors under state law. That is a key distinction at the state level. The state level state-registered domestic partnership is not sex-specific, so it can be same- or opposite-sex couples.

Also, a key piece of the same-sex marriage legislation auto-converted everyone at a certain date into a marriage unless one of the individuals was over 62. The Legislature narrowed the eligibility for state-registered domestic partnerships to be non-gender specific but still have an age requirement because there were other venues by which younger same-sex couples' relationships were now recognized under state law.

**Lou McDermott**: Wayne, to answer your question bluntly, yes. They must get married unless they fall into the criteria of one of them being 62 years of age or older. Just like currently in the PEBB Program, if you have an opposite-sex couple they're not going to get benefits until they get married. That applies to same-sex as well.

**Barb Scott**: As we walk through these resolutions, each time you make a decision that broadens your eligibility, that decision could also impact how you structure other benefits going forward. There will be give and take in different places, and SEBB 2018-01 probably is one of those.

**Lou McDermott**: I think that's why the communication plan with members will give them an opportunity to react and not discover on open enrollment day that they can't enroll their partner. Communication will be important with each iteration of the rules when

established as we move forward with plan selection and design. Members need to understand that ahead of time so they can make choices appropriate for them.

**Barb Scott**: It was a hard decision for the PEB Board when that change was made. These are difficult decisions. There was a good amount of communication that had to be done by the agency in order to make sure members understood the shift in policy. I do understand and recognize that this is a shift from where many school districts' eligibility sits today and I would expect that a good amount of communication will need to occur.

**Katy Henry**: So the recommendation is not to adopt broader eligibility criteria? Is that the same recommendation for grandfathering in the broader eligibility as well?

**Barb Scott**: We are not putting before you a recommendation to grandfather eligibility today. We're putting forward a recommendation to just cover legal spouses and state-registered domestic partners. The stakeholder feedback received was to broaden the eligibility to allow for domestic partnerships currently available under the WEA Select programs. If not that broad, then grandfather current domestic partners under the eligibility in the 2018-2019, 2019-2020 school years. That is not our recommendation.

**Alison Poulsen**: Do we have a sense of how many people the grandfathering would affect? Is it a huge number or a small number?

**Barb Scott**: I do not have numbers as to how big that population is today for grandfathering.

**Dave Iseminger**: We attempted to quantify that, but we weren't able to nail down a specific number. What I can tell you, although it's not the best proxy it's the only number I have in my head, Alison, is that when the PEB Board had its decision to expand or close down eligibility which is only a subset of this population, there were 117 domestic partners that didn't meet the criteria of being in a marriage. That was just in that isolated context. It was 117 out of our dependent coverage which is roughly 240,000-250,000 dependents in the PEBB Program. That's the best number I can give you.

**Barb Scott**: Initially when we looked at that for the PEB Board, the number was slightly higher. What we found as we reached out to each of those members to inform them their eligibility was going to be affected was that a number of them had just never let us know their domestic partnership had been converted to a marriage. So the number shrank by quite a bit.

**Dave Iseminger**: Alison, the other piece related to this is back around 2012 the Legislature had the agency embark on a dependent verification project to make sure all dependent rules were being adequately monitored and applied correctly. As a result of that multi-year process, it was roughly 5,000-7,000 individuals found to be not eligible under the dependent criteria across the population, regardless of relationship recognition. Given that the Legislature directed the agency to go through a dependent verification process six years ago, and coupled within the legislation on Slide 3, and the parts highlighted that reference state-registered domestic partner, we believe the

Legislature anticipated and was signaling in this area of eligibility a little more direction on this part of the dependent eligibility criteria.

When you couple the specific bill language and that the agency has been directed before to carefully monitor the dependent eligibility and verification process, it leads us to believe that the anticipated funding model wouldn't envision a broad dependent eligibility in this way. If the Board did pass a resolution in an opposite direction, there should not be an expectation that there would be additional funds. As Megan pointed out, just to move from the FTE to headcount piece is hundreds of millions of dollars. There are a lot of moving pieces that signal this is the direction that was anticipated, although there is Board flexibility legally.

**Pete Cutler**: I have to confess, maybe because they added the word "at a minimum" this year, but in the past when I saw this language I thought it was flat out that the Legislature was saying that the state-registered domestic partners eligible for coverage would be those as defined in that RCW. Two questions. Is that standard consistent with what PEBB Program has as eligibility for domestic partners?

**Barb Scott**: The eligibility that's being proposed?

**Pete Cutler**: Yes.

**Barb Scott**: Yes. It is consistent with what the PEB Board has in place.

**Pete Cutler**: Secondly if, God forbid, we were to decide okay we're going to go with the recommendation now, but after a year various information came in, and Board Members decided to revisit that policy and that rule, would we have the opportunity to do that next year?

**Barb Scott**: One thing I know for certain is that eligibility does evolve over time. I would expect that if the Board had an interest in looking at this at a future time, the Board could amend its policy. When we had the change to the PEB Board's policy and some eligibility taken away, that policy evolved. I remember walking them through the evolution of their policy over time.

**Pete Cutler**: My recollection when it surfaced was in the middle of summer for implementation in the following January, which was not ideal timing. It does show that if there is desire to modify it, it can be done down the road.

**Barb Scott**: I would expect that this Board will evolve its eligibility over time. We'll have many conversations.

**Dave Iseminger**: Remember when I said PEBB eligibility rules are roughly 30-40 pages? There are three sentences in state law now. There's a lot of scaffolding to build and certainly Barb, her team, and you are not going to make decisions that result in 40 pages in six months. It's going to be a very long process so it definitely will be iterative. I do want to correct one thing, Pete. The phrase "at a minimum" was in the original legislation. That was not added this year. That was in HB 2242 last year.

**Pete Cutler**: I stand corrected. I just missed it.

**Lou McDermott**:

**Policy Resolution SEBB 2018-01 - Legal Spouse and Domestic Partner Eligibility Criteria:**

**Resolved that**, eligible school employees enrolled in SEBB benefits may enroll a dependent that satisfies one of the following criteria:

- Legal spouse
- State-registered domestic partner

**Wayne Leonard** moved and Terri House seconded a motion to adopt.

**Lou McDermott**: Any comments from the audience?

**Julie Salvi,** representing the Washington Education Association. We put forward the recommendation to either stick with the same policy as the WEA Select plans or grandfather current individuals. To add information to this debate, in the WEA Select plans there are 609 individuals who are on those plans due to the domestic partner provisions filing that paperwork. WEA Select plans are not every plan in K-12. We are a significant share of that. There could be more individuals when looking at all school districts across the state, but in terms of the total number of people covered, it is a very small share of those individuals.

**Lou McDermott**: What is the total value approximately?

**Julie Salvi**: I would have to go back. I'm not going to make up numbers on the fly, sorry. I should have written that down, too. From our perspective if a provision is not added to grandfather these individuals in, then there will be individuals who are covered under a health care right now through WEA Select plans that will no longer be eligible to receive those benefits. So some of the families that we are serving in K-12 will no longer be able to cover all of the individuals in their household. So we had asked that either we go to the same provisions or at least grandfather in those who are currently receiving health care.

**Lou McDermott**: In Dave's example, we talked about when we went out and looked at the 117 folk. We found a portion of them had defaulted into marriage. The number you cited, was that taken into consideration? Or is it unknown?

**Julie Salvi**: That is unknown. So that could be true as well.

**Lou McDermott**: There is a portion of them, whether it's one, or five, or 400.

**Julie Salvi**: Right. Some portion of that would likely have that same conclusion.

**Lou McDermott**: Understood. Thank you. Appreciate your testimony. Comments from the Board?

**Sean Corry**: I have a comment. I'll announce that I'm going to vote against the resolution. I have been somewhat bothered by the language used in describing the circumstances here. Talking about very broad eligibility as if it's bad or that there aren't legitimate reasons to be a domestic partner that would qualify for coverage through the WEA program. For example, our program of eligibility at Seattle, or other large school districts that are not with the WEA, I think you're attempting to delegitimize. It bothers me that perspective is permeated here in the way you're presenting this. I truly believe there are legitimate reasons for people to remain domestic partners according to, for example, the WEA criteria, who are in all respects partners, and in virtually all respects except for the license, married. I don't want to question the reasons that they're making these choices. I just want to acknowledge that there are legitimate reasons to be in these circumstances. If the number is so small by your measure or by what we might speculate the measure being at the school districts, it's not a financial issue. It's a very small dust speck in the big picture. So I've announced how I'm going to vote, but I just really needed to say that I was bothered by the way it was presented.

**Dave Iseminger**: I really do appreciate that feedback, Sean. That certainly wasn't the intent. It's kind of acknowledging the journey that has gone on and the way the Legislature has made policy decisions along the way. We certainly are not trying to devalue relationships, but I do appreciate the sensitivity that you're describing and just want to convey that is not the agency's intent. We know that everything we do has real impacts on real lives. We're just acknowledging some of the different legal parameters and some of the different moving parts related to this particular topic that have evolved in the agency's experience. It's not meant to devalue individual's experiences. I do appreciate that feedback and we'll be thinking very carefully about how we present things.

**Barb Scott**: That's why we also recognize that if this eligibility does differ from what folks are used to today in some districts, there would be a need for good communication around that shift. When we did this with the PEBB Program, we reached out to every single one of those families in order to make certain they understood what was changing, and they could make decisions around that. It was a significant shift for the PEBB Program. We expect that a change in the eligibility for school district employees will be just as significant a shift. Communication will have to go out around it.

**Katy Henry**: Are you saying that if we go to this eligibility category we would be reaching to all of those affected participants?

**Barb Scott**: At this point, we don't know them in the same way that we knew PEBB Program individuals. We could identify employees within our data that had domestic partners enrolled so we reached out to them very intentionally in order to make sure they understood there was a shift in the eligibility occurring and that they would need to make decisions by the next open enrollment based on that change in the eligibility. For the school district population, currently I don't know the exact number. That is a piece of information we still don't have. In addition, at this point I don't know how they're identified in data to know whether or not we could do very intentional, specific, individualized communication versus just making sure that it is broadly communicated so members are made aware.

**Lou McDermott**: One of the things you'll find about the Employees and Retirees Benefits Division is that they care a lot about their members. Every conversation we have, every single day, every meeting, whenever the world is changing, the federal requirements are changing, state requirements are changing, the OIC has taken an action, somebody has done something, there is litigation – each conversation begins with "how does this affect the member?" What I can tell you is that as the SEBB Program population comes to the Health Care Authority, if we do have groups that are identified that there possibly is a negative impact and they need a direct communication, we'll do everything we can to acquire that information and make that communication. The hard part is sometimes acquiring it. There can be various reasons why specific entities would not want to share that information. It is confidential and they are protecting their members. We're going to do what we can to get that information, or at least provide a communication message that could be sent.

**Katy Henry**: So it wouldn't be the same type of communication that you used with PEBB members because you don't have access to those members; and, in addition, Spokane doesn't have WEA Select, but we also have as a district a broader eligibility criteria for members. You would attempt to reach out through the districts to get that message out, is that what you're saying, Lou?

**Lou McDermott**: We would attempt to reach out in any way we could. If we can get the data directly, we would send that communication. If we are unable to acquire the data, but we know someone has the data, we would give them a message to send out. We've had members in counties where their plan was no longer being offered, and found out late in the game. We handed out a list of names and phone numbers to our own staff to start picking up the phone and calling those members. There were members who had been in the same plan for over 30 years and we were giving them notice, but it was an incredibly short time frame. We will do everything we can to communicate either directly or through the party that has the information.

**Dave Iseminger**: Katy, it's hard for us to make commitments without having the data to know if we can even identify impacted members. But whatever we can identify or who we can work with to identify individuals, we'll do what we can. That's for any of the eligibility rules. This is Resolution Number One and there will be others. Whatever it is we can identify to help communicate to people impacted by different decisions, we'll do.

**Lou McDermott**: That impact goes both ways. For some people it will be a favorable impact. They will now be able to cover their spouse and kids. It will be affordable. Those messages getting to them so they understand that. We know there are a lot of districts and employees who may not at all understand the impact. They don't know what a 3:1 ratio is. They've checked into it, maybe, multiple years and they've decided it's either unaffordable or whatever reason they can't access it, so trying to get the message to them about what the benefits are going to look like starting in 2020 will be critical as well.

**Patty Estes**: A district like mine who switched over to PEBB Program benefits, did you have any of these kinds of problems or issues that arose? Because I know you said 70-something school districts are now in PEBB Program benefits so did we have anything

that happened like this where we have some sort of example on what actions were taken?

**Dave Iseminger**: Patty, I got a note during the break that it was 72 K-12 school districts and five EDSs for a total of 77. Just to correct that on the record, as well. Any time a school district, employer group, or local governmental entity contracts with the Health Care Authority for access to PEBB Program benefits, they are committing to follow the eligibility requirements of the PEBB Program. They can submit a request for revisions or amendments to them. Very few categories of revisions have been allowed by the agency. The more changes made to eligibility requirements, the greater the impact to the pool because those individuals are still in the same risk pools. I have been part of the approval process in various stages for the last four years and I am not aware of that exception ever being asked for or approved. Usually the types of changes approved are related to one of the other resolutions teed up in Barb's next presentation around medical effective dates. To my knowledge the question has not been raised about this type of issue on the spouse/domestic partner eligibility piece when a district has joined PEBB Program benefits.

**Patty Estes**: Okay. Thank you.

**Terri House**: What defines a legal spouse? Does that include common law?

**Barb Scott**: Legal spouse is defined in state law under Domestic Relations Law and I will have to look to see whether or not it includes common law.

**Dave Iseminger**: Katy Hatfield and I are going to chime in from our family law classes at the University of Washington Law School. Our state doesn't have common law marriage. It has a different type of relationship that has been recognized by the State Supreme Court which started off with the name "meretricious relationship" and then was morphed into "committed intimate relationships." They are similar but not equivalent to the concept of common law marriage.

**Terri House**: Does it go under the legal spouse umbrella?

**Dave Iseminger**: It does not. In my recollection of how committed intimate relationships work in our state is it's used more as a part of the equitable remedies of courts and being able to divide assets during dissolutions, but not necessarily granting affirmative rights in a way that is more typical of common law marriage in other states. We can do some additional follow-up about that. That one is ingrained in my mind from ten years ago. Katy, is there anything else you could add to that?

**Katy Hatfield**: My understanding is legal spouse means you've gone through the process of getting a marriage certificate and having filed it with the county.

**Dave Iseminger**: But legal spouse would include anyone that's recognized as a spouse under federal law or anyone that's recognized under state law.

**Barb Scott**: Yes.

**Katy Hatfield**: And it doesn't have to be from this state. You could have been married in Louisiana for instance, since some of us might know someone who just was. The state recognizes marriages from any other state.

Voting to Approve: 7
Voting No: 2

Yes: Pete Cutler, Alison Poulsen, Patty Estes, Dan Gossett, Terri House, Wayne Leonard, Lou McDermott
No: Sean Corry, Katy Henry

**Lou McDermott:** Policy Resolution SEBB 2018-01 passes.

**Barb Scott**: Policy Resolution SEBB 2018-02. This resolution has morphed a bit. The big changes to this really were to add clarity and additional details specific to over age 26 dependents who can remain on the coverage based on disability. There are a couple of specific changes. We removed the reference to "biological child" and "adopted child" because they are described under the reference to parent/child relationship as described in RCW 26.26.101.

On Slide 8, Bullet 1: Children of any age with a developmental or physical disability that satisfies all of the following criteria. Criteria pulled from the requirements in 41.05.095 was added. We wanted to make sure we aligned to those requirements so we added detail. We also changed the language slightly in order to support the use of respectful language as required under RCW 44.04.280, which has moved away from the use of the word "handicap," which you'll see in RCW 41.05.095. The detail added includes that the employee must provide proof of the disability and dependency within 60 days of the child's attainment of age 26. The employee must agree to notify the SEBB Program in writing no later than 60 days after the date that the child is no longer eligible under this section.

A child with a developmental or physical disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which he or she becomes capable of self-support. A child with a developmental or physical disability age 26 or older who becomes capable of self-support does not regain eligibility if he or she later becomes incapable of self-support. The SEBB Program will, with input from the applicable contracted vendor, periodically certify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two year period following the child's 26th birthday, which may require renewed proof from the employee. That last subsection meets a requirement of Title 48 in the OIC's regulation that regulates the insured plans you'll be looking at later. That's why it's included here as well.

**Sean Corry**: On Slide 7 when it talks about the termination of coverage in the event of a few things here, it says that the child's relationship to the employee ends on the same day the employee's legal relationship with the state-registered domestic partner ends through divorce, etc. The question I really have is a practical one about when does coverage actually end? Is it possible that coverage ends retroactively to the first of the

month during which that change occurs? Or is it always after, at the end of the month, when the change occurs.

**Barb Scott**: That is going to be one of the questions we will bring back to this Board at a future date. We'll be talking about when coverage begins later this afternoon. At the same time, we will end up talking about when coverage ends. Typically, for the PEBB Program plans, it is prospective. It is end of month in which eligibility is lost. Staff are prepping that type of resolution for me to bring before you. But for the PEBB Program it's end of month in which eligibility ends. In the PEBB Program we typically do everything by full month. There's no proration of premiums during a month so coverage is for full months.

**Lou McDermott**: Barb, is there any reason to believe the recommendation won't be the same? That it will be end of month? Because I think it is applicable to this vote, to understand what "end" means.

**Barb Scott:** I can't imagine it would be different. The resolution I bring forward will be end of month and that you do full months.

**Lou McDermott**: Thank you, Barb.

**Pete Cutler**: For the record, I am already in favor of that policy. The idea of ending it mid-month, having worked with administrative processes, would be a disaster.

**Barb Scott**: We did receive stakeholder feedback on this resolution. A question was asked about dual eligibility or dual enrollment. I couldn't tell them at this point whether or not dual enrollment will be allowed or prohibited. I expect a policy resolution related to dual enrollment or how we'll handle situations where a dependent might be eligible under more than one employee will be coming soon. A question was asked related to national medical support notices, which typically require enrollment of a specific individual.

Another question had to do with the eligibility ending for a stepchild if the spouse or state-registered domestic partner were to die, or through divorce, or dissolution. In answering that question we did reach out to the stakeholder and tell them that at this point in time we were moving forward with a resolution that still had coverage ending when the relationship to the spouse or the domestic partner ends. Our thinking behind that is because there is no legal relationship between an adult and his or her deceased spouse or domestic partner's child without a guardianship, adoption, or some other connection between the adult and the child. If a legal relationship still exists after death, then eligibility could be established provided the Board adopts eligibility for extended dependent children as recommended on what you'll see as Resolution 2018-03 today. Or through adoption.

**Dave Iseminger**: I'm sitting here reflecting on Sean's comments from before and what Barb just described as the answer. To a member some of this might sound a little cold. I can appreciate and understand that. One of the other frameworks we haven't described for the Board is that there is an overriding elephant in the room of a Cafeteria Plan. That is not meant to be said as an excuse, but it's an acknowledgment and part

of the rules. A Cafeteria Plan isn't what many people typically describe, which is "I can pick and choose among my benefits." A Cafeteria Plan is an IRS-regulated document that dictates when employees can use pre-tax dollars to pay for things. Under a Cafeteria Plan, there are very prescriptive legal rules about what can and cannot count. It gets into a lot of granularity which says this is in and this is out. That is yet another framework.

Barb was describing this individual, a stepchild, does not have a relationship with the surviving state-registered domestic partner or spouse. That's meant from a very technical legal perspective -- that there was not an adoption, there was not a guardianship. Unfortunately, when you're looking at tax dollars pre- and post-tax, there are often very specific lines. That's what you're hearing as a reflection in the language. I really do take to heart what you were saying, Sean. The agency used to think of it in that framework and understanding there are ways the Cafeteria Plan can be problematic if lines are crossed in very technical legal ways. That is not meant to say we don't acknowledge there are strong relationships between individuals, but unfortunately sometimes from a tax perspective, it can be very cold. When we're talking about being able to pay for benefits under a Cafeteria Plan, ultimately that dictates some of the lines here as well. I just wanted to acknowledge that. Barb had a conversation with that individual and was able to describe more, but it can come off as very cold and it's not meant that way.

**Pete Cutler**: My understanding from what you just said is we want to maintain the ability of, in this case, school employees to be able to participate, to purchase their coverage through the SEBB Program, through a Cafeteria Plan approved by the IRS meeting its requirements. And if I understand correctly, the main benefit of that is then those premiums can be paid on a pre-tax basis.

**Dave Iseminger**: That is correct, Pete. I know we talked a little bit about the Cafeteria Plan in some of Scott's presentations. The odd thing about the Cafeteria Plan is the way it was created in the Legislature. The authority of that lies with the agency. It's not something that's run by the Board. Nor does the PEB Board have jurisdiction over the Cafeteria Plan. It is an underlying assumption that people want pre-tax dollars used. There are multiple parts to a Cafeteria Plan, but one of the prominent ones that most Cafeteria Plans allow is the premium payment for employee contributions using pre-tax dollars. There are pros and cons to that. There are more questions about whether an individual in their circumstances wants pre-tax dollars taken out as they near Social Security age because it can impact some of the Social Security calculations. As we move forward we did have an underlying assumption, as an agency, that there was an intent for a Cafeteria Plan to be applied and that is part of the overlay of many of the recommendations that will come forward.

**Pete Cutler**: This issue is dealing with which persons can be covered as a dependent and still stay true with the IRS requirements for a Cafeteria Plan. This is just one of what will be a number of different situations where that question comes up. As long as you want to keep your qualification as a Cafeteria Plan so people can make their premium payments on a pre-tax basis, then here is a constraint that the federal government requires you stay within. Okay, thank you.

**Dave Iseminger**: Would it be helpful for the Board if we did a more thorough presentation on Cafeteria Plans and what they do and some of the overlay? Not a deep dive, but at least an overview since it's an overriding, significant framework in which many of the eligibility resolutions are coming from. We can talk about the pros and cons of it. We'll put that together for the April 30 meeting.

**Barb Scott**: I think the Cafeteria Plan is one thing, but as we look at each one of these resolutions, we try and think about a number of different regulations that would cause us to steer one direction versus another. The Cafeteria Plan and the ability to try and make it as simple as possible for employees when they make decisions related to Cafeteria Plan benefits is one thing. The other is the administration of continuation coverage. For certain dependents if they're not your tax dependents, they're not a qualified beneficiary when it comes to COBRA coverage, so we're thinking about that, too.

We're also trying to be careful around HIPAA provisions. I had a number of conversations with our HIPAA Compliance Officer around privacy concerns. We are trying to keep all of those in mind as we move forward. I'm not bringing all of that out as we walk through these, but at the same time those are shaping some of these resolutions. I will try to call out specifically those guardrails in the next presentation. There will be a couple of them.

**Alison Poulsen**: Can you give just a little of the rationale around the fourth bullet on Page 8, around becoming capable of self-support and later becoming incapable of self-support? I just want to make sure I understand that.

**Barb Scott**: What we've seen in administration of the PEBB Program is sometimes we will have children with a disability that can be overcome. It's short-term sometimes, not long-term. Sometimes those children will go on to become self-supporting and then their eligibility will end. I can't remember a case, but at some point we looked at if they became self-supporting and then they had an additional disability later on, could they come back? The answer was no at that point in time, because they had been able to be self-supporting at one time.

I can tell you in administration of that eligibility, we do watch for and make certain we are recognizing there are some children who are able to do some things based on their capabilities and that those things don't necessarily equate to being self-supportive. For example, there are a number of organizations that support and encourage folks to use skills that they have available to them and do work they're more than capable of doing. Sometimes, though, that doesn't equate to full-time employment or being able to be self-supportive, even if earning money. That's why you see in our resolution that we make those decisions. Not only do we look at it, but we also have clinical folks here and at the health plans look at the disability before a decision is made as to whether or not it meets the requirements of the eligibility.

**Alison Poulsen**: The example's very helpful. I guess my concern would be that between 27 and 30 you are self-supporting and then it turns out that life was more complicated than that. It's sounding to me like you would not be able to be re-eligible.

**Barb Scott**: You could not be eligible again under this eligibility.

**Alison Poulsen**: What would be the rationale if there's a threshold of determining self-sufficiency? I don't understand that part of it.

**Barb Scott**: Currently we rely just on the clinical decision. We don't use a threshold for how much income they're making. We leave it up to the physician to make a call as to whether or not that individual is capable of self-support. We make our decision based on what comes from the clinical advice.

**Alison Poulsen**: In that consideration, you'd be looking at it over not for that year, but over the lifetime of that person, that if they hadn't hit that self-sufficiency at that age, could potentially have had their health insurance covered?

**Lou McDermott**: Alison, I think one way of describing it would be if you had an individual who is temporarily disabled at 25 and by the time they were 28 they were better. So they were physically able to go out and get a job, self-sufficiency. Then at 35 had a car accident and was injured and now disabled again, continually bouncing back onto the insurance because of new circumstances, different circumstances. I think when these cases are reviewed, if somebody has a disability, the sense of disability when we think about it, it doesn't just go away. But there are reasons why folks aren't able to be self-sufficient right around that 26 age because of various circumstances. Maybe they were injured. Maybe this has happened or that has happened. I think it's viewed in a more holistic way. To your point, they're just barely self-sufficient and then a few years later their condition worsens and they're not self-sufficient, and now they're out – I don't think it's looked at that way.

**Alison Poulsen**: That's helpful. Thank you.

**Barb Scott**: The one thing I do want to be clear about is that the disability had to have occurred prior to age 26 in order for this eligibility to go into place. It couldn't happen at a later date after that, then gain eligibility at that point.

**Alison Poulsen**: Yes, I understand that. Thank you.

**Dave Iseminger**: This is why we have very detailed minutes for this discussion because it informs the record as to decisions that you're making. Another thing to clarify for you and the record as on Page 7, I just want to go back a little bit to that first bullet, the second sentence that talks about the child's relationship to the employee and that ending date. It's really going back to Sean's question. I want to make sure people are clear that this is about eligibility. When coverage ends is a separate concept, a separate resolution that Barb's foreshadowed the recommendation. Just making sure that's clear. Although those can be related, they do not have to be identical dates.

**Pete Cutler**: Since Dave brought up that bullet, I'm curious about whether, for state-registered domestic partners, the only ways the relationship can end is through a divorce, annulment, dissolution, termination, or death. Because if somebody just walked away – let's say you have people in a partnership, one of them had a child, that child gets under coverage, and then the parent of that child just abandons the

relationship. If they're married, they're still married. I have no idea how rules about domestic partnerships work.

**Dave Iseminger**: There is a registration requirement with the Secretary of State's Office and a formal dissolution process that has to go through a Superior Court. There is a legal piece of paper, essentially, similar in concept to filing a paper with the county clerk for a marriage license. Then it's not as simple as walking away. A spouse could walk away from a marriage in theory, but to actually dissolve or divorce there has to be the court proceedings. There is a similar formal court dissolution process for state-registered domestic partners.

**Pete Cutler**: That answers my question. That's all I was curious about. Thank you.

**Lou McDermott**: All right. Let's go through the voting process.

**Policy Resolution SEBB 2018-02 - Dependent Child Eligibility Criteria:**
**Resolved that**, the eligible school employees enrolled in SEBB benefits may enroll a child up to age 26 that satisfies one of the following criteria:

- Children of the employee based on the establishment of a parent-child relationship as described in RCW 26.26.101, except when parental rights have been terminated;
- Children of the employee's spouse, based on the spouse's establishment of a parent-child relationship, except when the parental rights have been terminated. The stepchild's relationship to the employee (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;
- Children of the employee state-registered domestic partner, based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the employee (and eligibility as a dependent) ends on the same date the employee's legal relationship with the state registered domestic partner ends through divorce, annulment, dissolution, termination, or death;
- Children for whom the employee has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
- Children specified in a court order or a divorce decree for whom the employee has a legal obligation to provide support or health care coverage; and
- Children of any age with a developmental or physical disability that satisfies all of the following criteria:
    - The employee must provide proof of the disability and dependency within 60 days of the child's attainment of age 26;
    - The employee must agree to notify the SEBB Program, in writing, no later than 60 days after the date that the child is no longer eligible under this subsection;
    - A child with a developmental or physical disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which he or she becomes capable of self-support;

- A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility if he or she later becomes incapable of self-support;
- The SEBB Program will, with input from the applicable contracted vendor, periodically certify the eligibility of a dependent child with a disability beginning at age 26, but no more frequently than annually after the two-year period following the child's 26th birthday, which may require renewed proof from the employee.

Katy Henry moved and Sean Corry seconded a motion to adopt.

Voting to Approve: 9
Voting No: 0

**Lou McDermott:** Policy Resolution SEBB 2018-02 passes.

[Alison Poulsen left to go to the Capitol for a bill signing. She will return. There was a pause in reviewing the resolutions and Megan Atkinson returned to answer questions that came up while the Board awaited Alison's return.]

**Megan Atkinson**: Slide 8 of my presentation. It's my understanding there were questions that came up after you had a chance to think through the financial discussion. There are a couple of things I want to clarify. On this slide, the statewide headcount of 133,906 and the statewide FTE of 109,902. In my conversation with you I also referenced state-funded FTE of 94,000. All three of those numbers are those individuals – headcount or FTE – at the 630 hours and above. I say that in the bullet, but I didn't verbally say that when we were having the conversation.

One of the questions I was asked was around what are these numbers, do they take into consideration the cut-off – the SEBB benefits eligibility cut-off of 630 hours? They do. The other point that was brought up to me – and it is 100% valid – is we do not currently have visibility or insight into whether the proportions of part-time versus full-time are different on the locally-funded staff than they are on the state-funded staff. It is very possible that those are different. If you took the segment of the population, the roughly 15% of the total that are locally-funded FTE, those could break out to a different proportion of part-time versus full-time. Then if you look at the 85% that are state-funded staff, it could be, for example, that there's a larger proportion of the state funded that are full-time, versus the proportion of the locally funded that are full-time.

What that means, to some of the points Wayne was making earlier today, is when you make the move from an FTE basis to a headcount basis, the sort of binary eligibility issue where you're either eligible or not at the 630 hour cut-off, if the locally funded staff have a different mix of part-time versus full-time than the state-funded, then the financial pressure to the state funding stream is different than the financial pressure to the local funding stream. That is absolutely correct. We just don't know. We don't have visibility into that breakout. One of the things we have talked about, as internally we are talking this through from an academic perspective only, it would be interesting to see if district hiring practices change with the bar set at 630 hours. With this move, at the 630 hours people fall in or out of eligibility. From a financial standpoint, this puts financial pressure

on the district that is different possibly than pressure at the state level. As we gain more visibility into that and can find and access more data around that, we will bring that to you. We are furiously combing through the data that are publicly available to us through OSPI. However, we have data limitations right now.

I also wanted to validate the current mechanism is FTE funding. I believe there's no one rule for the way it plays out across all the districts, but it's broadly implemented that if you are .3 of an FTE in terms of the number of hours you work, or .5, or .7 of an FTE, broadly speaking that is the portion of the health care benefit allocation that you receive. You make the rest up through your own resources. That is a different world than the binary world of you either get benefits or you don't. Is there any additional context anyone wants to lay on that because it is a shift.

**Patty Estes**: Can you give some examples of locally funded versus state-funded employees? I know there's basic education, all that. I get it. But just some examples so we can understand.

**Megan Atkinson**: I am just going to take a very simplistic one. The state has set certain class size requirements. The state then funds based on the district reported enrollment. The state then funds certain, I'm going to stay with the certificated staff, certificated staff assumptions based on the data around that district's enrollment. Those state-funded staff are recognized in the K-12 funding formulas and also recognized in the K-12 state-funded funding stream that goes to the districts. It is also very common in the districts that the districts supplement with other staff that aren't necessarily recognized in the state-funded funding formulas. So then those staff are locally funded. Again, there are different hiring practices across the districts in terms of how they supplement the state-funded and state-recognized educational program. That's a very high-level distinction between what the state recognizes and the state funds on the K-12 program – and then what the districts supplement with.

**Patty Estes**: Could you go into classified staff? I know that's where a lot of the under 1.0 FTE employees lie. They're mostly classified now.

**Megan Atkinson**: There's also recognition in the K-12 funding formulas for certain classified staff components. On the classified staff, again, it varies by district. I believe if you look at something like the food service workers where you're bringing in the classified staff, and it's either difficult or maybe even impossible for the district to put together a full-time position for those job duties. I don't know.

**Dave Iseminger**: I think Julie is offering to come up and provide insight.

**Wayne Leonard**: I will add, just quickly, our current accounting system doesn't really distinguish between the funding source of an employee and that's something the state Legislature is going to require us to go toward. But in the current accounting system, there's no distinction between employees that are state funded or employees that are locally funded.

**Julie Salvi**, Washington Education Association (WEA): Let me give you some examples. Food service is a program where it's largely federally funded or local levy

dollars so, food service workers would be an example. Think about special education and all of the paraprofessionals in special education. The state puts out money for special education, but districts are often spending a lot of local dollars to help make that program whole. So some of those staff are going to be considered state funded, some are locally funded. So there's a lot of nuance between types of positions and the state often funds some of what districts are using to operate their schools. But then anyone you think of that is dependent on levies or if levies are going away, those are the positions that are locally funded. The accounting system will catch up and districts will start dividing it and making it more clear as time goes on.

**Patty Estes**: Okay, so how are we able to come up with the financial numbers that we have on here, saying that its contributions in excess of $200 million when we don't really know what those state and locally funded things are. There's so much confusion around it, how are we coming up with any numbers at this point?

**Megan Atkinson**: We do know at the statewide, regardless of fund source, we know the total number of headcount and the total number of FTE.

**Patty Estes**: That's only the state funded?

**Megan Atkinson**: No, that's statewide. All the workers if you will.

**Patty Estes**: Statewide headcount, whether they're locally funded or state funded, will get an allocation of benefits.

**Megan Atkinson**: We know that statewide there are 133,906 headcount in the K-12 system.

**Patty Estes**: School employees system. Okay.

**Megan Atkinson**: Yes. And we know that there were, in this year, 109,000 FTE. We know in the statewide funding formula that the state-funded portion of FTE, if there's 109,000 total all funded FTE, 94,000 of them were state funded. What we did not know is how that 94,000 state-funded FTE plays out in terms of headcount. I do the same proportions on the statewide, regardless of fund source, the proportion of FTE to headcount, and I assume that same proportion, this is the big assumption. If I assume the same proportion applies to state-funded FTE to headcount, then I could calculate the delta and the impact of going on state funded from FTE to headcount.

**Patty Estes**: I'm still confused as to how that's hurting the district, to go to headcount. I feel like that's going to get more funding.

**Megan Atkinson**: Because the districts for the locally funded staff, the staff that districts are employing and using in their educational program who aren't recognized in the state-funded funding formula, the district is using local funds.

**Patty Estes**: That I totally understand. But if we're saying there's 133,906 headcount, then wouldn't we get the allocation for that headcount?

**Megan Atkinson**: No. You'll only get that state allocation for the state-funded headcount.

**Patty Estes**: But we don't have that number.

**Megan Atkinson**: That's the number I assumed and calculated.

**Patty Estes**: But we don't have it for sure.

**Megan Atkinson**: Right. It was an assumption. I calculated it based on the proportions.

**Patty Estes**: And that was the 109,000?

**Megan Atkinson**: Right, for the proportion of the 109,000 to the 133,000. What we don't know is if the hiring practices are such that the part-time staff are more concentrated with local dollars versus state dollars.

**Patty Estes**: All right. That's a little better.

**Dave Iseminger**: Chair and Board, I recommend we move back to the other provisions. Certainly not a light topic in that 15-minute filler for Megan. I appreciate her pinch-hitting. This is not the end of the finance conversation.

**Megan Atkinson**: We'll be coming back and I appreciate the engagement on this. I realize it's very difficult information. Thanks.

**Barb Scott**: Slide 9 - Policy Resolution SEBB 2018-03 – Extended Dependent Child Eligibility Criteria. We're going to pick back up on Policy Resolution SEBB 2018-03. There is a change in the last sentence of the resolution where it says, "Extended dependent child does not include a foster child unless the employee, the employee's spouse, or the employee's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption." This language was added in order to recognize that – and I'll connect it back to the other child eligibility slide we just finished up - we may have folks who are transitioning to adoption of a child. We often see this with foster children. The foster child will be taken into the home in advance of an adoption occurring. We wanted to recognize that for those children eligibility would exist. But for foster children where a payment is being received from a state under a foster care program, then those children would not be included under this eligibility criteria. We did have some stakeholder feedback in relationship to this eligibility. It was mainly in the form of questions related to it.

**Pete Cutler**: I don't think I've run across the term "extended dependent" before, so I'm lost right at the starting gate. What is an "extended dependent?"

**Barb Scott**: That is one of the questions we received from stakeholders, so it's obviously confusing. The most common example we use for this is grandparents who are custodian or have guardianship of their grandchildren. There are many other situations that exist, but that is one example. One of the questions we received from

stakeholders was specifically, “what children might qualify under this eligibility?” This is the example that we provided to them. The other question we were asked in relationship to this eligibility was if the eligibility would extend beyond age 26. Based on that question, we modified the policy resolution to include the limiting age of 26, which is stated in RCW 41.05.740. Eligibility can’t go beyond age 26, except in the case of children with disabilities as we already have a resolution that’s been passed.

**Patty Estes**: That was actually my question. There was no language in here about an extended dependent with disabilities, so that would refer back to – so even though it says that parent-child relationship needs to be established?

**Barb Scott**: In the earlier eligibility – I would have to look back to answer – you asked me a question that puzzles me slightly. I want to look back at that other resolution, but we do have under the extended dependent eligibility criteria some children, I believe, who are over the age of 26 where there is a custodial arrangement in place that would qualify under this within the PEBB Program. I know I’ve seen this example within the PEBB Program eligibility. There are very few of these. We have a small number of disabled dependents, I believe. Within the PEBB Program eligibility there are 549 children over the age limit who are on benefits under the disabled dependent eligibility criteria. There is a tiny number within that who are children who are also extended dependents, who are disabled and the disability occurred prior to the age of 26, and the child has been under the employee since that time. So they qualify under both eligibility categories, in order to retain the eligibility. If that answers your question I would expect that we would administer it in the very same way for the SEBB Program. That would be our intent.

**Patty Estes**: Okay.

**Lou McDermott**: **Policy Resolution SEBB 2018-03 - Extended Dependent Child Eligibility Criteria**:
**Resolved that**, eligible school employees enrolled in SEBB benefits may enroll a child up to age 26 that is an extended dependent in the legal custody or legal guardianship of the employee, the employee’s spouse, or the employee’s state registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child’s official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the employee, the employee’s spouse, the employee’s state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption.

Terri House moved and Patty Estes seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0
Absent: Alison Poulsen

Policy Resolution SEBB 2018-03 passes.

**Barb Scott:** The next step will be to incorporate these policy resolutions into SEBB Board rules.

**Eligibility and Enrollment Policy Development**

**Barb Scott**: I'm going to introduce three new draft policy resolutions for discussion by the Board. They are effective date of coverage following hire, election period for new hires, and SEBB Program premium tier structure. Again, we've included a slide with an excerpt from 41.05.740(6) just to draw you back to the RCW that authorizes you to make these policy decisions on these three items. Staff have highlighted in blue the area that covers the three proposals that you're going to look at today.

Slide 4: Proposed Policy SEBB 2018-12 – Effective date of Coverage Following Hire.

The first policy decision is to consider what the effective date of coverage should be for employees following hire. We may need to have future discussions regarding effective date of coverage for a number of other circumstances, for example, employees who regain eligibility or returning employees. This policy focuses very narrowly on the effective date for new hires. Staff looked through websites at information that was available to them to see what exists within school districts today. Within the eligibility for coverage following hire, they found a variety of different things. In some cases, it was after ten days of work within a district. Sometimes it's driven by when the pay periods are within a district, as well. There were a couple of places driven by when paperwork is turned in. What we found with all of them is that it is prospective. We expected to find that because it's consistent with taking elections under a Cafeteria Plan. Under the IRS code it's required that an election be prospective.

There is some eligibility in the PEBB Program that is also complicated and prospective, adding the complexity of what is the first working day for most employees within a calendar month. We didn't add that into this proposal. Instead, we tried to come up with a simple standard that could be understood by both employees and employers. What we are proposing is that for benefits-eligible school employees, the effective date of coverage is the first day of the month following the date the employee becomes eligible. We intentionally tied it to when the employee becomes eligible for SEBB Program benefits rather than their date of hire. Although we haven't had a deep enough dive to see all of the circumstances that exist, in my experience with the PEBB Program some employees are hired well before and work for an employer before they actually gain eligibility for benefits. I wanted to make sure we recognized that there may be a period of time before somebody hits eligibility in certain circumstances, based on hiring practices

**Sean Corry**: I have a question and it basically is a request for continued explanation about what eligibility means. The words here are "the date the employee becomes eligible." Eligible for what? For benefits?

**Barb Scott**: Eligible for SEBB Program benefits. In writing this, I believe staff were leaning on being eligible for the employer contribution toward benefits.

**Sean Corry**: If the employee becomes eligible for contribution for benefits on the first of the following month after the date of hire, when would coverage begin?

**Dave Iseminger**: The first of the next month.

**Barb Scott**: The first of the next month. In drafting this, we anticipated that employees could become eligible based on if an employee isn't anticipated to work 630 hours, but in the middle of the month they hit that threshold, then coverage would begin the first of the following month.

**Patty Estes**: So, the first of February?

**Barb Scott**: Yes, the first of February.

**Patty Estes**: Okay.

**Dave Iseminger**: Sean, we'll take back some feedback to see if there's a way to add "for what" at the bottom for clarity. But this is designed to hit both the complicated factor of anticipated to work and then actually working. Despite everyone's best intentions, sometimes anticipated to work doesn't hit people who actually meet the requirements and so it has to straddle both of those pieces. That's why it sometimes has been tied to the employer contribution. It's really "meets the eligibility requirements" whether that's anticipated to work or actually working.

**Barb Scott**: Sean, did you have some specific thoughts on wording because I want to hear those if you do.

**Sean Corry**: I don't have specific thoughts on wording. I'm just trying to work through in my mind how the administration will work, how money will get transferred, how payroll deductions will work. I'm trying to get clearer on the trigger dates.

**Dave Iseminger**: There is an operational piece about this I want to make sure is clear. It could be that the form is received and the enrollment is retroactive even though the eligibility is prospective. What I mean by that is, in the January situation we just described, let's say an individual hits the eligibility requirement of 630 hours on January 15 and they have 31 days to turn in their election. I chose 31 days based on the next resolution. They have until the middle of February to elect a plan even though the effective date of that plan will be February 1. Until they elect a plan, there won't be a payroll deduction, so there'll be a catch-up in payroll to accommodate the retroactive piece. And that's why on the next resolution, the length of election period is so key because one of the things it impacts is how long that retroactive period can be and how much catch-up there has to be from a payroll perspective. That doesn't mean that benefits aren't effective February 1. It's just the person might not have their card until they've turned in their election. If they turn it in on the last day allowed, the enrollment is made retroactive. Any services they had that qualify for coverage under that plan would then be covered services.

**Barb Scott**: Sean, as you looked at the words and "Eligible for what?" did you have some thoughts as to how you filled in that blank?
**Sean Corry**: Not at the moment.

**Barb Scott**: In drafting this we are thinking the effective date of coverage should be tied to when the employee actually becomes eligible to receive dollars toward paid benefits

rather than to a hire date. That's really what we were trying to sync up. Any thoughts you may have related to that, I would love to hear.

**Patty Estes**: I'm going to use an example. A substitute employee is working and then gets hired on permanently, has already worked 630 hours as a substitute, and is not voted on to become an employee until the School Board meets, votes on that, and then they are hired and become a school employee. How is that kind of situation handled with this?

**Barb Scott**: In what you're describing to me, regardless of the hire date, because that employee is employed by the district they would have eligibility when they hit the 630 hour threshold. The other piece you're describing seems to be a formality and will have nothing to do with benefits.

**Patty Estes**: Okay, because currently it does.

**Barb Scott**: This shows me some lack of understanding for how things are functioning within districts so I'm listening here and hoping to understand.

**Dave Iseminger**: The key piece being once eligibility is attained, a benefits offering has to be made. This resolution is about the effective date of those benefits.

**Patty Estes**: Okay.

**Barb Scott**: I'll add one piece to that. We have a good amount of history with higher education faculty and you'll see staff trying to be attentive to how these things are structured in order to not create labels. You'll see us taking extra care in order to not recreate some of the situations that higher education has walked through with litigation. Patty, you described that a substitute hits a 630 hour threshold, but didn't formally get hired yet, that would cause me to think it's just a formality and the eligibility had already been established when they hit the 630 hour threshold.

**Sean Corry**: Lots of districts have lots of substitute teachers who are not benefit eligible who work more than 630 hours.

**Dave Iseminger**: If they're employed by the district and they end up meeting and hitting the minimum threshold, they become benefits eligible.

**Sean Corry**: Right. For some districts that's an additional number of employees who might not be funded by the state.

**Dave Iseminger**: Even if they weren't anticipated at the point of hire, if they hit the eligibility requirement and they are an employee, they become benefits eligible.

**Patty Estes**: That was partially my point, is that it's going to add quite a bit to that benefit coverage in the middle of the year.

**Terri House**: I have a different part to that question. A lot of classified employees are bus drivers and their times shift drastically during the school year. One month they

could drive eight hours a day. Another month they could drive four hours a day. Another month they could drive two hours a day, depending on student transports. My question is are we basing it on what they start at and if they slide up and down, as long as they accumulate the 630 hours?

**Dave Iseminger**: We're going to spiral quickly into a lot of other parts of eligibility that have yet to come to the Board. This resolution that we're teeing up is about when benefits are effective and all of the questions you're asking about are extremely important, but there is a framework that we're building on. There is a chicken and the egg and where do you start? I don't want to stifle conversation, but I do want to make sure that we get to all of the parts of the agenda and the votes that are necessary because we have to proceed with procurement at the end of this month. I do want to make sure that we do that piece. At the same time I know there are important questions about eligibility.

**Barb Scott**: Send us any thoughts you have that relate to this. Like I said, we will be releasing these to stakeholders and we've committed to two calendar days after Board Meetings. We'll get their feedback. We don't want to miss insight that we truly don't have at this point in time. Staff are trying to map these out and run scenarios in order to figure out how this looks. Are there things that we might need to come back to you and pick up as we learn more?

**Dave Iseminger**: Terri, related to your question, this Board will still have to address things like what hours count, do training hours count, etc.? You're possibly talking about averaging of hours across a period. Or there might be individuals who work at multiple school districts and we have to talk about stacking. Those are all things related to the eligibility framework and I just want to remind you this resolution is about when the benefits for people who are eligible, the medical effective date of those benefits. I should clarify what I just said. I said medical effective date. It's not just medical effective date, it's all of the benefits, the effective date for them.

**Barb Scott**: That is why we move from hire date to eligibility. That is specifically the reason we moved away from the word hire.

**Dave Iseminger**: The last piece I want to add is context, because Patty asked this question on a different resolution. When school districts have joined the PEBB Program, one of the most frequent requests of changing eligibility granted by the agency is the extra complexity layer that Barb glossed over, which gets to this exact setting. In the PEBB Program, if the first working day is the first of the month, benefits can begin then, but it's one of the most frequently requested changes by school districts joining PEBB Program benefits. Instead they ask to have the effective date of benefits be the first of the next month. We took that experience into consideration in making this recommendation.

**Barb Scott**: The only guardrail I had on this one, so far, is that you could not go out more than 90 days post eligibility. The Affordable Care Act limits you to less than 90 days.

**Patty Estes**: I think where a lot of us are becoming confused and I know you don't want to say "hire date," but if this is specifically for a new hire, I think the "becomes eligible" portion is where we are all spiraling out because somebody can become eligible in the middle of a year. They could become eligible six months after they're actually hired. That's where I think, if this is specifically towards new hires, I think the wording needs to change in some way, shape, or form to specify the new hire.

**Barb Scott**: Working the minimum number of hours; something like that?

**Patty Estes**: Something along those lines. I think that's why we're all going "oh my gosh." "Becomes eligible" is such a big, giant monster.

**Barb Scott**: Slide 5. The second policy decision is to consider what the election period is, and once again, I have new hires here. Maybe we need to pull back from that, I'm hearing. What that should be, and when we talk about an election period, we're really talking about the period of time in which an employee is allowed to make an election for medical coverage, to make elections under Cafeteria Plan. So FSA, DCAP, depending what ends up being offered under a Cafeteria Plan. Elections for dental, life insurance, disability, whatever types of insurance, we're talking about all of those elections in the time period based on when the employee is newly eligible.

Proposed Policy SEBB 2018-13 – Election Period for New Hires. An employee must make enrollment elections, including an election to waive SEBB medical no later than 31 days after the employee becomes eligible for SEBB benefits. We'll come back to waiver in a separate resolution at a different date, as to what would be included in that. We looked at what districts are offering. Most all of them are prospective and most all of them have either a 30-day or a 31-day deadline. We went with the longest, being 31 days. The only guardrail on this one was within the IRS code as far as election periods, there's a recommendation that it be 30 days. 31 days is what the PEBB Program uses.

**Dave Iseminger**: One other piece for clarity. We've talked about the Cafeteria Plan and the need for prospective elections, but even within that prospective election requirement, there is that slight allowance for a modest retroactive enrollment. In the January example we talked about earlier where somebody turns in their paperwork in the middle of February and the benefits are effective February 1. That's all permissible with the Cafeteria Plan because that's still deemed prospective. The Cafeteria Plan is designed to not allow significant hindsight, perfect 20-20 vision, and then utilize that to your tax advantage. There is this allowance for a slight retroactive enrollment timeframe.

**Barb Scott**: The election has to be based on an event and the election has to be made within close proximity of whenever that event was, and 30 days is close proximity.

**Dave Iseminger:** Other questions, comments, thoughts, at this initial proposal stage? We will have another resolution at a future time about what happens when an individual doesn't do whatever they need to do within the prescribed time period.

**Patty Estes**: How does this play out with the allocation funding? When would the school districts get the funding for those benefits? So, say 31 days, but they don't

actually get that allocation for 60 days or something like that. Do we know that timeframe?

**Dave Iseminger**: Let's bring that one back to you. I have strong ideas as to what the answer to that is, but not enough that I feel comfortable answering it now.

**Barb Scott**: Let's move to the final policy decision for today. Slide 6 is a policy decision that would have the Board consider what the SEBB Program premium structure should look like. Within the premium structure for the SEBB Program, this slide would propose there be four tier categories with the premium tier ratio for each of those tier categories shown here. These premium tier ratios would achieve the 3:1 ratio, which is required. The premium tier ratios shown are not exact to what the PEBB Program has currently for premium rate structure. Theirs is slightly different.

**Dave Iseminger**: A couple of things I alluded to in John's presentation. Remember that under the PEBB Program structure, it's very similar to this except for the 3 at the subscriber spouse/state-registered domestic partner and any children is a 2.75 ratio in the PEBB Program. Now under the legislation, again not yet acted on by the Governor yet but we're going forward with an assumption based on agency request legislation that was supported, at least this provision, from the Governor's Office, the maximum that range could be is a 3:1. We know there has been such variability in the system and this movement to a 3:1 ratio, in and of itself will be part of the major disruptive force within this consolidation effort. Our recommendation is to simply utilize the full compression ratio allowed under the law. I do want to highlight that under the legislation you are only required to have two tiers because it only describes the ratio between what this calls "full family." In being thoughtful, we've decided not to use the phrase "full family" because we don't want to suggest to the community that the only people who are families are people that have a significant other and children. You can be a subscriber, have children, and be a family. We're not using the language that is in statute, but that is effectively what is meant by the 3:1 ratio. You're only required to have what is that lowest tier, the lowest on the page here, of all dependent coverage at 3 and a subscriber at 1.

We moved forward with the recommendation for four tiers in part because of the data we saw and the benchmarking we did had generally four tiers. There were a few school districts that had five or six tiers, generally in a situation that distinguished between number of children. We felt the majority of what we saw was a four-tier world and we put that forward. Additionally, we put forward the 1.75 and 2, in recognition that there were more people in the data we looked at that had added children before they had added any spouse or state-registered domestic partner. This would continue to encourage enrollment in that same way.

You, as a Board, have flexibility to say "two, three, four, six tiers." You also have discretion within 3:1 to put those numbers where you want. But our recommendation is this structure. You, of course, could flip the second and third tier and have some sort of extra encouragement for adding spouses or state-registered domestic partners over children. This recommendation is based in part because of the data I had pointed out earlier with John's presentation related to children enrollment numbers.

The other piece I want to make sure is clear is that this premium tier structure ratio would apply for any benefits where dependents can enroll, regardless of the payment structure. What I mean by that is medical, dental, and vision. Anywhere there's a premium differential. It would not apply in instances like life insurance because dependents don't have separate enrollment rights. That's actually the employee who is electing coverage on their own behalf to cover their dependent. That's not an independent right, so this wouldn't apply to life insurance or disability insurance. This would be a premium tier structure that could apply in the medical, dental, and vision scenarios.

**Pete Cutler**: Can you send us the premium tier ratios for the PEBB Program and are you anticipating that those will stay the same as they are currently, going forward for your procurement?

**Dave Iseminger**: I can give them to you now. It's the same structure and wording on this page except the "3" is "2.75."

**Katy Hatfield**: Except the spouse is $10 more.

**Dave Iseminger**: You're right.

**Barb Scott**: There is an additional $10, so it's 2.75 plus $10.

**Dave Iseminger**: We'll send it out afterwards, it's not as simple.

**Pete Cutler**: I think it would be helpful to have it in writing. Is there any exploring the option of changing it in PEBB or is the idea would be to break from PEBB?

**Dave Iseminger**: The idea would be breaking from PEBB at this point. There's not a specific discussion about changing tier structure rates in the PEBB Program.

**Pete Cutler**: Would it be reasonably easy to calculate if the PEBB Program used the 3:1 ratio proposed for SEBB, how that would affect the cost of the family coverage and the other coverages? Just to get a sense, because right now it's very abstract. You have the general point that this will result in the family coverage being a little more expensive compared to the PEBB Program, with all other things being equal, but much less expensive compared to what most school employees have as their option now. It would be nice if we had some kind of number to have a sense of order of magnitude in terms of an example.

**Dave Iseminger**: Let me clarify, Pete. That's what I was thinking you were asking, is an order of magnitude difference using the PEBB population as a proxy for whether you may want to consider, as a Board, compressing further to 2.75.

**Pete Cutler**: Right.

**Dave Iseminger**: Okay. We can follow up with that.

**Lou McDermott**: I think on that issue the thing to keep in mind would be, yes, there would be a difference in the premium calculation to what a full family would pay as opposed to a single individual. But it would be hard to know what they currently pay under the current situation because that would be the difference. That's where the 3:1 ratio is going to go a little easier on the single subscriber than a 1 to 2.75 ratio will put more pressure on the single subscriber premium. We can look at that.

**Wayne Leonard**: In this slide, this is the same as – I think it was described earlier in your summary of ESSB 6241 and the 3:1 ratio – but back a few pages, where it has RCW 41.05. Instead of the premium payments being 3:1, it talks about the cost to the employee, the cost of family coverage.

**Dave Iseminger**: Wayne, if you follow along at a further part it says, "Not exceed three times the premiums." So that's where the shift is focusing to the premium differential.

**Wayne Leonard**: So the clarification, are we talking about the out-of-pocket cost to the employee when you're talking about premiums.

**Dave Iseminger:** No, we're talking purely about the employee contribution per month from a premium perspective. Not things like coinsurance, out-of-pocket, deductibles. It's just the premium piece. Monthly premium.

**Wayne Leonard**: Right. I'm just making up numbers here, but for a single employee they pay $200 a month out of pocket –

**Dave Iseminger**: For premium.

**Wayne Leonard**: For premium. The policy for a single employee might be a lot more; it might be $1,000, but they're paying $200 and the married full family is $600, so we're talking about out-of-pocket premium.

**Dave Iseminger**: Out-of-pocket monthly premium. Yes.

**Wayne Leonard**: Is the 3:1 ratio?

**Dave Iseminger**: Correct. I'm always trying to say, "Full-dependent" coverage instead of "full family." Barb, we're going to work on modifying these resolutions based on Board feedback regarding new hires and eligibility and then send to stakeholders for comment.

**Barb Scott**: Good enough. So we'll modify them, send them to stakeholders for their feedback, and bring back to you at your next meeting. Thank you. I know this is hard work and I really appreciate it.

**BREAK**

**SEBB Policy Resolutions: Benefits**

**Dave Iseminger**: These resolutions are identical to the ones presented to the Board at the January meeting. As we move forward, we'll put the eligibility rules into a robust

stakeholdering process. These benefit resolutions went through that process. I will go through some of that feedback.

Slide 4: Resolution SEBB 2018-04. This resolution is about a fully insured medical plan. The agency is anticipating that this resolution is probably fairly non-controversial and you want us to look at a wider carrier offering than exists within the PEBB Program population. The only way we can do that is with procurement. We're anticipating you're looking for multiple carrier options that have widespread coverage across the state, but not necessarily a single carrier that has statewide coverage. We didn't receive feedback on this resolution.

**Lou McDermott**: **Benefits Resolution SEBB 2018-04:**
**Resolved that**, the School Employees Benefits Board Program shall perform a fully insured medical plan procurement from multiple carriers with widespread coverage offerings.

Patty Estes moved and Katy Henry seconded a motion to adopt.

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-04 passes.

**Dave Iseminger**: Slide 3: Resolution 2018-05 relates to self-insured medical and is at a high level. This is one of those chickens and eggs. At some point there has to be a discussion at the state level as to whether the liability for claims is something the state wants to take on and then there is discussion about reserves. Passing this resolution would help set in motion further discussions that this Board is indeed interested in having this self-insured plan similar to Uniform Medical Plan. Not necessarily identical, but would be a self-insured plan in the state that has statewide coverage and generally similar features described in the resolution about provider networks, clinical policies, and an integrative pharmacy benefit.

From the Board's perspective, we'd proceed with discussing financing with other parts of the authorizing environment. And then there will be subsequent resolutions in the next couple of months talking about more granular benefit design. This is really at the high-level macro stage that the Board would be interested in having a self-insured plan in the mix if the state will take on the financial responsibility associated with that. No specific feedback received on this one.

**Pete Cutler**: Could you comment briefly on the concept of "leveraging features?" I take it to mean that it doesn't have to be absolutely identical to the Uniform Medical Plan in every respect. Does the Health Care Authority have any other kind of comments it could add in terms of what it has in mind with that phrase?

**Dave Iseminger**: Pete, the state recently awarded a contract for the third-party administrator (TPA) of the Uniform Medical Plan to Regence for January 1, 2020 through December 21, 2029. Part of that contract went ahead and envisioned a possibility, and we negotiated some features of that contract including a per subscriber

per month administrative rate for the SEBB Program, depending on how similar the structure of the plan is to the Uniform Medical Plan. If there are enough similarities between the plans, then we can immediately leverage that contract. That is envisioned more with levels of the benefit coverage. We would think the core things of what's generally covered. It's possible to have some refinements, not extensive ones, but using the same provider network and clinical policies would be much more similar than different, more identical and the real differences might be in more granular aspects of the covered benefits.

That's what we're trying to get at with leveraging, is we're trying to make these core pieces, the clinical policies administered under the plan, how the pharmacy benefits are integrated, the provider networks are the same - those would be much more identical. When it comes to covered benefits, there might be more nuances there. That's the granularity I was referring to, coming back to the Board with subsequent resolutions.

**Sean Corry**: What I'm hearing is that the contract that runs in more than a decade now has wired into it, effectively, restrictions – in some respects – to what we might have otherwise have wanted to implement.

**Dave Iseminger**: No, that's not what I meant to say, Sean. We tried to anticipate a world in which HCA might be able to use our existing contract. If the plan is not the same and the Board specifically wants something very different, we wouldn't be able to use that contract. To be very forthright, we wouldn't have time to create a whole separate self-insured plan for 2020. It takes three to four years if you were to start from scratch for a self-insured plan. For a self-insured plan to be on the table for 2020, it would need to be pretty similar, but not identical. We were able to negotiate in advance a potential PSPM (per subscriber per month), if the plan designs are similar. That does not lock this Board into a specific decision. If this Board reaches decisions, and we'll make sure that we're clear about those as we're going along in a granular discussion, that's an impact.

As I've said, if we started from scratch for a self-insured plan for this Board, we would need to separately procure a TPA if it was substantially different from the Uniform Medical Plan, and we wouldn't be able to do that for 2020. It took us three years to do the procurement for the TPA for the plan that we already had. Building up the plan from scratch, we wouldn't be able to hit that for a self-insured option for 2020. This was a way for us to set in motion ways to leverage the contract negotiation we were already in, but that does not lock you in. It just locks the TPA in, if we produce something that is similar enough.

**Sean Corry**: So we all have a strong incentive to have something similar. That's basically it. Because otherwise we sort of blow things up.

**Dave Iseminger**: That's regardless of the contract provision on a PSPM. If you want something that is substantially different from the Uniform Medical Plan, we would have to start from scratch and there simply isn't a long enough ramp for that. The question would really be, do you want something that's substantially similar to the Uniform Medical Plan or no self-insured plan at all because we wouldn't be able to launch a new self-insured plan for 2020. That would be in the pipeline for more like 2022. That's just

the realities of this self-insured option. I recognize that does put you in a bind with regard to some of the aspects of a self-insured plan, but that really is the only path forward for a self-insured plan for 2020 given the benefits launch date. However that doesn't, and you're not required, statutorily, to have both self-insured and fully insured plans. There's no obligation for you to offer a self-insured plan. If you do, and you want it for 2020, it would need to be pretty similar to the Uniform Medical Plan.

That doesn't mean coinsurance couldn't be different. There could be different copayment mechanisms. There could be some refinements around some of the covered benefits or exclusions. But a wholesale new plan that has wide differences would never have been in the cards, regardless of what our contract was on the Uniform Medical Plan TPA. We just had that opportunity while we were negotiating, and tried to pre-negotiate a piece to take another work stream off the table if the stars aligned in that way.

**Sean Corry**: Thank you. That was helpful. Just a question really of where the margins are. What the limitations on our practical choices will be.

**Dave Iseminger**: We'll be going through that with the more granular pieces of this. This is just setting the stage for the conversation that we want to keep going on that journey.

**Lou McDermott**: **Benefits Resolution SEBB 2018-05:**
**Resolved that**, beginning January 1, 2020, the SEBB Program will offer self-insured medical plans that leverage features of the Uniform Medical Plan such as covered benefits, provider networks, clinical policies, and an integrated pharmacy benefit subject to final financing decision.

Terri House moved and Wayne Leonard seconded a motion to adopt.

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-05 passes.

**BREAK**

**Sean Corry** left at 3:30 but will continue participating via phone.

**Dave Iseminger**: Slide 4. Resolution 2018-06 relates to the concept of fully insured dental plan. I presented this at the last meeting. The Board would say for the launch of SEBB benefits, leverage – and by leverage I mean completely use, in this instance – the fully insured dental plans that are in the Public Employees Benefits Board Program. You may remember from the comparators done at the January 29 meeting when we looked at Lynden, Spokane, Seattle, WEA, and the Health Care Authority, all of those plans, all of the carriers were either Willamette, or Delta, or a self-insured plan that was administered by a TPA. That was an important piece of acknowledging that there was a significant amount of carrier consolidation on this particular benefit design. Recognizing

that, although it's not a complete consolidation, those carriers represent a significant portion of the market.

The number of procurements necessary in order to launch SEBB benefits. HCA is trying to balance different interests and the recommendation is to launch with the PEBB benefits for fully insured dental; but, you notice for this resolution in particular, we recommend setting a timeline and an expectation from the Board back to the agency about visiting this decision right after launch. But given the amount of work that's before the agency and before this Board in the next 18 months for launching benefits, all things considered, this is the recommendation for moving forward with fully insured dental.

I did receive feedback, as did all of you I believe, from Kaiser Permanente Northwest. They sent a letter to the Board, which I believe you all received, that had a description of six school districts in southwest Washington, in Clark and Cowlitz counties, and some of the membership in those counties within their network or their carrier plans. I did want to acknowledge we know and are aware of that concern and balancing a lot of different competing interests. I believe their request wasn't about asking you to endorse a new, fully insured dental procurement, but seeing if there are other ways to thread that needle. I want to acknowledge their feedback, but since I anticipate they want to provide some feedback, I'll let them speak for themselves.

**Lou McDermott**: **Benefits Resolution SEBB 2018-06:**
**Resolved that**, beginning January 1, 2020, School Employees Benefits Board Program will offer fully insured dental plans, leveraging the fully insured dental plans offered under the Public Employees Benefits Board Program.

Alison Poulsen moved and Wayne Leonard seconded a motion to adopt

**Nick Abraham**, Dental Manager, Kaiser Permanente Dental Northwest
**Mike Plunkett**, Associate Director for Strategy and Business Development for Permanente Dental Associates within the Kaiser Permanent system in the northwest. On behalf of Kaiser Permanente in the region and the members that we serve, we appreciate the opportunity to address this critical issue. We'd like to respectfully call to your attention that the resolution currently under consideration would disrupt care and coverage for Kaiser Permanente members in southwest Washington and would be contrary to SEBB's guiding principles. We'll explain that further. We are here to request your consideration to allow for additional services in the fully insured medical RFP to include plans that integrate medical and dental care. Kaiser Permanente Dental is not currently offered as an option within the Washington PEBB Program structure. So if SEBB agrees to offer dental plans and benefits only within the PEBB Program structure, members in southwest Washington school districts would lose their Kaiser Permanente dental plan and ability to see their current dentist. Dr. Mike Plunkett is going to go over more of our medical/dental integration and how that ties back.

**Mike Plunkett**: Thank you, members of the Board, for hearing our concerns. Kaiser Permanente's (KP) integrated medical and dental care is designed to support SEBB's guiding principles and initiatives. Those include evidence-based medicine with a special focus on outcomes for individuals with chronic disease, increased utilization of preventive health services, and better coordination of care, including use of electronic

medical records that promotes more efficient physician order entry and increased access to health information for both consumers and the providers that serve them and lead the care teams. In KP, this includes dentists assisting in closing care gaps for medical members. It also includes physicians closing dental care gaps for members.

Our dentists and physicians use the same electronic health platform. Therefore, we can see patients' health care information and better coordinate services. In fact, Kaiser Permanente was the first system nationally to partner with Epic, the large electronic health record system we use nationally, to integrate dental. We're currently working with them on optimizing that to enhance that care.

To help illustrate this level of integration I'd like to share with you a story about a 40-year old member. I may say "patient," because as a doctor I use it interchangeably because I see patients and do business work. So to demonstrate to you, we have a 40-year old member that came into one of our offices and there was a heightened awareness of this member because she had end-stage renal disease and she was looking to get on a transplant list. Well one of the things that you need is a dental clearance in addition to other services. She was able to come in to one of our offices and get the dental exam. We had a hygiene appointment available so we got her cleaning done. Because our teams work together on electronic record systems, the dental team was able to see that she also needed hemoglobin A1C testing because she is diabetic, and her complete blood count for her renal health. So in this office, we happen to have an integrated medical staff. We had an LPN that day who came over, drew the blood in the dental environment, and that patient who relies on assistance for transportation, was able to in one appointment get her dental exam, her cleaning, and blood draw for both her renal health and her diabetes. That's extraordinary. We do that for most all of our members that we can. Especially where we have integrated care teams.

**Nick Abraham**: So to end it, the recommendation is to ensure that members won't lose the benefits of that integrated medical and dental services that Dr. Plunkett just talked about. Kaiser Permanente requests that SEBB allow members in southwest Washington schools to keep their Kaiser Permanente dental plan. One way to do this is to modify the SEBB fully insured medical RFP to allow for additional services. This change could allow plans that demonstrate the ability to provide medical and dental integration to provide dental services, which to my understanding, SEBB may also be considering possibly for vision services.

**Pete Cutler**: From what you said, it sounds like the resolution we already passed about having an RFP process for fully insured benefits seems like it was flexible enough that it would allow the HCA to include that flexibility to allow a carrier to suggest integrated medical/dental coverage. As you read the provision, or as you understand the provisions we currently have in place in the PEBB Program for the separate dental, could you be offering your integrated medical/dental plan in a way that was consistent with what goes on in the current PEBB dental programs? Or would there have to be changes? Because right now the resolution in front of us is basically to say we'll copy what's going on in PEBB with the dental.

**Nick Abraham**: I think it would probably take a change.

**Pete Cutler**: Significant change?

**Nick Abraham**: That would have to be determined from how the enrollment would flow, how that option would work.

**Pete Cutler**: It seemed clear to me that if somebody signed up for the Kaiser Integrated they would not enroll in one of the separate dental plans with PEBB and I'm not sure whether the PEBB Program thinks of that as a technical, administrative structural thing or whether it would have significant benefit impacts.

**Dave Iseminger**: Pete, what I'll say about this topic, first, I don't think this resolution in combination with I believe it was Resolution 2018-04 precludes further review of the suggestion being brought before the Board about potential integrated dental care. We're working on an RFI on medical first. The RFP on fully insured medical is a couple of months down the road. We can further investigate this if that's what the Board wants us to do and bring some additional information back to the Board at the April or May meeting before procurement is actually released.

When it comes to the PEBB Program, there are a couple of different moving parts that would need to be evaluated so I can't answer the question today. For example, the way the employer contribution is done for medical and dental under the collective bargaining agreement that applies to the PEBB population, we have to think about that because dental is 100% employer paid versus medical is an 85%/15% weighted-tiered average amount. We would have to think about how that would be sorted out.

There's a bunch of different frameworks that we'd have to think about in the PEBB Program for this to be integrated in a way that would fit under this resolution. I think that there are multiple ways if the Board wants us to evaluate this further, that we could proceed with these resolutions and still work on evaluating the option that's put forward for the Board to consider about integrating with the medical.

**Pete Cutler**: So, very simply for here and now, adoption of the resolution in front of us, 2018-06, would not preclude exploring having them provide information, and potentially including that in the actual insured medical plan.

**Dave Iseminger**: Correct.

**Patty Estes**: I have asked before, and I don't think the Legislature has defined it further, currently dental is paid for, for school employees. How many of the dental only members that you have are just enrolled and they don't have dependents enrolled in the dental? I know that is a big thing in our district. That's actually a big subject. I know that legislation hasn't said anything about that funding yet, for dental specifically, but that would be a big question from me for the numbers that you have because your dental only numbers are pretty significant compared to your medical/dental. Do you happen to know?

**Nick Abraham**: I do. So, if you're asking how many are subscribers or employees that would be 875 that have dental only.

**Patty Estes**: Okay.

**Dave Iseminger**: So does that mean the remaining roughly 1,200 are dependents?

**Nick Abraham**: Correct.

**Wayne Leonard**: It sounds like an interesting program, an interesting offering, and I notice it's in six districts. But there's a lot of districts in the Clark and Cowlitz County areas that are not involved in this. Is this something that's being marketed to other school districts, or is it offered by a certain broker? How come there's only six districts participating?

**Nick Abraham**: It's an option that any district in the southwest Washington area could purchase. It is being marketed. Some school districts have chosen to add it. Others have not. Doesn't mean they're precluded from offering it.

**Dave Iseminger**: Could you describe to the Board what is meant by southwest Washington geography? Is that Clark and Cowlitz County?

**Nick Abraham**: Yes. Clark and Cowlitz County.

**Sean Corry**: Just to put a finer point on this, the KP coverage that is down in the southwest corner is out of Kaiser Permanente Northwest, which is an organization based in Oregon, which preceded Kaiser taking over Group Health up here in the rest of Washington State. So it's a different licensing, different company that's providing the service. It that correct?

**Nick Abraham**: That's correct.

**Sean Corry**: So one other essential question, because when Pete was talking you were cutting out, Pete, and I couldn't hear. I think my question is if we move forward with the resolution as it's written, it doesn't preclude us from continuing to consider this as part of a component of medical coverage. Is that correct? Did I get that right, Pete?

**Dave Iseminger**: Sean, I believe the answer is yes. Pete is nodding his head "yes."

**Sean Corry**: Okay, great. Thank you.

**Patty Estes**: Do we have coverage for these employees, dental-wise with PEBB benefits, in these areas?

**Dave Iseminger**: Yes. The Uniform Medical Plan Self-Insured Dental is statewide coverage and also there is access to the other dental plans. I believe we went through those maps last time, but I think there is an overlay. The answer is yes, there is coverage. There may be options as well as coverage.

**Patty Estes**: Just not with Kaiser so they would have to switch doctors, providers, okay.

**Dave Iseminger**: For context, we did do a provider disruption piece, which doesn't get to individual members. It just looks at the providers that are in the KP Northwest versus Delta, which is what the Uniform Medical Plan provider network plan is. There are 329 providers in the KP Northwest Clark and Cowlitz County area. There are 195 of them that are within the Delta provider network so that represents a roughly 40% provider disruption. Now that isn't getting to members impacted. That's just the provider disruption piece.

Voting to Approve: 9
Voting No: 0

**Katy Hatfield:** That was just the first half of the resolution. We haven't done the second half.

**Dave Iseminger**: You only read the first "Resolved" clause, Mr. Chair. Oh, because it's not in the annotated agenda.

**Lou McDermott**: Katy Hatfield, do we have to start over with the voting?

**Katy Hatfield**: No, you can start with the second half now.

**Lou McDermott**: **Resolved further that**, the Board will evaluate in 2020 whether the SEBB Program should pursue a fully insured dental plan procurement to consider additional or different offerings.

Wayne Leonard moved and Terri House seconded a motion to approve the second part of SEBB 2018-06.

**Patty Estes**: So it doesn't specify when in 2020. Is that something that once we get closer we can define that timeframe?

**Dave Iseminger**: Correct, yes.

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-06 passes in its entirety.

**Dave Iseminger**: I'm going to assume from the Board's responses and questions, you would like future meeting time taking into consideration dental with the fully insured medical.

Slide 5 - Resolution 2018-07 is about self-insured dental. Very similar in concept to Resolution 2018-05, but in this instance there are not any contracts that have envisioned anything remotely similar to the conversation we had on Resolution 2018-05. I will say the same thing that I said about self-insured medical, if we needed to start from scratch on a self-insured dental, start a completely new plan and procure a new TPA, that would be highly unlikely for 2020. We have not undergone that recently, as an agency, but knowing the ramp that we are on for 2020, if a self-insured option is to

be on the table it will need to be fairly similar to the Uniform Dental Plan. But then again, there can be some refinements to that benefit design. We'll bring back more granularity on some of those pieces. No specific feedback received on this one.

**Lou McDermott**: **Benefits Resolution SEBB 2018-07:**
**Resolved that**, beginning January 1, 2020, the SEBB Program will offer a self-insured dental plan that leverages the features from the Uniform Dental Plan such as covered benefits, clinical policies, and provider networks, subject to financing determinations.

Patty Estes moved and Terri House seconded a motion to adopt.

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-07 passes in its entirety.

**Dave Iseminger**: Slide 6 - Resolution 2018-08 relates to long-term disability. In particular, while this resolution highlights that the request would be for procurement on both employer- and employee-paid coverage lines, that does not lock you into anything at this point. This is just giving the direction that you're interested in learning about those via procurement. No specific feedback received on this one.

**Lou McDermott**: **Benefits Resolution SEBB 2018 -08:**
**Resolved that,** the School Employees Benefits Board Program shall perform a procurement for long-term disability insurance that includes employer-paid and employee-optional coverage lines.

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

**Patty Estes**: We decided to do this because PEBB didn't have this?

**Dave Iseminger**: The recommendation from the agency to go for procurement on this because based on the benefit comparison, there was a stronger benefit in the school district comparators and the WEA plank compared in particular to the basic benefit, the employer-paid one in the PEBB Program .

**Patty Estes**: Okay. I just wanted to make sure I was remembering right.

**Dave Iseminger**: Yes, you were.

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-08 passes in its entirety.

**Dave Iseminger**: Resolution 2018-09 is with regard to short-term disability. This resolution would have the agency only for employee-optional coverage. This is drawn from the comparison we did that there's often an offering in districts, but very little uptake. John's presentation earlier showed one to two percent uptake depending on

the employee population. So, the recommendation is to simply have a look for employee-optional. Again, this doesn't lock you into doing a benefit, but it would be limiting the procurement to employee-optional coverage lines. No specific feedback received on this one.

**Lou McDermott**: **Benefit Resolution SEBB 2018-09:**
**Resolved that**, the School Employees Benefits Board's program shall perform a procurement for short-term disability insurance that includes employee optional coverage.

Wayne Leonard moved and Katy Henry seconded a motion to adopt.

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-09 passes in its entirety.

**Dave Iseminger**: Before moving on to 10, just a little bit of insight. We're working on the procurement documents for a disability insurance. At this time we're anticipating it will be one procurement for both long-term and short-term disability, but crafting it in a way that does not lock in that it would have to be a single carrier. We want to make sure the member rates would be the best regardless of who the carrier is, but we are trying to consolidate it into a single procurement, if at all possible. That procurement would goe out in the next month or two.

Resolution 2018-10 relates to life insurance and accidental death and dismemberment insurance. This is a resolution that really is borne from a couple of different pieces. I did receive feedback from one carrier and I wanted to let you know how I responded. There was a request asking if there would be a competitive procurement. The reasons why the agency put forward the recommendation we did, to leverage the PEBB contract but not necessarily the exact benefit coverage lines was really borne from the legislative expectation that there are efficiencies in launching and administering the SEBB Program. Second, the directive to this Board to "leverage efficient purchasing by coordinating with the Public Employees Benefits Board Program," and then third, the recentness of which the agency did a life insurance procurement in 2016.

We know that the populations are different. This isn't locking in rates. It's not locking in coverage lines. Those will be taken into account in a contract negotiation. But considering the procurement recentness and those other pieces of the Legislature directive, this seemed to be a very prime opportunity to streamline some work and leverage the coordination with the PEBB Program. I do want you to know that there is at least one carrier that contacted me to see what some of the reasons were.

**Lou McDermott**: **Benefits Resolution SEBB 2018-10:**
**Resolved that**, beginning January 1, 2020, the School Employees Benefits Board Program will offer life insurance and accidental death and dismemberment insurance with coverage offerings and covered benefits that leverages the offerings under the Public Employees Benefits Board Program.

Terri House moved and Patty Estes seconded a motion to adopt.

**Pete Cutler**: This is one where my years of working with employee benefits and with insurance, I have to admit that accidental death and dismemberment insurance, I don't understand why it is offered by employers, frankly. If you die or become disabled there is no additional reason why there is a need for additional financial support compared if it happens through a disease or some other means. They generally have a very poor payout ratio from premiums in terms of private insurance companies. If members want it, I'm not going to throw myself in front of the bus. I have to admit, in the years of working with benefits and really understanding long-term and short-term disability, life insurance, all those things where you can say "okay, there was this loss, this need for financial protection," why we have a type of insurance that just says if you happen to die or be disabled from one cause, we'll give you more money. Anyway, that's just my observation. I will not oppose the Board going forward if that is the choice of the Board on that part, but personally it's not something I'm a big fan of making a priority for a benefit.

**Lou McDermott**: You want my honest, knee-jerk reaction? It's dirt-cheap. I think that's why a lot of people pick it as an optional benefit because it's so incredibly cheap. You can pick up a quarter million dollars of this for a few bucks a month.

**Dave Iseminger**: I can tell you, Pete. If I paid two extra bucks a month and I could have another $100,000, it would take me 4,000 years in monthly premiums to offset that, so I like those odds better than a lottery ticket.

**Pete Cutler**: It's like a lottery ticket. That is basically what it is. I mean its fine, and I'll confess my wife signed up for it with her employer. She liked it. In all the years there was actually one time one of her coworker's husband was killed in an auto accident and that was the silver lining, and it was that they had that coverage. But I by and large, from a policy point of view, we could offer lottery tickets. But that's fine. I understand it's popular and I'm not against offering it to those who like it.

**Lou McDermott**: My father passed away from an accident and my mother benefited from the AD&D component, which was triple indemnity beyond the standard life insurance. So it really was the difference between her being financially sound. It is interesting because it is like a lotto ticket. It's very random. So if, depending on how you pass away, you either cash it or don't. I hear you on that.

**Dave Iseminger**: Can I add one piece because I know Pete really meant to ask this question. What does leverage mean in this one? Leverage in this one directly relates to leveraging the contracted vendor that the Health Care Authority has. I'll try to be clearer about that in the future, but at least the record can reflect that "leverage" in this instance is trying to leverage the HCA contracted vendor.

**Pete Cutler**: I do want to confirm that this is a motion to both offer the life insurance and the AD&D. So as long as I'm in favor of offering life insurance options, I guess I can support the motion because it's in the right direction.

**Lou McDermott**: Vote with your conscience, Pete. I can tell we're getting near the end of the day.

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-10 passes in its entirety.

**Dave Iseminger**: Resolution 2018-11 is about vision and performing a procurement for a standalone vision benefit. For complete clarity on the record, "standalone vision" one might think of as not integrated within a medical plan. This recommendation is borne from knowing that many of the school districts currently offer a non-integrated plan, which is standalone in some people's vernacular. HCA anticipates this is something the Board would want to at least pursue and see if it's an option and if there's a better vision benefit that's borne from a separate stand-alone plan. No specific feedback received on this one.

**Lou McDermott**: **Benefits Resolution SEBB 2018-11:**
**Resolved**, the School Employees Benefits Board Program shall perform a procurement for a standalone vision benefit.

Wayne Leonard moved and Patty Estes seconded a motion to adopt.

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-11 passes in its entirety.

**Public Comment**:
**Fred Yancey**: Good afternoon. My name is Fred Yancey. I am here on behalf of Washington Association of School Administrators. First of all, thank you for your very hard work. This is a very complex topic and I've got some points that I might raise that may show my ignorance more than being valid, but you be the judge. First of all, the very fact that you suggested earlier, Mr. Chair, that the HCA would develop tools to assist districts in predicting the impact of this, is a great idea. I know we eagerly look forward to it because of the change from headcount to FTE is going to be a substantial financial cost to districts. Included in that financial cost I hope it's recognized as you cost out the impact on districts, is the $28 million that was granted to the Health Care Authority that is to be repaid by school districts, with interest. I'm not sure the terms under which that money will be repaid, but it was granted in this recently approved – not approved budget yet – but recently passed budget that's before the Governor. And the point about the Governor not having acted yet, all of these legislative things are still very much in doubt. But there is the IOU of $28 million that will fall on school districts, plus interest, that needs to be repaid. In addition, districts already have to pay over $60 per FTE fee/rebate to the state to offset the retiree subsidy.

Some districts, I'm a retired school superintendent, and in my district I took that benefit money out of the benefit pool before I turned it over to the bargaining table and said, "Okay, this is what you have left to bargain." Some districts pay that out of general

fund. But that's a cost to districts that needs to be accounted for. I know you're going to study the retiree issue in terms of what pool they belong to in the future, but at this point that's still a cost for districts.

You talked about qualifying hours. You did not talk about, and I understand why you didn't yet because it probably isn't ready, but it certainly raises the question about extracurricular positions. Are those to be moved to an hourly basis now? Will those employees qualify for benefits? Coaches? Debate coach? Play director? Do those fall under the 630 hours? We have never, that's a broad generalization, I apologize, but we have never taken hourly sheets from extracurricular contract providers. You guys do? Okay.

**Patty Estes:** Classified employees that are coaches are now required to submit time sheets because it goes towards their benefit hours, their retirement hours, sick time, all of that. I know, because I am one. I just had to start filling them out, which was very telling.

**Fred Yancey**: So a new change. Again, I don't think it applies yet to certificated, but maybe.

**Patty Estes:** No. It does with classified.

**Fred Yancey**: Classified only. Substitute retirees can sub up to 867 hours. I'm a substitute retiree. I have PEBB coverage. Now do I also get SEBB coverage? How does that work? I would qualify once I hit the 630?

I would draw your attention to two more points, then I'm done. On 6241 I would draw your attention to sections 33 and 34. 33 says, basically, that we move to a headcount reimbursement system. 34 says – my words – the state is going to look at whether or not it really is going to fund it. There is no funding for this yet. There is a promise, but section 34 says we're going to look at it and then make a determination even though we kind of intend to fund it, but we're still going to look at it. Well, I think you should be cautious in that respect because it will be a substantial cost. I just want to make sure, and this is my lack of knowledge here, everybody talks about the 85/15 split. Is that in this law? Meaning employees will not be responsible for paying any more than --

**Lou McDermott**: That is not in this law.

**Fred Yancey**: It's the state law.
**Lou McDermott**: The amount that's going to be covered by the state versus the employees will be determined in collective bargaining this summer.

**Dave Iseminger**: When people talk about 85%/15%, they're using as a proxy the state obligation in the PEBB world. That is what was negotiated in the PEBB world under the applicable collective bargaining agreement.

**Fred Yancey**: But it has not been fixed to be in the SEBB world, is what I'm hearing you say?

**Dave Iseminger**: Correct.

**Lou McDermott**: That is correct.

**Fred Yancey**: The 3:1 on the premium ratio is what, and I studied this about three years ago, the Health Care Authority did and they closed the ratio. It suddenly became less than the 7:11 or 11:1 ratio, but they did that by raising the premium. If you raise the individual enough, then the 3:1 ratio closes. So it was an interesting sort of switch. This happened about four years or so ago, when they did the first study. Anyway. I'm done.

I appreciate your time. I appreciate the time you gave to this. I report back to school districts and give them a heads up on this. As Mr. Leonard said, they've been tied up in this McCleary sort of stuff. They have yet to really pay attention to this issue, but it's a substantial hit to districts. Remember that districts now, the only discretionary money they're going to have is money for enrichment through local levies. So how do you pay for excess benefit costs? Unless you define benefits as enrichment and I don't think I've read anything that says that they're defined as enrichment. So it's a confusing world we're in. Thank you very much for your time.

**Julie Salvie**: Good afternoon. Julie Salvi, from Washington Education Association. I'll be brief, because you heard from me today, but I did have a couple more points I wanted to make. On the proposed policy 2018-12, which is the effective date of coverage, Fred brought up the point about retirees, which I also had. Another question I had was how this might affect different employee groups differently. I'm thinking about a number of school districts that start their school year right after Labor Day. And a number of their certificated and professional staff start a few days earlier to set up classrooms and such. Probably start in August. So I would assume their benefits, if they're anticipated to work 630 hours, would start in September. A number of the classified positions may not start before the school year starts. They would start in that case in September and not have benefit eligibility until October 1 if they were in those positions and anticipated to work 630 hours. So I am concerned about the fairness among the groups of employees and to have what turns out to often be our lowest paid employees having to wait one more month for health care coverage.

So that would be something I would ask the Board Members, especially those who work in K-12, to think about and talk to others in the next month as you're considering this policy. A lot has been said today about the FTE and headcount issue and the funding on districts. I won't drag you down to the details, but I did want to point out that's driving some of the differences you also saw in your presentation earlier, when you're looking at the cost on families and you're looking at the actuarial value of plans. A lot of that is driven by the underfunding of K-12 benefits right now compared to what state employees have. So, I just wanted to point out that drives a lot of the differences we see in K-12 right now.

One other point I wanted to make was there was a lot of discussion about the 70-some districts who are in PEBB right now. But I wanted to point out while that sounds like a lot of districts, when we look at percentage of staff across K-12, it is actually very small because they tend to be the smallest districts and even sub-sets within those districts. They tend to be the groups that have full-time employees. Because even in those

cases, districts are having to make up the difference of the rate between K-12 and state employees right now, but they aren't also having to make up that FTE difference. So I would just be cautious. It's a point of interest to look at those districts that are in there, but they may not be representative of the whole of K-12. Thank you for your time.

**Overview of April 30, 2018 SEB Board Meeting**

**Dave Iseminger**: The Board will be asked to take action on the three resolutions brought before you today. Barb will be presenting additional eligibility resolutions. Possible topics are when coverage ends, dual SEBB coverage, and the concepts of waiver. Those may be some of the topics you see in those resolutions.

Because the meeting is at the end of April and we're hoping to have various data from the OIC and carriers earlier in the month, we may be able to put something together on that data to present to you. It just depends on how that information comes in. We'll work on giving you an update on where we are on the medical RFI. We're hoping that it's completed, though there probably won't be slides. We'll also start down the journey of more granular benefit design with regards to self-insured plans to be able to put more eggs in that basket for that chicken and the egg game we're playing on self-insured.

**Lou McDermott:** Meeting adjourned.

Meeting adjourned at 4:10 p.m.

# School Employees Benefits Board
# Meeting Minutes

**Draft**

April 30, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:00 p.m. – 5:00 p.m.

TVW was present and did a live stream of the meeting. The meeting will be on the TVW website in their archives folder.

## Members Present:
Lou McDermott
Alison Poulsen (arrived late)
Dan Gossett
Katy Henry
Patty Estes
Pete Cutler
Sean Corry
Terri House
Wayne Leonard

## SEB Board Counsel:
Katy Hatfield

## Call to Order
**Lou McDermott, Chair**, called the meeting to order at 1:03 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

## Meeting Overview
**Dave Iseminger**, Director of the Employees and Retiree Benefits (ERB) Division provided an overview of the agenda.

## Approval of November 6, 2017 SEB Board Meeting Minutes
**Lou McDermott:** Pete Cutler moved and Katy Henry seconded the motion to approve the November 6, 2017 SEB Board meeting minutes. Minutes approved by unanimous vote as written.

**Pete Cutler:** I apologize. I should have commented beforehand, but I do want to go on record saying I really appreciate the thoroughness of the minutes. I felt like I was going through the Board meeting a second time all the way through, and it was since, I think

especially the discussion from Dr. Lessler had a lot of detail. It was really helpful to have a second go.

**Prior Meeting Follow-up Questions**

**Dave Iseminger:** I have six areas, some of them are questions, some of them clarity and context to prior discussions, not in any particular order. The first one is to follow-up on a long-standing question I believe Wayne originally asked in the fall about whether school Board Members themselves would have eligibility for benefits. Under state law now, there is authority for school districts and ESDs to make coverage available to their Board Members. Nothing within House Bill 2242 or Senate Bill 6241 changed that authority, so that authority still exists for school districts and ESDs in the post-January 1, 2020 world. If the school districts elect to provide benefits to those members, they still have that ability to contract with the Health Care Authority for benefits. Nothing changed in the current world for school Board Members and district authority to offer benefits to them.

**Wayne Leonard:** I saw where it talked about legislative bodies being ineligible, but would that include them if they did not meet the 630 hours?

**Dave Iseminger:** We believe there's separate express statutory authority for school districts and ESDs that is particular to school Board Members and their ability to offer benefits to those members.

The second question came up at the last meeting during my legislative briefing. I believe it was also from Wayne. This question was about optional benefits under 6241, meaning those benefits that are outside this Board's authority, whether those optional benefits in the post-2020 world were employer paid or could be employee paid. Under the legislation, it's Section 29 of the bill, that amends RCW 28A.400.280. The language there describes school districts may provide employer contributions for optional benefits, and it goes on to define those optional benefits, again, as those that are outside this Board's authority for offering. There isn't anything that expressly prohibits or authorizes employee-only scenarios. The statute is silent as to whether it could be an employee-only piece, but it does allow for an employer contribution. That's what the statute says.

Number three follow-up was a Pete question, which was about the context of Resolution 2018-12. This resolution prompted many questions from the Board. This resolution is about the effective date of benefits. You'll see it's not here for you to take action on today. Stakeholders had a variety of different opinions and ideas for how that resolution could work. We're still working through that feedback and realized it was not ready for this Board to take action on today.

In that context, Pete asked about the Department of Retirement Systems (DRS) eligibility requirements and the framework for the Teachers' Retirement System (TRS) and the School Employees' Retirement System (SERS). I'm going to summarize and if anyone wants to correct my oversimplified explanation, please do so. In general, under DRS, if a school employee works at least 70 hours per month for five months within a

school year, and that school year is defined as September 1 through August 31, the TRS plans require the employer to anticipate the employees work for one year, while SERS plans require an employer to anticipate employees work for two years. We believe there are approximately 7,300 people in TRS and 15,700 in SERS. That's about 23,000 people between those two systems.

Fourth topic for follow-up is not a question, but some nuance that I want to make sure is clear on the record. When we talk about the 3:1 ratio, I want to clarify some nuances between what we understand exists in the current K-12 system and what the legislation requires. There's been talk about what school districts in the current K-12 system have or haven't been able to achieve on the 3:1 ratio. The agency's understanding at this point is that many of the carriers have produced premium ratios that fit within that 3:1 ratio. But the way the state allocation has been rolled out does not necessarily translate to a 3:1 employee premium contribution. What the legislation did in 6241 is mandate that the *employee* premium position be within a 3:1 ratio. I did want to clarify that our understanding is that carriers may have been submitting premiums that fit within a 3:1 ratio, but the legislation now requires that the employee contribution also be within a 3:1 ratio.

My fifth area is an update. Since we last met, 6241 was signed by the Governor, which then triggered claim submissions by both OIC and carriers. We received OIC's data the same afternoon that the bill was signed, and we had already begun communicating with carriers about the expectation for data and what needed to be submitted by the April 1 deadline, which ended up only being eight days after the legislation was signed. I am happy to report that the majority of carriers provided at least an initial data set by the end of the first business day of the month. We've gone through an iterative process over the month with carriers to improve the data and we have a robust data set. It does have some missing pieces but overall it's a pretty solid data set. I want to make sure the Board was aware that the carriers provided a substantial amount of data that will help us do enrollment and financial modeling going forward, as well as, inform procurements.

Number six is an update on the Requests for Information (RFI) that the agency did, also since the last meeting. You remember we released an RFI on vision to get information from the carrier community about what they see and what experience they have to inform an eventual RFP for a standalone group vision benefit. That RFI was due to the agency last Tuesday and we had ten responses. The carriers that provided insight, in alphabetical order, were: Ameritas; Davis Vision; EyeMed; MetLife; Northwest Administrators, Inc.; Premera; Superior Vision; United Healthcare; Unum; and VSP. It was not mandatory that a carrier respond to the RFI for vision in order to participate in a later procurement. We'll review that information and bring back to the Board insights we gained as an agency.

At the same time, we're doing the RFI for the fully insured medical. That was due last Friday, and unlike the vision RFI, a carrier had to respond to the RFI in order to be eligible to participate in the eventual procurement process later in this calendar year. We had six responses to the RFI on Friday. They were: Aetna; Kaiser Permanente

Northwest; Kaiser Permanente Options, which for those not familiar is their PPO product line; Kaiser Permanente of Washington; Premera; and United Healthcare. [Editor's Note: At the May 30, 2018 Board Meeting, the record was corrected indicating a seventh RFI, from Providence, had also been received.]

We've already had a lot of interest from stakeholders into learning about the responses that were received in the RFIs. We are working with the carriers to identify anything that they deem proprietary or confidential, and then we will post redacted versions on the Health Care Authority's website after that process is complete. Our public records office is going through that process with both the vision and medical carriers to ensure we adequately redact what the responders believe is proprietary and confidential.

[Sean Corry and Alison Poulsen arrived.]

**Cafeteria Plan Overview**

**Tristin Sullivan-Leppa,** Supervising Staff Attorney, Health Care Authority. I provide support to the PEBB Program and the SEBB Program. A Cafeteria Plan is a written plan document maintained and designed by the employer. Here under state law for Cafeteria Plan purposes, the employer is the Health Care Authority. It is maintained for employees and must meet specific requirements set forth in Section 125 of the Internal Revenue Code. A Cafeteria Plan document is the only way an employer may offer employees benefits on a pre-tax basis.

**Dave Iseminger:** Many people, I've learned, think a Cafeteria Plan means "like a buffet" where you get to pick and choose different benefits. The central idea of a Cafeteria Plan is the vehicle by which pre-tax payroll dollars can be used for certain types of benefits. A lot of people will throw around the phrase "Cafeteria Plan" thinking it means, "I have a choice in medical benefits," when really it's about how you're paying for those medical benefits and whether it's pre-tax or post-tax.

**Tristin Sullivan-Leppa:** An employee agrees to contribute a portion of their paycheck on a pre-tax basis to pay for benefits offered under the Cafeteria Plan. These salary contributions are funds not actually received by the employee; and therefore, these contributions are not considered wages for federal income tax purposes. Because it lowers taxable income for individuals, the IRS has strict rules that must be followed.

Slide 4 contains the benefits currently offered under the state's Cafeteria Plan administered by the Health Care Authority. You may recognize the slide because it's from a previous presentation done by Scott Palafox at the December 2017 Board meeting. In the Appendix to my presentation, you will find slides from the December presentation that explain each of these benefits.

The IRS has strict, narrow rules about who can participate and be covered under a Cafeteria Plan. According to Section 125, employees may participate in a Cafeteria Plan, and the regulation allows participating employees to cover their spouses and dependent children. Spouses and dependent children can only participate if the employee also participates.

**Dave Iseminger:** At the last meeting, there were questions around language the agency was using in presenting the resolutions. We wanted to be very clear that under IRS rules there are often strict, black and white, lines as to who counts from a legal standpoint that an employee is able to take those contributions on a pre-tax basis. There could certainly not be a Cafeteria Plan, and then school employees wouldn't be subject to the IRS rules, but then they also wouldn't get the advantages of having a lower taxable income when taxes are due.

**Tristin Sullivan-Leppa:** Participants can choose the type and amount of benefits offered under the plan they want to elect. There are three events that allow for someone to make elections under the plan: when a participant first meets eligibility requirements, during the annual open enrollment, or during a special open enrollment period.

The IRS provides strict rules for when elections become effective. Generally, elections are made in advance on a prospective basis as opposed to a retroactive basis, with very narrow exceptions. Two of those exceptions are: one for newly eligible employees, employers may allow retroactive enrollment for up to 30 days from the date of hire; and second, when a participant experiences a birth or adoption of a child, the participant may retroactively enroll that child onto his or her benefits. The last point on Slide 6 is that elections are generally prospective because the IRS does not want individuals to have hindsight knowledge to impact his or her taxable income.

**Dave Iseminger:** The first sub-bullet on Slide 6, “Employers may allow retroactive enrollment for new hires,” is directly related to Resolution SEBB 2018-13 that's before the Board for action today. Someone may say 31 days isn't the same as 30. I always had this problem with math in school. It's fence posts versus lengths. There's actually 30 24-hour periods (i.e., fence lengths) between 1 to 31 days (i.e., fence posts). So the recommendation to the Board was to allow the maximum allowed period for the retroactive enrollment. While it may seem counterintuitive to an employee, "I just started work. How am I being retroactively enrolled?" That's how narrow the IRS rules are.

**Tristin Sullivan-Leppa:** Slide 7 – Can Participants Change Their Elections? Under a Cafeteria Plan, elections are generally irrevocable for a 12-month plan year. However, if a participant experiences one of the specified special open enrollment events, they may be permitted to make mid-year plan changes.

Slide 8 – Where Does the Money to Pay for These Benefits Come From? I touched on this on Slide 3. A participant pays for benefits that he or she elects by agreeing to reduce his or her salary on a pre-tax basis. Employees can elect benefits offered under the plan with pre-tax dollars. Slide 9 includes some advantages for employees: buying qualified benefits with pre-tax dollars; lowering taxable income; and specifically, for flexible spending arrangements there is an idea called "First Dollar Coverage." This essentially means that an employee can use all of the dollars they’ve elected to contribute for the plan year at the beginning of the plan year, even though the contributions are spread out over the entire plan year.

**Dave Iseminger:** I see puzzled looks on that one, so I'll describe that with an example. Let's say on a medical FSA I elect $1,200 for the year, roughly $100 a month, and I'm a 24 pay-period employee. That means $50 is coming out of every paycheck. On January 1 I have immediate access to all $1,200, even though a single penny hasn't come out of my first paycheck. That is what “First Dollar Coverage” means in this context.

**Tristin Sullivan-Leppa:** Slide 10 addresses disadvantages for employees with the Cafeteria Plan. Elections are irrevocable for the plan year, except for the narrow exceptions. Some Cafeteria Plan benefits, such as FSA and DCAP are subject to a "use or lose" rule, meaning that if an employee's eligible expenses incurred during a plan year are less than the amount they elected to contribute, they would forfeit the difference. An example would be if you elected to put $1,000 into your FSA and you only spent $500 in qualified expenses, then you would forfeit the remaining.

**Dave Iseminger:** Under IRS rules, the forfeiture goes to the employer, which for purposes of the Cafeteria Plan is the State.

**Tristin Sullivan-Leppa:** A salary reduction reduces the employee’s earnings, which may reduce his or her social security benefits. In other words, participating in a Cafeteria Plan saves you money now by reducing your social security taxes because the lower your income, the less your taxes; however, your lifetime social security benefits would be calculated using those lower salaries.

**Dave Iseminger:** A little more context: Under the consolidation for the SEBB Program, there's the authority for a Cafeteria Plan, but it's not under the Board's jurisdiction. It's under the Health Care Authority's jurisdiction, just as it is for the PEBB Program to administer a Cafeteria Plan. The agency is responsible for creating and maintaining the benefit structure of FSA, DCAP, and the other benefits that fall within the Cafeteria Plan.

We have been working under the assumption and building towards having a robust Cafeteria Plan, including the same benefits on the slide that Tristin presented for the SEBB population. The premium payment plan is an important one that directly impacts most people. It allows people to have all their medical premiums taken on a pre-tax basis. In order for that to be part of the Cafeteria Plan, which we've been assuming would be done for the SEBB Program, we have to present certain resolutions to you in a way that comply with the IRS regulations to be able to administer those prepayment payroll tax deductions.

**Sean Corry:** I think you answered my question, but just for clarification: I know from experience that Cafeteria Plans have various provisions that an employer might choose or not choose. That might not apply to us, is that what I heard you say? That variation is on how to deal with run-out money, or spending money from the last plan year, that kind of thing, that's not our purview? That would be the purview of the Health Care Authority?

**Dave Iseminger:** That's correct, Sean. For example, when Tristin described the "use it or lose it" rule for FSA and DCAP, there's also an alternative scheme where you have an extra grace period and you have a longer time for your plan year to incur and submit expenses, and in the Cafeteria Plan document, the employer has to pick one or the other. The authority for setting up the Cafeteria Plan structure is with the agency versus with this Board.

**SEBB Financial Considerations and State Budget Calendar**

**Megan Atkinson:** I'm going to do a quick run through revisiting information that we talked about last time.

At the last Board meeting there were questions and we wanted to revisit a few concepts and then introduce new material, largely around the state budget calendar and the timing of rate procurement, legislative action, collective bargaining, to get that calendar in your mind. Then Pete had a question about the tiering ratios. We did a calculation to illustrate if we looked at changes or comparisons to the PEBB Program tiering ratios.

Slide 3. One of the things we wanted to level set for everyone was a reaffirmation of the current way K-12 health benefits are funded, and then the way they would be funded under the SEBB Program. Currently in the K-12 world, we have a state allocation provided in the budget bill each year. The state funding is currently on a per-FTE basis. We'll talk more about that, but that was a foundational difference between the current K-12 world and the SEBB world FTE versus headcount. The third bullet, all of those can vary by district. You do have some variability by districts across the state. In addition, your bargaining agreements can vary by district. Finally, some districts do allocate the employer contribution proportionally equal to the percent FTE. Essentially, if you are a half-time employee, some districts allocate half of the benefit allocation and the employee makes up the rest.

Slide 4 – SEBB Health Benefits Funding Structure. In the SEBB construct, because of the consistency in the statewide approach, there's some significant differences. The first one is still the same: the state allocations provided in the budget bill each year. We already know there's statute guidance that the amount allocated for state funded staff in the 2019-21 budget will be no less than the per employee PEBB funding.

**Pete Cutler:** When it talks about the amount allocated for state funded K-12 staff, it's to be no less than the per employee PEBB funding. For PEBB, as you mentioned, the budget structure has agencies determine how many PEBB eligible employees they have and they get a full $800, $900 a month, whatever, allocation for each of those PEBB eligible positions. For state funded K-12 staff, is this language intended to mean the same thing, that if a school district has positions that are going to be eligible for SEBB coverage under the 630-hour rule that they would receive the full amount of however much? Or is it intended to continue the funding by FTE, at the FTE level, and then have some breakdown of that afterwards? Is that clear?

**Megan Atkinson:** That is very clear. Trust Pete to dig in right on the crucial question right out of the gate. The issue of per-FTE funding in the current world and the need for

per headcount funding in the SEBB world, is the crux of the issue in moving from the current funding model to the SEBB funding model since the Legislature has not taken action to fund the SEBB Program, and they wouldn't. It's not time for that yet. That decision will be in front of the Legislature in the upcoming 2019 legislative session. I can't say what they're going to do. We talked about this last time, and what I said I think got misunderstood by some people. The minimum eligibility criteria of anticipated to work 630 hours, and the statutory reference to the per-employee funding, signals a headcount funding model, but the Legislature hasn't funded it yet. That is the crucial thing we'll be watching and discussing next legislative session: exactly how much does it take to go from a per-FTE funding to a per-employee funding? How much of that is on the State? How much of that will be left the responsibility of the districts? Those are all crucial questions that we just don't know yet what the Legislature is going to do.

**Lou McDermott:** Megan, do you think that will partially be addressed with collective bargaining?

**Megan Atkinson:** I think it could be. Again, I can't speak to what ultimately ends up in the collective bargaining agreement, but I think the stakeholders both on the executive side and the district side, the employee side, everyone is aware of this crucial issue.

**Lou McDermott:** I would imagine that they would want to at least have a framework for their collective bargaining to say, "We think the world's going to look like this; and therefore, we're going to bargain this," and understanding that seems like it would be pretty critical.

**Megan Atkinson:** It is a significant question.

**Dave Iseminger:** For the record, the second bullet on Slide 4 is designed to mirror the language of Section 34 in Senate Bill 6241. If for any reason there's any variance, it's unintentional and not meant to signal to anyone something different.

**Sean Corry:** I think I might be stepping on Pete's toes a little bit, but I still want to make sure that I understand what "no less than" means in this bullet. Does this mean that whatever the dollar amount per head allocated to PEBB employees, whatever that number is, the SEBB dollar amount per head for SEBB employees needs to be no less than that? Is that how "no less than" applies in this? What does that "no less than" mean?

**Megan Atkinson:** I believe that is a clear, plain English read of it. I'm not legislative budget council. I don't want to get outside my professional swim lane, but I think the words "no less than" have a plain English read interpretation.

**Sean Corry:** On an individual employee basis as opposed to an aggregate basis, different numbers of employees, of course, in each pool.

**Megan Atkinson:** The language in the bill does say "per employee PEBB funding." That is in the bill.

**Sean Corry:** I'd like to note before pushing the button here that the population that will be going into the SEBB Program is, of course, a different population than what's in the PEBB Program. Different demographics, different location, maybe in the aggregate, maybe not substantially different but certainly different, and so if the funding itself is not necessarily tied to the risk pools would call for - am I thinking about that correctly that there may be too much money or not enough money because of this "no less than" restriction?

**Megan Atkinson:** Yes, I think, Sean, you're hitting again on a crucial point. The PEBB population and the SEBB population are significantly sized populations; and therefore, you could make some analytical argument that the demographics would start resembling one another because of the sheer size of them. There's likely to be some irrelevant differences in demographics, but then there's also the issue around the dependent load in each population. The SEBB employees might bring with them a different compliment of dependents than what we see in PEBB, as well as, how they enroll across the plan. It's not just the tiers that I described, but also across the plans. There are likely to be differences in the populations and in the risk pools that then would make adhering to this target more or less difficult. Once we have our models and once we have rate information for the plans, as we move down this journey over the next 12 months, having models, through collective bargaining this summer, nailing down procurement with the plans, nailing down rates with the plans - each step along that journey gets us better information. Any time we talk about this internally, we end up saying, "it's not going to be that big of a deal because the population's going to look so similar," and then all the way over to, "We don't know how it's going to lay out." Until we get more information, it could be right on or it could not.

**Lou McDermott:** You always tell us that we're going to guess wrong. There's just no way. There are many things we don't know with all the different plans that are going to be available. We don't know: what the membership is going to do; how many spouses are going to come on board; how many dependents are going to come on board; what the utilization will look like, somebody goes into a new different plan, maybe they all go in right away to see their doctor because they want to make sure their benefit works. It's going to be very difficult to tell. The one thing Megan's correct about is we're going to guess wrong, but experience over time will level that out and correct it and we'll be able to provide the Legislature and the Board with very accurate information on what the actual experience was, but it's just going to take time. There is no getting around that.

**Megan Atkinson:** I appreciate that clarification from Lou. I do want to set that understanding with you that as we bring you modeling results and model outputs, perhaps you will see those changing. It may or may not be significant changes as we move through these next 12 or 13 months. Understand that it's not intentional, it's that we're modeling a world that none of us have been in. Every time we get information, we can overlay an assumption with actual information, or maybe just a better assumption. As we do that, it's going to change. Keep in mind when we're looking at expenses for a population of this size, a very small change in a factor will drive tens and tens of millions of dollars. You will eventually become more comfortable with those conversations, but it

is startling how much just the tiniest tweak drives a significant sum of money because of the sheer size of the population that we'll be dealing with. Health care is expensive.

**Dave Iseminger:** Bullet three, Megan.

**Megan Atkinson:** We've talked a bit about the employee union. There is a Coalition that will bargain with the State this summer. That is a significant input into our modeling. We already discussed the eligibility criteria is standard. Dependent coverage and benefits package both set by you, and you're familiar with that because you're working through those resolutions. Then employer and employee contributions will be standard for all districts by plan and by tier.

Slide 5 – Headcount vs FTE. Headcount is the actual number of employees, regardless of hours worked. A full-time equivalent (FTE), the hours that must be worked for an employee to be considered full time. As you know from your life in the districts, the employment patterns can create a significant difference between headcount and FTE in that district. We are starting to learn more about that, and we're learning what many of you already knew. Seeing the data now, it is more significant on the classified ranks than on the certificated ranks. Slide 6 is an illustration; I liked it so much I put it back up, with the little people.

I did get some feedback that this perhaps seemed a little tone deaf that I was using the 2,080 hours. I wasn't trying to be tone deaf to real life in K-12 districts. When we worked through the math, the 2,080, by the time we started dividing it out, it worked better than starting with the 1,440 for a certificated staff member. Again, just illustrating the difference between headcount and FTE.

Slide 7 is a slide from last month. I did get quite a bit of feedback on this slide. We struggled a bit with it if you remember in the meeting last month. We simplified it and updated the numbers to be closer to the amounts in the current budget. This is illustrating that when you have an FTE-based state allocation, and yet you have employer benefit contributions required on a headcount basis, you end up with a difference. That's the crux of what Pete was discussing, what we've been discussing already. Who will pick up that difference? Will it be borne entirely by the districts? Will it be born somewhat or fully in the state funding model? We don't know yet.

**Wayne Leonard:** I have a quick question or comments on this slide. One of the slides, as I recall from the last meeting that caused so many of the questions, indicated that the Legislature intended for school districts to continue to pick up the cost of employees above the state funded level. That leads me to think that the Legislature is going to continue to do what they've always done, which is fund their formulas, which would still mean they'd be funding it based on the FTE model and local school districts would have to pick up the rest. There is some discussion around that because they had estimated, I think in your slide from the last meeting was about $200 million, that difference, the delta.

When we got to this headcount vs FTE funding, there was discussion on different aspects of this. This is helpful because I went back to my district and started looking at this and this scenario is probably bigger than my district. This probably would be applicable to a 15,000 - 16,000 student district, but your presentation uses the amount we currently get, and if this goes up to the new higher SEBB levels then this $205,000 would be higher.

**Megan Atkinson:** Correct.

**Wayne Leonard:** Is this difference a monthly difference? On an annual basis, that's close to $2.5 million for the school district, that difference in funding. If you use that higher SEBB level, it's closer to over $2.8 million, another $300,000, and then…

**Lou McDermott:** Wayne, can I ask you a question? I'm trying to follow. If they increased the number, like in the model, let's say they don't make any adjustments to the FTE count but they do increase the number, wouldn't it reduce the $200,000?

**Wayne Leonard:** Well, there would be an additional contribution for their model assuming this additional 250 headcount difference or this 250 difference between the FTE and the headcount is all on the local levy.

**Lou McDermott:** Right. I guess I'm thinking that the $820 satisfies a certain funding level, provides a certain service, and then the higher amount would be providing a similar service. There would be extra money there. I'm not trying to get in the weeds. I'm trying to say there's multiple levers the Legislature can pull. Am I thinking about this wrong, Megan?

**Megan Atkinson:** There are a couple things. I think the point Wayne is making is that even if the per employee or per FTE allocation goes up, and if we use the amount in the current year from the $820 currently in the K-12 part of the budget to the $916 on the PEBB side of the budget. Even if it went from $820 to $916, that drives more money out, but the amount the districts are expected to pay in per headcount also increases from $820 to $916. It doesn't address the gap.

**Wayne Leonard:** We get additional funding for the state funded employees, but for employees funded on the levy, there is no additional funding.

**Megan Atkinson:** Wayne, I want to address your concerns. On the slides used last month, and a little even on this slide, I've created a fundamental error that fiscal staff try not to do, which is I used real dollars when what I'm trying to show is an estimate. I'm trying to illustrate an issue. Last time, with the $200-$300 million, that was trying to illustrate the funding gap. That funding gap has not been calculated by anyone, and we can't calculate it until we get further along in our modeling. Your point is well taken, Wayne, the way the state is funding K-12 health benefits now on a per FTE basis, and the way we will need to collect from districts in the SEBB world on a per headcount basis that leaves that funding gap. What we don't know yet is how the Legislature intends to address that, if at all.

**Wayne Leonard:** Okay and I took your last meeting slide to indicate that they were not planning on addressing it at all, that they were going to leave it as it currently is with their current funding model.

**Dave Iseminger:** I think Megan was illustrating the potential extent of the problem, but not chiming in on the potential policy solutions that the Legislature has. That's a good clarification. That was not the intent of Megan's prior or current presentation to suggest the Legislature has made a decision one way or another on that particular issue.

**Wayne Leonard:** Right. I think this FTE headcount piece is the major piece of it but the 630 hours, also. Our current eligibility is 720 hours, so 630 hours is lower and would create additional insured eligibility. I think it was mentioned that substitute teachers and substitute employees, if they work more than 630 hours, would gain eligibility. That would further increase the costs to school districts, and the increase in the rate from the current school rate up to that SEBB rate also increases the cost of school districts. There are multiple factors driving the cost up for school districts if it stays as is. This addresses the major one, but those others add costs on top of that.

**Megan Atkinson:** Your points are well taken, Wayne. Slides 8 and 9 lay out roughly the next nine months or so of the state budget calendar. I thought it might be helpful for you to have this calendar as we're driving towards setting up the SEBB Program, working through collective bargaining, working through modeling. There are crucial time periods or activities that we're trying to feed information into. We've released an RFI on the fully insured medical plans; we talked about that last time. The next big piece of work is this summer when collective bargaining occurs, and that will nail down some critical pieces of information that we will use to inform the modeling. This summer we have an RFP process for the fully insured medical plans. That will help us nail down the carriers we will be contracting with. September of this year is when agencies submit their 2019-21 biennial budget requests to OFM. These requests feed into and inform the Governor's budget and that starts the budget debate in the Legislature.

In the Governor’s proposal, you will be able to see the Governor's proposal around this funding gap that we see in SEBB. January through April of 2019 is the legislative session, and hopefully if there are no special sessions, the final 2019-21 budget when we would definitively know what's happening. Around that same timeline is when we would finalize bid rates for the fully insured medical plans. The reason we have those occurring around the same time is finalizing those bid rates allows us to feed that information and final modeling into the legislative budget writing that happens during session. Finally, looking towards next fall, open enrollment and then, of course, January 1, 2020 when benefits begin.

**Sean Corry:** I have a question. It's sort of a general question with respect to the collective bargaining that either has just started or is about to start. Dave, do you know, is there an end date to when that has to be concluded?

**Dave Iseminger:** The collective bargaining process doesn't officially begin until July 1, so it hasn't kicked off yet, although our understanding is that there's pre-work being

done. At this point, the last number I heard is there are 912 unions that represent some aspects of the K-12 system. There's a lot of pre-work to understand how to bargain within a coalition that size, but under collective bargaining laws, the collective bargaining process is to conclude by September 30. So, July 1 through September 30.

The other piece that I want to be clearer about is the finalized contracts with the fully insured medical plans and the relationship of the agency versus the Board. Most of the time, whenever we execute contracts with carriers, our contracts have a qualification that's subject to final decisions made by the Board, because obviously if you don't authorize a plan, then the contract related to that plan doesn't work for everyone. We go through the process and tee everything up so you have the final decision, and then it's ready to go from the contracting standpoint. I want to be clear that we're not pre-supposing. We always have mechanisms within our contracts that can take into account the Board's decisions.

**Megan Atkinson:** Slide 10 is about the financial impacts and considerations of the tier structure. The premium tier structure is a mechanism to allocate costs between members with dependents and members without dependents, and there's no right or wrong way. It's not like you can research and say, "Oh, this is the blessed tier structure." It's not like that. They can be unique and often are unique to different populations, different companies, different employer organizations. The tier structure does not increase or decrease the aggregate program cost, nor does it shift cost between the employer and the employee. It is a way of distributing cost across your employee population based on how you subdivide the population.

**Sean Corry:** Does that mean, in the PEBB example, in the PEBB world, the employee contribution that is taken out of their paycheck to say employee only contribution is the same percentage for each employee, regardless of the health plan the employee chooses?

**Megan Atkinson:** There's a little bit of settling out that happens, but they are within the ballpark of the same percentage, yes. They might fluctuate between 13%, 14%, 15%, but they're right in there.

**Sean Corry:** The percentage of employee's share of the richest plan is roughly the same percentage as for the least rich plan for PEBB employees, all around, circling around that 15% premium?

**Dave Iseminger:** The collective bargaining agreement within the PEBB context is a tiered, weighted average. It's within a range, but it's not the same percentage for every person because the funding mechanism is based on an average person, and as we all know, no one's average, everyone's unique. The 85%/15% split that's talked about in the collective bargaining agreement on the PEBB side is an aggregate average. No one person is guaranteed an exact 85%/15% percent. It's an aggregate.

**Sean Corry:** I'm sorry for being thick. I understand the aggregate being close to 15%, but on a plan-by-plan basis? Is there a similar tight margin of a point or two around the 15% on each of the plans?

**Megan Atkinson:** We have the 85%/15% split agreed to in our collective bargaining agreement in the PEBB world. It is the weighted average across all plans, across all tiers. So, yes. In SEBB, we have a statutory requirement that the employee premium tier ratio be no greater than 3:1. We'll look at that on the next slide. The procuring of all benefit plans on a consistent tier ratio dampens the risk pool from selection risk by plan. Let me explain what those words mean. If we didn't hold all plans to the same tier ratio, then different plans could come in and bid their premiums according to different tier ratios to essentially cherry-pick certain segments of the population. We don't want that to happen. We want all plans to be competing on equal ground against one another so the employee uses his or her enrollment decision to act like a defacto market so the employee's enrollment behavior rewards or punishes the plan's financial performance and how they bid their product. It will be the same tier ratio across all the plans.

This last bullet is a reminder that no tier ratio is perfect. We'll talk about the values. Those are not as critical as the consistency of the application across all plans in the program.

**Pete Cutler:** By saying tier ratio is not perfect, does that go to the question of does it generate exactly as many dollars as you expect that tier level to cost the plan? That would be a question for any tier level. Are you collecting about the number of dollars that people will have as claims or as costs?

**Megan Atkinson:** What I meant is that pre-supposing a conversation about the tier ratios in SEBB being different from the tier ratios in PEBB, it's not necessarily that the PEBB ratios are perfect tier ratios for PEBB; and it's not that the SEBB ratios will be absolutely mathematically perfect tier ratios for SEBB. It's the principle of them and the strength of them, and what you get from them is the consistency of the application.

**Pete Cutler:** Okay. Thank you.

**Megan Atkinson:** Slide 11, I've again put a lot of information on a single slide. The heart of the slide is a requested scenario that Pete asked about last month in looking at the difference between the proposed SEBB tier ratios, contrasted with the current PEBB tier ratios.

The first column is just the four tiers. You have employee only, your single subscribers we often call it; employee plus a spouse or domestic partner; employee plus children - this tier is one adult and some number of child or children; and the fourth tier being the employee, a spouse or partner, and then some number of child or children. Those four categories are proposed to be the same in SEBB as they are in PEBB, and you can see the PEBB ones down below but they're the same: employee only; employee plus one adult; employee plus children, no additional adult; and then the employee plus one adult and children.

The next column over is the way the current K-12 population, according to the Office of the Insurance Commissioner (OIC), I think it was year five data, falls out across the four tiers. Over half of the current K-12 population is enrolled as a single subscriber. Only 9% enrolled with a spouse or partner. About 23% with a single adult with child or children, and then about 11% in the final tier. If we had a hypothetical 100,000 enrollees, and I used 100,000 for a nice round number, the simple math of 100,000 times 57.2% gets you 57,200 enrollees at the first tier, and then you follow the math down.

The next column over is the proposed tier ratio for SEBB. It's 1.0 for a single subscriber. Employee plus another adult is 2.0, that math is easy. Then employee plus child or children 0.75. Then ending up at the maximum 3.0 on the final fourth tier.

Stay with me as I explain this next part. You don't start with the rates. You start with the amount in aggregate you need to provide health care to the population, and for purposes of this illustration, that hypothetical amount I set is the $900 million at the top of the far right column. What I'm essentially saying in this example is, in our hypothetical K-12 world of 100,000 enrollees, providing health care to that population for a year, takes $900 million in total revenue. Then you solve for the rates and you use the tiering ratios and the population on each tier. In this example where we have 57,000 people on the first tier, or 57% of the population on the first tier, and we need $900 million in revenue, the rate for that first tier is $507. That would generate $347 million in revenue from people on that tier. That's employer and employee contribution. The tier ratio is silent to the split between employee and employer. If you follow down through, the $507 gets to $1,014, which is twice the $507. The $887 is 1.75 times the $507. The $1,521 is three times the $507.

What we wanted to look at for this scenario is how the rates change as you change the tier ratio. In PEBB, the tier ratio is a maximum of 2.75. It's not a maximum of three. Everything else in the example is the same between the two constructs: 1.0, the 2.0, the 1.75. What this shows you is if you lower the 3.0 factor on the fourth tier to a 2.75, you're still solving for the same amount of money. What that means is the rates on the other tiers would go up consistently 1.9% in each tier, and the rate for that final tier would go down about 6.6% because you've shifted.

Remember, your tier ratio is how you're spreading the cost across the different tiers, and one of the things we talk about in health care pricing is: are the single subscribers subsidizing the subscribers with families; and if so, to what degree? What you can see here is if you use the 1:3 tier ratio that we've proposed to you then you have less of a subsidization of the fourth tier. You would see that same type of shifting as you increased or decreased any of these.

**Sean Corry:** Understanding the math to the best of my ability, I have a more fundamental two-pronged question. We have in the upper section a full family number of 3.0, and then you compare it to what? Before I saw the bottom, I totaled up the top three, which came to 2.75, and so my first question is why did the full family become 3? Because that's an extra quarter point thrown in.

**Megan Atkinson:** That's a great question and we've had a lot of conversations about that internally. First, there is direction in the statute that it cannot be any more than a 1:3. The approved ratio doesn't have to take up all the capacity. We are uncertain what the dependent enrollment will look like in SEBB. We are uncertain if the number of children coming in under the employee and child/children tier versus the employee plus partner/spouse plus child/children tier would be more or less. The decision was to weigh our options and interpret the legislative direction as more than mere intent and to not leave any unused tiering capacity on the table. To my earlier point, it's not perfect. It is simply trying to use up all the tier capacity that we had in a world where we know little, at this stage in the game, about the population and its enrollment behavior for next year.

**Dave Iseminger:** There is already going to be a lot of shock in the system. Earlier I answered in the follow-up questions that there is a difference between what the carriers provide and how the allocation was driven out, and what employees are currently paying. When we look at the OIC year five data, the aggregate across the system looks like it's somewhere between an 8:1 to 10:1 ratio. There is variability of some school districts who were over a 10:1 ratio, some with a very large difference, and then the vast majority of districts fall under a 10:1. With this amount of shock that will be in the system, our recommendation is to not further shock the system by taking advantage of the full ratio that is allowed under State law. You could compress the tiers a bit further.

Also for the record, whereas there is a maximum 3:1 employee premium mandate within the SEBB framework, there is no comparable piece within PEBB. The PEBB Program historically has stayed within a 1 to 2.75 ratio without legislative mandate or direction.

**Sean Corry:** Finally, with respect to the ratios that are apparently going to be in the proposal that we'll discuss and vote on, how close are these ratios to the current PEBB population? Is it essentially the same or are there noticeable differences?

**Megan Atkinson:** You mean how close are the PEBB tier ratios to the way the PEBB population splits off across? They're pretty close. The actuaries did the math in the last couple of weeks and they are very, very close.

**[Break]**

**Dave Iseminger:** Before Shawna starts, I thought I would make sure the Board and public are aware where we are in the story arc of benefits design. I'd say we've closed chapter one with the Board. We did a lot of foundational information with you and the public. We talked with you and you had actions at the March meeting that said: these are benefits where the agency should go forth with its current vendors negotiate and others go out with a procurement.

We're entering chapter two of the story, which over this meeting, the next meeting, and the June meeting, we talk with more granularity about the self-insured benefit plan options and the Uniform Medical Plan that the State has. The Uniform Medical Plan is an umbrella that has a substructure of multiple plans within it. We will go over medical

this month. We'll go over follow-up medical pieces next month, and do pharmacy next month. I want to be very clear that just because pharmacy isn't in today's presentation doesn't mean that there's not a pharmacy benefit. It just means we've bifurcated and put pharmacy at the next meeting instead of putting everything into one meeting. We will ultimately be asking the Board to take action on some to-be-written resolutions in June that we will present at the May meeting.

After June is done and hopefully we round out self-insured plan benefit design with the Board, we would then move into chapter three, which is the more granular benefit design of all the other benefits.

**Uniform Medical Plan**

**Shawna Lang**, Senior Account Manager, Portfolio Management and Monitoring Section, ERB**:** The objective of this presentation is to inform you about PEBB's Uniform Medical Plan and options for the benefit coverage levels and member cost-shares for SEBB self-insured plans starting on January 1, 2020. UMP's third party administrator (or TPA) is currently Regence, who provides customer service, claims administration, provider network, and clinical policy administration for UMP's medical benefits. UMP's pharmacy benefit administrator is MODA, who provides customer service, claims administration, retail, and specialty pharmacy network for UMP's pharmacy benefit. More on pharmacy at the May meeting.

To summarize the UMP, there are three plans. UMP Classic plan is a wide-ranging preferred provider organization (PPO). Currently, about two-thirds of PEBB membership have selected this plan. UMP Classic has worldwide coverage. UMP consumer-directed health plan (CDHP) has a health savings account (HSA). This plan was first offered in 2012 as a high deductible health plan with an HSA and allows members to pay a lower monthly premium in exchange for a higher deductible health plan. They also can save money in their HSA for use in IRS-approved medical expenses. For clarity there is an RCW requiring PEBB to offer a high deductible plan, but not for SEBB.

**Dave Iseminger:** That means this Board has discretion as to whether to offer a high deductible health plan with an HSA, whereas the PEB Board does not have discretion and they offer one.

**Shawna Lang:** The third plan is called UMP Plus. It was first offered to members in 2016. Members in this plan have the ability to select one of two accountable health networks: The Puget Sound High Value Network and the UW Medicine Accountable Care Network. UMP Plus expanded to nine counties in calendar year 2017, and will continue to look for more growth opportunities throughout Washington State. Membership also expanded from 17,000 to 26,000 from calendar year 2017 to 2018. Members in UMP Plus have access to a primary care office visit at no cost-share and have lower deductibles. UMP Plus also has a higher out-of-network cost sharing to incentivize in-network provider use for more coordinated care.

Slide 5 you saw in December when Scott Palafox first presented, but I have added current UMP memberships as of March 2018. Current membership in UMP classic is 210,000, membership in UMP's CDHP is 20,000, and UMP Plus is 26,000.

**Dave Iseminger:** One thing to add is when the Uniform Medical Plan Classic was created in the 80s, there was not 210,000 people. Over time, people began to see the value and understand the quality of the benefit offered within the Uniform Medical Plan and there was a migration over the years that resulted in the numbers you see today.

**Shawna Lang:** Year after year, UMP receives very high health plan ratings through the Consumer Assessment of Healthcare Providers and System surveys, also known as the CAHPS survey. These surveys ask consumers and patients to report and evaluate their experiences in health care. The survey covers topics that are important to consumers and focus' on aspects of quality that consumers are best qualified to access such as communication skills of providers and ease of access of health care services. Slide 6 includes quotes from UMP members. As you can see, they have all given UMP health plans high health plan rates and praise year over year.

**Sean Corry:** Is this 100% representative of all the comments? There are three very glowing comments here.

**Lou McDermott:** Yes, it is.

**Shawna Lang:** We do have a lot of people who love UMP but, of course, we always have our appeals and complaints and we always take that into consideration. We have processes to make sure we get back to every member who actually has any type of concern or issue with UMP.

**Lou McDermott:** And we have processes in place where if somebody complains to their Legislator or the Governor's office, those get transferred to us and we move those through the system. There are various complaints that happen within the program and some of them are technical issues that happen; some of them are needing additional information; and some of them are just clarification of benefit issues where the person will not be satisfied because x, y, or z is not covered. We handle all kinds of complaints and praise, depending on the individual and circumstances.

**Dave Iseminger:** I also want to add that once benefits go live, if you as individual Board Members start to get member complaints of appeals or requests for exceptions to coverage policies, we ask that you forward them to the Health Care Authority. We'll look into the matters, get back to you with whatever information we can. Keep that in the back of your mind as you start to get individual circumstances about benefit issues that you can always refer those to the Health Care Authority and we'll work with the member.

**Pete Cutler:** Back on the chart with the three comparisons, on the CAHPS scores. Were the CAHPS scores calculated separately for the Classic PPO, the consumer-directed plan, and the UMP Plus, or were they all rolled together?

**Shawna Lang:** They're calculated separately.

**Pete Cutler:** Did their numbers vary by any material amount between the three types of UMP?

**Shawna Lang:** I would say UMP Classic and Plus don't have much difference between them. UMP CDHP is lower than the other two, and that goes with the consumer-directed health part of that.

**Pete Cutler:** Great, thank you.

**Shawna Lang:** Slides 8 through 12 provide a high-level summary of the benefit coverages and member cost-shares. These are in categories of highly utilized member service categories or where member inquiries typically come in. Although SEBB self-insured plans must be very similar to the benefit offerings in the PEBB Program, during the review please highlight any particular benefits you think have unique aspects for school employees and may warrant different benefit levels. We want to bring detailed information in the May meeting for those types of issues. For example, state and federal laws that are guardrails on benefit levels. Examples of this are Health Technology Clinical Committee (HTCC) coverage decisions. UMP has to follow those HTCC determinations, and that will also be part of the SEBB self-insured plan, if that moves forward as well.

**Dave Iseminger:** I saw a couple inquisitive faces so I'll try to describe this a bit more. Bullet 2 on Slide 7 is to remind you that in order to launch a self-insured plan, the TPA procurement that we recently did for the PEBB Program took two and a half to three years to write the RFP, go out for procurement, select, and then another year and a half to two years of implementation.

If this Board wanted to launch a completely separate from-the-ground-up self-insured plan, it would not be viable and available for 2020. We'd be talking several more years out for a completely separate self-insured plan.

As the agency was going forward, coincidentally, the PEBB contracting and procurement process was around the time SEBB was starting to be an idea in people's minds. We went ahead and created the contract mechanisms through the procurement to be able to pull that lever immediately if this Board wanted to offer a self-insured plan for 2020. It does not need to be identical. Shawna's least favorite words are "substantially similar." I can't tell you exactly how different a plan could be to be able to pull our self-insured plan contract lever. But it does need to be very similar, substantially similar, materially the same, those types of words.

We're asking you as we go through the next couple of slides, to highlight benefits that you think there might be something unique about school employees. We'll bring back the complex federal and state law framework that overlays each of them. We didn't want to go through all 40, 50, or 60 core benefits. There are many different benefit pieces and we could go through and describe each of the overlapping different

frameworks, but to launch a benefit in 2020, something pretty darn similar to UMP is needed. We want to narrow in on areas that you think may warrant benefit differences, and then talk about your discretion.

**Sean Corry:** We talked about this at the last meeting. I questioned it then. When I looked at the material here, I circled it as well. Where it says "very similar to," which is not clear enough yet for me, and I'm not complaining about that, but I did give some thought since our last conversation about what's driving this. It's not legislative. It effectively has been because of the Health Care Authority contracting with the administrator that was likely to pick up this business, too. I mean, it's sort of an agency dynamic in negotiating with the administrator that's giving us the restrictions in what we can do, as opposed to legislative intent or legislation.

**Dave Iseminger:** There are a couple of different pieces. The timeline for launching the benefits is certainly a factor. The agency stepped back and said if the SEB Board wants to have a self-insured plan, because it certainly has that discretion within statute, how could we go about administering a plan for 2020? The potential SEB Board - you weren't even named at the point we were starting to have these conversations - how would we give you the ability to pull that lever versus the agency coming to the Board and saying: "There's no way to do a self-insured plan for 2020. You're only in the fully insured market. Let's talk about whether you want a self-insured plan for 2022," just to throw out a date.

Instead the agency took it upon itself to say, "What can we create as a mechanism to be able to have a self-insured benefit that could be launched under the timeline that was set by the Legislature." It's really a confluence of a couple different pieces, and the agency came up with a way to present you with an option rather than no option. The alternative would have been to not engage in that conversation with the TPA and say, "we don't have an option for you to do anything in this part of the book of business." I think the agency was very thoughtful in trying to come up with a way to present you with something that you could leverage. You still don't have to do this.

**Shawna Lang:** For Slide 8, we're going to talk about medical deductible and out-of-pocket limits. UMP Classic medical deductible for subscriber only is $250 and for family deductible it's $750. The out-of-pocket limit for UMP Classic is $2,000 per subscriber, and $4,000 per family. The UMP Plus deductible for subscriber only is $125 and family deductible is set at $375.

Out-of-pocket limit for UMP Plus is the same as UMP Classic. UMP CDHP deductible is $1,400 per subscriber and $2,800 per family for two or more. UMP CDHP meets the minimum qualifications for a high deductible health plan. Out-of-pocket limit for the UMP CDHP plan is $4,200 for a subscriber and for two or more people is $8,400. Once an individual meets $6,850 in covered out-of-pocket expenses annually, the plan will pay 100% for services after that point for that individual.

**Dave Iseminger:** Two things. Shawna is not going to read every chart for the next four pages; she will do highlights, but this is a particularly important one. The second piece

is I wanted to highlight the CDHP, which is our high deductible health plan on the PEBB side. That $1,400 sounds like a lot of money, and it is a lot of money. At the same time, many times you'll see high deductible health plans that have much larger deductibles. This is what some people call a generous high deductible health plan because it has a lower high deductible compared to other high deductible health plans. I want to assure you that the plan does meet the requirements under federal law to qualify as a high deductible health plan.

**Lou McDermott:** Isn't there also an HSA contribution from the State?

**Dave Iseminger:** On the PEBB side there is an employer contribution. There's still some evaluations that have to occur with regards to how that could work on the SEBB side, but regardless, there's an HSA that comes with a CDHP and then the employee can contribute funds to that HSA alongside of any employer contribution that might exist.

**Shawna Lang:** For most in-network procedures, a 15% coinsurance will be paid by the member after the deductible is met in each plan. UMP CDHP plan does not have copays for ER or in-patient. Instead, it has a straight 15% coinsurance after the deductible is met. Examples of benefits in these slides are covered as if the member is using an in-network provider. UMP Classic pays 85% for in-network services and 60% for out-of-network services, and then UMP Plus pays 85% for in-network services that aren't provided by a Primary Care Physician (PCP). All PCP visits in UMP Plus are paid at no cost and then it has an out-of-network benefit of 50%.

**Dave Iseminger:** Shawna was describing the 85% and the 60%, which is what the plan pays. These slides are from the member's perspective and the "you" in these sentences on this slide is what the member would pay. Whereas the plan pays 85% of a preferred provider acupuncture visit for UMP Classic, the member pays 15%. As we're going through these slides, if there's any specific benefit you want to ask questions about or want more detail on at the next meeting, let us know. As an example, if you wanted to say, "We think with acupuncture there's something unique about school employees that we want, as a Board, to evaluate acupuncture visits. Tell us more about the framework that resulted in a 16-visit limitation." That's the type of thing we'd bring back at the next meeting. So identify benefits you want us to describe the framework behind which that benefit was born in the original UMP or in the current UMP.

**Shawna Lang:** I'm going to highlight limits and differences between the three plans. Acupuncture has a limit of 16 visits per year. Chiropractic has a limit of 10 visits per year. Chemical dependence in-patient for UMP Classic and UMP Plus has an in-patient copay of up to $600. For UMP CDHP, it's a straight 15% coinsurance. ER has a copay of $75 in UMP Classic and Plus, but is waived if the patient is admitted. There are no copays for the UMP CDHP.

**Dave Iseminger:** For clarity, if you're not highlighting a benefit, we're going to be under the operating assumption that as we move forward, we would start to align what's on the

page as the foundational structure of the benefit for the launch of a SEBB self-insured benefit. We want you to be questioning and highlighting areas that you want to focus on as a Board as potential changes of benefit design. In addition, eventually, you will have to answer the question of which of these benefits structures, Classic, Plus, CDHP do you want to offer? You'll have that choice as well, columns, as well as, any differences within the rows. Sean, I'm sure I'm not saying this clearly enough.

**Sean Corry:** No, I think that was clear. I'm really asking this question on behalf of others who represent employees and other constituents. Just with respect to the timing because, frankly, I didn't look at this until this weekend. When do you need these suggestions back by? When's the drop dead? It's certainly not this meeting. It's got to be before the next meeting.

**Dave Iseminger:** Correct.

**Sean Corry:** How much time do Board Members and others have a chance to bubble up?

**Dave Iseminger:** We are in constant Board preparation mode at the Health Care Authority. Every week, if we're not meeting with the Board, between the two Boards, we're preparing for a Board meeting. We would need feedback by the middle of next week to be able to get the adequate information, put it together, and vet it through the process to make sure we have everything as cleanly prepared as we've been trying to produce for the Board. If we're unearthing different parts of federal law and then talking about the best way to present it, succinctly yet comprehensively, that building process takes time. It's a very fast four weeks between meetings here at the agency.

Partly why we're on this chapter two journey that I described earlier, culminating in the middle of June with votes about the structure of the plan is so we can work with vendors and our own IT systems to build the actual group structure, to build the eligibility framework from an IT perspective. We need the Board to start to coalesce around what the benefits will look like for 2020, knowing that you will be able to revisit different pieces as we get more experience with the population. We'll track complaints and appeals, you'll hear concerns come up at Board meetings in public comment. Over time the benefit will get refined as you learn more about the population you're serving, but we need the Board to coalesce around different parts of it so we can actually build the IT infrastructure to support the benefit selection process and the administration of the benefits.

**Alison Poulsen:** I'm curious about the limits on these things and how that's set. Not so much thinking that we need them to be more but can you provide some feedback on that?

**Shawna Lang:** These limits have been in place for since 2007 at least. This will take some research to understand historically where they came from. I can get back to you.
**Alison Poulsen:** I think part of my interest is as we think about preventive care, acupuncture, chiropractic, massage, all three things that I think have been important to

my health, those are pretty limited benefits. I'd be curious about the evidence-based practice for the limits?

**Dave Iseminger:** We will bring more back about the generality of the creation of treatment limitations at the next meeting.

**Lou McDermott:** Shawna, if I'm correct, there are exceptions, correct? You can extend beyond the limits.

**Shawna Lang:** In some cases, yes.

**Patty Estes:** I would have said exactly what Alison said with the chiropractic and the massage. Not so much the acupuncture. In my experience with my members that I've been in contact with, but definitely the mental health treatments. I know that there has been some limitations in some of the plans that have been offered by PEBB, only because my school district is in PEBB. So, some of the members that I know, I think they're on the Kaiser plans that are offered through PEBB, so not the UMPs, but knowing some of those limitations within mental health, in addition to the ones that Alison said, would be great.

**Shawna Lang:** Mammograms are covered at preventive rates, at 100%, as long as they're billed with preventive codes; and they're covered at 15% coinsurance when billed with diagnostic screening codes. Massage has a limit of 16 visits per year and members must use an in-network provider. Mental health treatments for UMP CDHP only has coinsurance and no copays. Naturopaths are covered as a PCP type for UMP Plus, so there's no cost-share for them.

Obstetric care in UMP CDHP only has coinsurance and no copays on all services. Office visits for UMP Plus, for all office visits with PCP providers, are covered at no cost to the member. Again, that's why we're different on the office visits. Preventive care and immunizations are covered at 100% in all plans. Skilled Nursing Facilities are limited to 150 days per calendar year. Surgery for UMP CDHP only has coinsurance and no copays for all services.

**Patty:** Under preventive care, does that include birth control?

**Shawna Lang:** That's a pharmacy-related question.

**Patty:** Okay. If it's administered by a doctor?

**Shawna Lang:** If it's administered by a doctor, yes. For example, IUD is covered at 100%.

**Dave Iseminger:** We will bring back more detail about what is within preventive care within these plans. That builds off of Alison's prior question.

**Shawna Lang:** Next we're starting with therapy; both physical therapy, occupational therapy, speech therapy, and neurodevelopmental therapy. This combined benefit does not include ABA therapy. I want to make sure that's noted.

**Dave Iseminger:** Shawna, because ABA therapy is covered under a separate benefit line, not in this chart but it's a separate benefit line within the plan?

**Shawna Lang:** Yes. Back to the combined therapy benefit, In-patient the limit is 60 days per year; outpatient is 60 visits per year. Routine eye exams covered at no cost-share and vision hardware for adults is $150 every two calendar years. Vision hardware for children is one pair of eyeglasses, frames and lenses, covered at the allowed amount once per year.

**Dave Iseminger:** Shawna, will you make sure it's clear for the Board, on the PT/ST/OT/NDT, the 60 visits, that's with a referral and a member can get additional visits that are needed and supported by medical necessity determinations.

**Shawna Lang:** Yes, we've had that happen.

**Dave Iseminger:** 60 visits in a year is a little more than once a week and it's a combined limit between all of those services.

**Sean Corry:** Thanks for bringing me back to this row because I see that neurodevelopmental is in there with limits, and in the insured world, there are some neurodevelopmental therapies covered by the Mental Health Parity Act because the codes are in the DSM5. Help me understand whether those requirements of coverage apply to the self-funded plans here and if you know whether the outpatient visits, 60 visits maximum per calendar year, apply to things covered under the Mental Health Parity Act.

**Dave Iseminger:** I'm going to recommend we bring this back as part of the next presentation. I know we start to get complex real fast and I don't want to say something wrong on the public record or force Shawna to say something wrong on the public record. This is exactly the type of thing I wanted the Board to identify. We'll bring back more detail about this particular benefit and its relationship with the Mental Health Parity Act. I think implicit into that is the question is what would be your discretion to have different treatment limitations. Katy Hatfield, we'll be needing some assistance.

I do want to highlight, in the Uniform Medical Plan, vision is embedded within the medical benefit. From the Board's actions last month, we are working on the procurement and completing the RFI for a standalone group vision benefit. You'll be able to compare and contrast with what exists within the embedded, and you still have the choice before you as to whether you want to embed it in the medical benefit plans or have a standalone benefit. If you want to have a standalone group vision, then we would come back to this piece and talk about carving out vision from the Uniform Medical Plan in our contract with the TPA. We already have the idea that we may want to, on both programs, have carved out vision benefits. One of those reasons being the

Cadillac Tax. There are many reasons why it might be appropriate to have a carve out. We have a contract mechanism to be able to work on carving out the benefit within the existing Uniform Medical Plan. That vision question will be for another day for the Board once we have tested the hypothesis as to what a standalone group vision benefit could look like and compare and contrast it with this.

I also want to use the vision lines as an illustration of the complexity of federal and state law. On Slide 12 you see two rows for vision hardware distinguishing between adult and children. Pediatric vision and hardware must be covered and the 100% coverage is to ensure compliance with federal law in a way that is not mandated for adult hardware. It's an example of how complex it gets when you're looking at overlapping federal and state regulatory frameworks.

Before we move on, I want to catalogue what I think we're bringing back, and if there are any other additions from the prior slides let us know because we need to get to work on that next month, which is tomorrow! I have us bringing back information about general treatment limitations, specifically chiropractic, acupuncture, massage, and mental health treatments. We will bring back what preventive care includes, talk about the preventive benefit and how it intersects with the pharmacy benefit. We'll bring back information on speech therapy, occupational therapy, physical therapy, and neurodevelopmental therapy, the intersection of that with the Mental Health Parity Act, and any discretion you have as a Board to have a different range of treatment limitation options.

I think we should bring back more about how the provider networks work. We've talked about the preferred provider network and how it's a 15% member cost-share when it's in-network and it's 40% when it's out of network. Especially when you get into the Uniform Medical Plan Plus, it's a bit more complicated than that and I think it would be important for the Board to have an understanding of the provider network interactions and how that plays out whenever you're part of these plans. I've added that to the list as well.

**Shawna Lang:** Slide 14 – Appendix. In the appendix you will find a description of fully insured and self-insured plan types, coverage counties for UMP Classic and CDHP, coverage counties for UMP Plus, UMP membership population that resides outside of Washington State, and medical benefit comparisons to other school districts that were presented by Scott Palafox.

**Pete Cutler:** As a follow-up on that last point. I noticed that the coverage by county for the UMP Plus has enrollment numbers but the coverage counties for the classic and CDHP do not. Can we get a version of coverage counties with the enrollment?

**Shawna Lang:** Yes.

**Policy Resolutions**

**Barb Scott**, ERB Division Policy, Rules, and Compliance Section Manager. Today we have two policy resolutions that were introduced at your last meeting that we're going to ask you to take action on.

As Dave noted earlier in the meeting, SEBB 2018-12, which is the resolution titled Effective Date of Coverage, we are going to continue to work with stakeholders to refine it and then bring a resolution back to you. We're still working with them and figuring out how that would best look. You're not going to see that one in front of you today.

I'll walk you through the feedback we received, give you time to discuss, take public comment, then vote. As is our typical process, we've included a piece of the RCW that ties into the policy resolutions you're going to take action on today so you'll have that as a reference point. Staff have been shading the text in blue in order to help you focus on the area they believe is the area of your authority that you're working under as you look at these policy resolutions today. You'll see staff do this on each slide set as we walk through both the ones we're introducing, as well as the ones you're taking action on.

The first policy resolution for you to take action on today is Policy Resolution 2018-13 - Election Period. The recommended policy was slightly changed, from the one originally introduced to you, based on a recommendation from the Board. We added clarity at the end of the resolution. The policy resolution addresses all elections are due regardless of whether they are employee elections for benefits that the employee's paying for versus employer paid. We added the word "all" at the beginning so it reads, "… resolved that all of the school employees' enrollment elections…," not just a part of them. It's every election is due.

We also have clarified the trigger for measuring the 31-day deadline is eligibility for the employer contribution rather than hire date. I'll give you an example. Oftentimes an employee is hired and may not originally be anticipated to be eligible. We see this in the PEBB population, so after their hire date, they're determined to be eligible. To tie anything to the hire date was tying it back to a date that didn't matter. The employee's eligibility for the employer contribution is a much better date to measure from and that's why you're seeing that on this resolution as well.

We did receive questions back from stakeholders and we received feedback recommending the words "employer paid" versus "employer contribution." However, we believe using the word "employer paid" may lead to confusion that benefits are fully paid by the employer so you'll see in the resolution before you we're using the words "employer contribution."

**Dave Iseminger:** There was no phrase "employer contribution." The recommendation was "employer-paid contribution," but because of the concern stakeholders highlighted, our recommendation is "employer contribution". We took the feedback provided, considered it, and added words to the resolution that give the clarity that's necessary.

**Barb Scott:** We did receive questions from stakeholders regarding what the default enrollment plan would be as far as the medical plan or dental plan. Since plans aren't determined yet, we didn't include a specific plan or talk about a default plan at this time. Once the SEBB plans are determined, we'll bring back a resolution for this Board to decide what the enrollment of an employee who doesn't take action and elect during their 31 days will be. We'll ask you to adopt several policies related to what is the default position when an employee doesn't take a needed action. We also received questions regarding the ability for an employee to waive coverage. We will work on a policy to address which SEBB benefits could be waived, as well, and we'll bring that back to you in the future.

**Sean Corry:** I have a question about process. This is a complicated issue for school districts because of the way they currently do eligibility and put people into coverage. I fear that in the future we're going to run into circumstances we haven't discovered yet about difficulties with respect to this process. So my question is a little broader. If we run into those circumstances and we understand that it might be something we need to address, what's the process for rethinking what we're about to vote on and maybe changing it to meet the needs that we don't now know?

**Dave Iseminger:** I think I've said in many environments, but I don't think I've said it to this Board, if you look at the PEBB rules, they're about 30-40 pages in length. That didn’t happen overnight. That happened over a many-year process, and as we learn more about the system, we'll bring refinements to you.

You will raise issues saying you are hearing about something in the school districts. Can the agency look into this? The staff can investigate and understand circumstances with more granularity. We will then report back to you if and why your current policy actually meets the needs of members or the districts. In other instances, we will recommend a refinement of your eligibility rules. This is an iterative process, where we are at this juncture with the knowledge we have. At the same time, with the amount of change that's happening in the system, there will be pieces that have to be cleaned up as we're stabilizing the program. We're not anticipating that with this particular resolution, but I understand, Sean, your question about the larger process for all of the resolutions and the eligibility framework. It's building the ship as we go along and recognizing that we may have to change course on some pieces. There may be pieces that we pick up and are able to refine before launch.

We're thinking that the things we're bringing to you we feel reasonably confident that, after stakeholdering, it is a good solid foundation for the launch of benefits on 2020. As you identify pieces and stakeholders identify pieces, we will have an annual iterative process where we look to you to refine different parts of the eligibility framework, hopefully for the next 30 or 40 years, and get to the same level of detail as PEBB rules. When you look at the PEBB rules, there are many different parts. Just as there are hundreds of different types of employees in the PEBB population, there are hundreds of different types of employees within the SEBB population. Is this Board and the agency going to come up with recommendations on every single iteration of all those employees for January 1, 2020? Absolutely not. As we learn more about the

population and we identify different parts of the population that don't quite fit the rule, we'll work with you to create a policy that fits that situation and addresses that part of the population.

**Sean Corry:** Thank you.

**Patty Estes:** I have a concern with the "becomes eligible" because of the wording now with “anticipated to work 630 hours.” With this “becomes eligible,” does that mean when they hit 630 hours or when the district anticipates them to work 630 hours?

**Barb Scott:** This was written in a way that we hoped would take care of both situations. The "becomes eligible," we thought could come two different ways and that's why I said we didn't anchor it back to the hire date. You will have folks anticipated to work 630 hours and deemed eligible maybe as early as at-hire. You will have others who may gain that over time because they were not originally anticipated to work 630 hours, but the reality is they did work 630 hours. We tried to write this in a way that it would function in both of those scenarios.

**Patty Estes:** My concern is that some school districts will wait until those employees hit the 630 hours to let these employees be eligible versus saying, "Oh, we didn't anticipate them to work, so they weren't eligible." Then they worked 630 hours but they've been working for four months without benefits when they originally could have been anticipated to work that. That's where that ambiguity could hurt members. When they should have been eligible they were not eligible because of that anticipation versus this wording that says, "just becomes eligible." It’s concerning.

**Barb Scott:** Is there another word you were thinking of that could work?

**Dave Iseminger:** Let me interject a couple of different pieces. First, the way the rules will be written and codified in the Washington Administrative Code will flush out some of the extra details. We’re getting the Board to make a policy direction and making sure you understand the implications of this. Barb is putting on the record the intent and your understanding of the intent, if you were to adopt the resolution, is it takes into account both of those worlds of anticipated, as well as actually worked 630 hours. In the rule, we may write a subsection one that describes it in a new hire way and a subsection two that writes it the other way so there's even more clarity as district officials make those eligibility determinations. I wanted to be clear the rule that's written from this will probably be longer and describe even more granularity. I can’t remember the second piece I want to highlight! I'll think of it.

**Barb Scott:** I think Dave is describing that we will end up writing rules that will talk about when an employee becomes eligible for the employer contribution. Those rules, those resolutions, that will help to build those rules, haven't been brought before you yet. I think those are ones you're describing so there can't be gaming of the rules. How that will be resolved we're not prepared for yet; but at the same time, we thought writing this the way we did would allow for any situation by which an employee is deemed eligible. They would have a period of time in order for them to know they were eligible

and be able to make elections. Under Cafeteria Plan administration, IRS rule allows employees 30 days to make an irrevocable election. The reason it's written as 31 days is because a rule will be written to say you must have your form in no later than the 31st day. We expect it's turned in by the 31st day and that gave the employee the full benefit of the 30 days allowed under Internal Revenue Code rules to make decisions about their election.

**Patty Estes:** Okay.

**Dave Iseminger:** Patty, I remember the second thing I was going to bring up. There will be an eligibility appeals process crafted and put in place where HCA could identify an employer not following the rules as envisioned by the Board. There's an opportunity to train and educate an employer who may not understand the rules. We have staff that work with employers on the PEBB side now and will work on the SEBB side, too, to help them understand the intent and requirements of the rules. Ultimately, if we have a particular employer, I think this is on the SEBB side as well, not following the rules, HCA can recommend that this Board take action against that employer to help them understand the ramifications of not following the Board's rules.

**Patty Estes:** Okay, thank you.

**Lou McDermott: Policy Resolution SEBB 2018-13 - Election Period:**

**Resolved that**, all of the school's employee's enrollment elections, including an election to waive if allowed, must be received no later than 31 days after the date the school employee becomes eligible for an employer contribution for SEBB benefits.

Wayne Leonard moved and Alison Poulsen seconded a motion to adopt.

Voting to Approve: 9
Voting No: 0

**Lou McDermott:** Policy Resolution SEBB 2018-13 passes.

**Barb Scott:** The next policy resolution for you to take action on is SEBB 2018-14 - The SEBB Program Premium Structure. The recommended policy was changed to clarify that it will apply to benefits where there is an employee and employer contribution. I think this was a question or we noted it last time for you. We did receive comments on this policy and stakeholders were not concerned with the use of this premium structure and these four tier categories.

**Lou McDermott: Policy Resolution SEBB 2018-14 - The SEBB Program Premium Structure.**

**Resolved that**, within the premium structure for the SEBB benefits where there is both an employer and employee premium contribution, there will be four tier categories. The

premium tier ratio and the employee premium contribution for each tier will be: Tier

| Category: | Subscriber Only | Premium Tier Ratio: | 1.0 |
|---|---|---|---|
| | Subscriber and any Child(ren) | | 1.75 |
| | Subscriber and Spouse/State-Registered Domestic Partner | | 2.0 |
| | Subscriber and Spouse/State-Registered Domestic Partner and any Child(ren) | | 3.0 |

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

Voting to Approve: 9
Voting No: 0

**Lou McDermott:** Policy Resolution SEBB 2018-14 passes.

**Barb Scott:** The next step will be to incorporate the policy resolutions into program rules and benefits.

**Eligibility and Enrollment Policy Development**

**Barb Scott:** These are new Resolutions you haven't seen yet but we're introducing. Today we have five Resolutions and we are looking for discussion and feedback on them. Staff included language from RCW to support you as you walk through them. We have included additional ones from the budget bill as well to help you look at language that supports the decisions in front of you. Highlighted is the part that indicates the Board determines the terms and conditions for school employee and dependent eligibility criteria and enrollment policies.

The first proposal is SEBB 2018-15 – Dual enrollment in SEBB Benefits is prohibited. School Employees Benefits Board (SEBB) medical, dental, and vision coverage is limited to a single enrollment per individual.

This policy mirrors one the PEB Board has in place to prohibit an individual who had more than one source of eligibility for PEBB coverage to a single enrollment. They did that subsequent to the Legislature including language in the budget that assumed within the PEBB funding rate that dual enrollment would be prohibited by the PEB Board. Knowing that the Legislature went down that path for the PEBB Program, we're bringing this to you to think about in the context of SEBB.

For example, with PEBB eligibility, because my husband also happens to be a state employee, I could be covered on my own PEBB eligibility as an employee, or I could choose to be enrolled on his coverage as a dependent. But the Legislature said although I may have eligibility from both places, I don't get to draw money out of the State coffers in order to support me being enrolled in both of those places. When that was allowed in the PEBB Program, I benefited from not having any out-of-pocket copay when I went to the doctor's office. My children were young at the time. I didn't pay out-of-pocket, necessarily, because of coordination of benefits when I took them to the doctor or when we filled prescriptions.

When PEBB went down this path, one of the things noted was that as employee premiums increased over time, the employee's share that was the cost of coverage for medical coverage became less and less important to employees. By the time you're paying a significant cost out of your own paycheck in order to cover those family members, then not paying a $20 copay at the doctor's office becomes less valuable to you. You would have to use more and more office visits, so this policy gets to that. Only one eligibility could be used.

**Dave Iseminger:** You can think of this as a fundamental assumption that we believe the Legislature has, even though there aren't many things known about the funding questions. We believe this is an underlying tenet about the funding solution will need to be created, as well as a potential cost containment piece.

**Katy Henry:** Does this apply to dependents as well? If you had two spouses who were going to be in SEBB, could they both enroll their children, employee and children under each of them, or does this prevent that?

**Barb Scott:** In my personal example, when my husband and I were both state employees and we had children at home, the advantage was that we both double covered the kids because they were the ones who were using benefits more than us. This type of resolution when passed by the PEB Board prevented it prospectively. We had to make a decision which one of us would cover the children based on preference in the same way we made the decision whether I would waive my medical coverage, I could have waived my medical and been covered on his medical along with the children. The PEB Board left up to the individual to decide how best to cover family members. This policy would allow that as well. It just limits it to a single plan enrollment.

The other place we saw folks sometimes had dual eligibility was as an employee and also as a dependent child - young adult children still being able to be covered on their parent's coverage. That young adult who's working and eligible for SEBB benefits would have to decide to between their own coverage versus they could waive and be covered on their parent's coverage. That might be advantageous if there were other children already. The way the premium rate structure is, there is one cost regardless of the number of children you cover. Families would be able to make decisions but they would be limited to pulling dollars out of the pot one time.

**Dave Iseminger:** Katy, the answer to your question was yes. [laughter]

**Barb Scott:** I could have gotten there much faster by saying yes.

**Dave Iseminger:** I do want to put on the record that this is just one piece of dual enrollment. We know that there are other situations to be addressed by the Board, for example, when an individual and their family circumstance has dual eligibility between PEBB and SEBB. Now that both of those funding structures will be coming from the state, if you have a school teacher and their spouse who is a faculty member at a higher education institution, is dual enrollment something that's allowed? We're not asking the

Board to determine that now. We still have a lot of evaluation to do in that area, but we felt this piece could be brought to the Board to at least address within-the-program dual enrollment.

**Pete Cutler:** Do we have fiscal analysis on this either for SEBB or the combined SEBB/PEBB dual enrollment policies? My understanding, and I probably was on a budget committee at the time, was that there was a certain amount, it had an impact on the funding rate whether or not you allowed double coverage. I'm just wondering whether we have any kind of fiscal analysis around that?

**Dave Iseminger:** Duly noted request, Pete.

**Barb Scott:** Staff included language out of the budget bill to provide you with language related to the next couple of resolutions. In the budget bill this last year, there was language included requiring a $25 per month surcharge related to tobacco use and a $50 per month surcharge for a spouse or domestic partner who had coverage available to them through their employer that has benefits and premiums with an actuarial value of not less than 95% of the Public Employees Benefits Board plan with the largest enrollment. PEBB's plan with the largest enrollment is the Uniform Medical Classic Plan.

**Dave Iseminger:** It might sound counter-intuitive to have the benchmark for a SEBB surcharge be the PEBB plan, but in reality, it is just that, a benchmark. One of the reasons the PEBB plan was selected was there are no plans in SEBB to use at this time. Second, the agency has already implemented surcharges using this benchmark and it eases implementation. HCA also won't have dueling surcharge calculators on the website that inevitably somebody uses calculator A when they're supposed to use calculator B. It's just a benchmark for an actuarial equivalency and premium equivalency.

**Barb Scott:** The agency did implement surcharges consistent with these for the PEBB Program in 2014. In implementing those surcharges, we learned a lot. We recognized that there are a number of decisions within the HCA's purview, and then there are policy decisions we will bring before you that are consistent with those we brought before the PEB Board. I want to run through some of the HCA decisions so that you'll be aware of them. HCA rules require a subscriber's attestation for both the tobacco use, as well as for whether or not their spouse had coverage through their employer. We chose not to do any tobacco testing. There was a conversation about what testing is available and whether or not we would just rely on the subscriber's attestation. We also made the choice to not audit whether or not a spouse's employer is offering coverage to them. Instead, again, we take the subscriber's attestation at face value. We assume that we're going to do the same thing for the SEBB Program as we implement these surcharges.

**Dave Iseminger:** We have made clear that if individual employers learn about an individual not accurately providing information, it's up to the individual employer to decide whether that's something they want to review under their HR policy. HCA is not

the tobacco police. The employer can decide what it wants to do, but the Health Care Authority would take the attestation and apply or not apply the surcharge based on what the member provided.

**Barb Scott:** We also plan to implement in the same way we did for the PEBB Program, but the $25 tobacco use surcharge will be a single amount added to the premium for the subscriber, regardless of the number of members on the account who use tobacco. For example, if Dave and I were married, I have him enrolled on my account, and he smokes tobacco and I don't, I would have to pay the tobacco surcharge. If we both used tobacco, I would still only pay a $25 tobacco surcharge. It will be one surcharge per account, not multiples.

Another HCA decision is a subscriber will not be assessed a tobacco use surcharge if all members enrolled in medical coverage age 13 or older who use tobacco products are enrolled in a tobacco cessation program. If they're enrolled in a tobacco cessation program we don't charge them a surcharge. We plan on doing the same with the SEBB Program population. You note I said "age 13 or older." When we implemented for the PEBB Program, we found there are no smoking cessation programs that can be put in place for a population under the age of 13. That's why there is an exception for a tobacco use attestation for children under age 13. We also found that if there were failures on the employee's parts about attesting for a child, it was usually a newborn child.

**Lou McDermott:** We were deeming newborns as smokers for a little while, right?

**Dave Iseminger:** We did hear from members whose babies were deemed smokers. That decision was modified.

Federal laws also require reasonable accommodations for tobacco surcharges. To comply with them, a member must be able to avoid the tobacco surcharge if they are in a tobacco cessation effort.

**Barb Scott:** Most medical plans have a tobacco cessation program for 18 or older. For a member age 13-17, what we did for the PEBB Program was described resources aimed at teens on the Washington State Department of Health's website. Our medical plans weren't able to put a smoking cessation program in place for teens. So, we are utilizing what Washington Department of Health has in place.

For the spouse and domestic partner surcharge, we created a worksheet and a calculator tool. When you look at the budget bill, it requires comparing actuarial values. The easiest way to help our members was to create a tool to help them compare plan AVs with the UMP Classic AV.

**Dave Iseminger:** There are so many different employer situations that we couldn't centralize and do the calculator on behalf of everyone. We had to create something that allows a member to input a couple key features of a plan to say this is equivalent or not equivalent to the AV of the benchmark plan, and then a premium comparison, too.

**Barb Scott:** We also plan to include a provision in the Cafeteria Plan document for the SEBB Program that will allow a member to change their tobacco use status mid-year. Also a provision if there's a change in their dependent's employment.

**Dave Iseminger:** What Barb's saying here is that although an individual may have to pay a tobacco surcharge, they can use pre-tax payroll dollars to pay and they are able to change that attestation and get out of paying it within Cafeteria Plan rules.

**Barb Scott:** Those would be a couple of the special open enrollment events that Tristin talked about earlier, and our purpose in including them in the Cafeteria Plan document then meets the requirement of being able to administer using payroll dollars on a pre-tax basis.

If the Board adopts a policy that allows an employee to waive enrollment in medical, we'll create an exception to the spouse and domestic partner surcharge so an employee is not assessed a surcharge because their spouse waived their own SEBB medical in order to enroll as a dependent. For example, if Dave and I were married, we were both SEBB eligible, and we decided it was best to be covered on one person's coverage versus the other, then we wouldn't have to pay a spousal surcharge if one of us waived and was covered by the other.

**Sean Corry:** In the definitions of tobacco products, it specifically excludes e-cigarette or whatever, other terms apply in that general category. Why is that?

**Barb Scott:** If we flip to the proposed resolutions we can talk about that. The first resolution is the definition of tobacco product, and as Sean noted, tobacco products excludes e-cigarettes. The definition of tobacco product is closely aligned to the definition used by the FDA. However, it differs from the FDA's definition of tobacco products in that one area where we have exempted e-cigarettes. The reason we exempted e-cigarettes is because, in working with our Chief Medical Officer, the science behind e-cigarettes is still evolving. Whether e-cigarettes actually help folks who are trying to stop using tobacco products versus them having a negative effect in and of themselves, is still undetermined. The FDA does now include e-cigarettes in their definition of tobacco product, but based on just the science itself, we have exempted them at this time.

**Dave Iseminger:** When the tobacco surcharge was originally included in the PEBB population by the Legislature, the FDA had no rulings on e-cigarettes one way or the other. The tobacco surcharge was implemented without e-cigarettes counting as tobacco products by the recommendation of our CMO and then the PEB Board's action. Since then, the FDA did take action and included e-cigarettes within its tobacco product definition, but only for the consumer marketing regulatory framework. The FDA did not put e-cigarettes within their framework of treating them as chemically equivalent. The FDA included e-cigarettes in its ability to regulate packaging and marketing. The FDA wasn't focused on necessarily the health implications, and so while the FDA has started down the road of some e-cigarette regulation similar to tobacco products, it's not full regulatory equivalent authority that they are applying.

Another piece we looked at is how the state treats e-cigarettes. We looked at a similar piece where there is some regulatory authority regarding consumer marketing aspects of e-cigarettes. But e-cigarettes are not taxed in the same way as other traditional tobacco products. Those distinctions prompted a recommendation to the PEB Board that this is still an evolving area, and the PEB Board should continue to exclude e-cigarettes from the definition of tobacco products. For those same reasons, we are making the same recommendation to you as you launch the definition of tobacco products for these surcharges.

**Barb Scott:** The FDA was looking at the marketing to those under the age of 18 because e-cigarettes were coming out in multiple flavors. They were trying to protect children under the age of 18 from starting to use tobacco products. They really were focused on that population with the changes they made.

**Wayne Leonard:** Given the divergence in the federal and state regulations around cannabis, would it someday be included since our bus drivers can't have marijuana in their bloodstream to maintain their Commercial Driver's License (CDL). All school districts have drug-free workplace policies, but we're going after tobacco and not other forms of inhalants with this surcharge.

**Barb Scott:** The budget bill was very specific to tobacco products and did not just say "smoke." What we brought forward is tied directly to what is in the budget bill. If there is an interest to apply something beyond that, it isn't required by the budget bill.

**Dave Iseminger:** If this Board wanted to take additional action, we could evaluate that, but again, in this context, the phrase "tobacco products" was deemed not to include cannabis or marijuana because it's not from a tobacco leaf. We learned all about tobacco leaves several years ago. In fact, there is tobacco infused vodka and there was a question, "Is that considered a tobacco product under this definition?" Our members never cease to amaze me with their creativity. [laughter]

**Barb Scott:** I don't remember the tobacco infused vodka. I do remember the one sprinkling tobacco on food, and any way you ingest tobacco would be considered "use."

**Dave Iseminger:** In the instance of tobacco infused vodka, that was infused, not derived from the leaf, and I think the derivation matters. It gets granular very quick.

**Lou McDermott:** This is bringing back a lot of good memories. [laughter]

**Pete Cutler:** I would note that the surcharge, when it was implemented in PEBB Program, pre-dated the legalization of marijuana so the policymakers didn't have to address that question. It really is a question going forward, something the Board could look at, but it would be going beyond what the Legislature has in the budget bill.

**Dave Iseminger:** We crafted the tobacco product resolutions and put them in the Briefing Book and then realized we needed to explain surcharge implementation for

context. I apologize for you not having slides about some of the implementation aspects of the surcharges to read in advance.

At a later point, we'll give a presentation to the Board about how the surcharge implementation. But I wanted Barb to give a framework of some of it so these weren't resolutions without any context.

**Alison Poulsen:** I'd be curious when we do that deeper dive, the percentage of folks who attest to using tobacco products and how it compares to state or national average use, or however you might look at that.

**Dave Iseminger:** Before Barb moves on, I'll add one more thing about the surcharges because I know it's something that kind of permeates this topic. I said we weren't the tobacco police, but you'd be surprised that members come forward and say, "I said no, but I really smoke. I feel bad. Can I pay it?" And we say, "We'll change your attestation." Divorcing couples, nosy neighbors, and colleagues try to turn in people they see smoking or suspect lied on their attestation form. We say, "Feel free to talk with their employer about your concerns." We take the attestation on its face.

**Barb Scott:** That is true. The next definition is the use of tobacco. Proposed policy SEBB 2018-17 would define tobacco use to mean any use of tobacco products within the past two months. Tobacco use, however, would not include religious or ceremonial use of tobacco. We've included definitions for religious use and ceremonial use of tobacco in order to add clarity to tobacco use. Religious use would be for part of a formal traditional, rite, or ritual, and ceremonial use would be connected with the practice of a traditional ceremonial ritual.

**Dave Iseminger:** Federal law requires exemptions of this nature.

**Barb Scott:** This is consistent with the PEBB definition.

**Dave Iseminger:** The two-month look back is something that we need a tobacco definition regarding the life insurance benefit, and we've been able to coordinate on the PEBB side the look back period for the surcharge with the look back period for life insurance. If this Board adopted a similar two-month look back, that would provide additional framework and context for the agency in negotiating with our vendor to have a similar two-month look back on the life insurance benefit.

**Barb Scott:** Proposed policy SEBB 2018-18 - Tobacco surcharge attestation default. This is the default position. If a subscriber doesn't attest to tobacco use, then how would districts complete that portion of the employee's elections. The recommended default would be to charge a subscriber's account a surcharge if he or she fails to attest that any member, again age 13 years old or older only, enrolled in medical coverage on his or her account does not engage in tobacco use.

**Lou McDermott:** Barb, why do we mention the dollar amount in the spousal surcharge and not the tobacco surcharge? Is there a particular technical reason?

**Katy Hatfield:** The budget bill says it's $25 a month for tobacco, but it says it can be no less than $50 for the spousal surcharge. So, the Board could set the spousal surcharge higher if they wanted.

**Dave Iseminger:** Some of the policy reasons you might want to do this are probably obvious but I want to state them for the record. If you had the default be that nobody is a smoker, then no one would engage in the surcharge process. The other piece is there are known claims cost risks to a plan because of the health effects of smoking, and you want to mitigate this cost by getting people into tobacco cessation programs or quitting tobacco.

**Pete Cutler:** I'm not sure exactly how germane this is to our deliberations because I understand the Legislature, if I remember correctly, has said it will be a $25 smoker surcharge. Have the actuaries for the Health Care Authority and for the UMP specifically done analysis, or have data that's done through any other national studies, on the average additional cost that is incurred by health plans for smokers versus nonsmokers? My understanding is the surcharge is only a small portion of the additional cost that the health plan probably incurs because of a person smoking.

**Barb Scott:** I don't know if we'd have any of that from our wellness stuff or not.

**Dave Iseminger:** We will see what we can bring back at a future meeting, Pete, on the relationship between the $25 and plan costs.

**Barb Scott:** The next proposed policy is SEBB 2018-19 - Spousal Surcharge Attestation Default. Just like the tobacco surcharge, we'll use a premium payment plan to collect the premium surcharge on a tax-preferred basis. An irrevocable election is required in order to do that. This policy would set the default at charging a $50 monthly premium surcharge if the employee failed to attest. Again, the Cafeteria Plan will be written to allow the election to be changed annually or when there is a change in status. An example would be if a spouse stopped working, then the employee could attest to no employer coverage being available and change their attestation going forward.

We will get these to stakeholders and bring them back to you at your next meeting to take action on.

**Public Comment**

**Fred Yancey:** My name is Fred Yancey and I am here today on behalf of Washington State School Retirees Association. I also work on health and pension issues for school administrators and school principals. I would draw your attention to a particular slide. It was page three on tab five, and it talks about the current K-12 health benefit funding structure, and I just take issue with the words: "State funding is provided on a per FTE basis. For school districts it's on a formula per FTE basis." Now, that's a different distinction. I don't know if, when I look at a state budget, they'll show an agency, they'll show a number of FTEs, and maybe that is the number of full-time employees that a state agency might have, but school districts have a number of FTEs. Many of them, particularly, and it was pointed out, the classified employees are in excess of the

formula allocated to school districts. So, it's important to understand that. I think your comparing apples to oranges when you talk about FTE basis. The FTE basis for the state is, I believe potentially, different than the FTE basis for a school district. So, I just wanted to make sure, and it was spoken to, but it's an important distinction because that's exactly the financial hit that school districts are going to have is because the difference between headcount and formula funded FTE employees.

**Lou McDermott:** That was something Megan was addressing, that the Legislature when they come back to town, have an opportunity to address that with the formula: making a modification to the formula and also the funding rate or a combination of both. I think everyone is aware of that issue and we'll definitely bring that up with the Legislature as we go through the next session.

**Fred Yancey:** We're all eagerly awaiting a more educated guess as to what the financial obligation is going to be for the State. I understand that $200 to $300 million was just a rough figure, but we're moving towards a little more definition towards that, but we know, we, meaning representing school districts, know it's going to be a substantial hit to districts.

**Lou McDermott:** I think as the claims data comes in, as the modeling begins, as collective bargaining takes place, it'll put everything into a finer focus to be able to determine that hit.

**Fred Yancey:** That's correct. When you talked about the biennial budget and this is my question and I can do this offline, and Dave and I could email, but the collective bargaining negotiations that occur, whatever agreements they have, are not run through a Health Care Authority budget for the SEBB piece? Or is that a separate ask of the Legislature?

**Dave Iseminger:** After the CBA process is completed, an agreement has to be run through a financial feasibility and cost study by the Office of Financial Management, but there's not a special process that goes through the Health Care Authority. There may be consultation that OFM asks of HCA as it does its fiscal feasibility analysis, but there's not a special HCA one.

**Lou McDermott:** What happens is, if we were to modify the collective bargaining on the PEBB side, for example, and let's say we went from 85%/15% to 80%/20%, that would have an impact on the total funding available to PEBB from the state, and we would incorporate that in the Health Care Authority's budget. There will be a budget item, depending on how collective bargaining goes and what the model looks like. So, yes, it is taken into consideration.

**Fred Yancey:** Although the budget item would not be, if I understand you correctly, do you ask for the state match of benefit payment. That would not be part of the Health Care Authority budget.

**Lou McDermott:** Probably not. It would probably be part of the K-12 budget and it would go through that. Wherever the money lies, they're the ones getting allocated the money. The Health Care Authority, we might get set a funding rate and then that's the funding rate that embedded into the agencies or, in this case, the school districts, and then the school districts need to pay us that money. It's all addressed in global budgeting.

**Fred Yancey:** Gotcha. Thank you very much.

**Dave Iseminger:** To be clear, we use modeling during the CBA process to help everybody understand the potential cost. We're aligning the budget with the CBA agreement, but the actual fiscal study is done by OFM. We're reflecting it within our budgetary ask. That's what I meant by there's not a special analysis done after the CBA. It's really done by OFM, but we do have to reflect it in our budget documents.

**Fred Yancey:** That was my question. Thank you very much. For whatever it's worth, the policy in prohibiting dual enrollment, I think school districts would be speaking from the management side would be very much in support of that.

Speaking as an individual that uses the vision plan, I think it's ridiculous the low figures they reimburse for glasses. $150 for a frame is nowhere near what frames cost nowadays, particularly when 90% of the companies that furnish frames are owned by one company. It's quite a monopoly in terms of furnishing that, and as two lenses, the coverage doesn't reflect the aging population and the offset that you need for bifocals is an example. That's just feedback there.

My last piece is you still have the retiree issue and what to do with the K-12 retiree population. If you choose to put them into a separate risk pool, that's one thing that will reflect on rights. If you choose to put them in the K-12 pool as a total, that will say something regarding rates. If you choose to put them in the PEBB pool generally, or as they are now, separate, in the PEBB. All of this will be rates, but all of these, what you do with retirees are going to affect program design and rates, and that recommendation from your committee, if I understand the law correctly, is due in December.

**Dave Iseminger:** There is the K-12 retiree study that has to be performed. We've begun work with our actuaries to provide a couple of different potential impacts for different scenarios. Under state law, both the PEB and SEB Boards have to be consulted in that process and we have plans this summer to bring you information. The report's due in the middle of December, we will get your insight and provide it along with the agency's report to the Legislature.

This Board doesn't have, nor does the PEB Board have, the authority to move the risk pools. That's the legislative piece, but certainly your insight about the implications of different risk pool arrangements is the purpose of the report. We're working on this topic and it's another important moving piece of this SEBB Program puzzle.

**Fred Yancey:** We believe, meaning school retirees, that should it be more affordable for retirees to get insurance by combining in the regular risk pools that we are prepared to seek legislative change to change the law to have that done and, assuming we're successful, there's enough timeline to do that before SEBB has to be implemented as a whole. So, thank you very much for your time. Thank you for this service on this committee, too. I tell you, it is highly technical, very confusing to a layperson. So, I appreciate the fact that you're willing to spend the time you do to understand it. Thank you.

**Julie Salvi**, representing the Washington Education Association. I wanted to pile on a little bit to this FTE headcount discussion and mainly just to point out one part of the law. When, in one of the presentations, I think it may have been Megan's, it was referencing the requirement for the two systems to be funded at the same rate, and that was from section 33 of Senate Bill 6241. The following section after that, section 34 really talks about the intent of the Legislature to review the state funded staffing assumptions and to consider the assumptions to reflect the proportionate share of headcount eligible employees. So, it is true, there's no solution out there yet, but in the latest legislation that was enacted just this year, the Legislature took a nod towards noting that it does need to be considered and adjusted. They didn't have a solution yet, but it is on the radar and so I don't expect it to be, in the end, continue to be funded just on the FTE basis that it has been in the past. They just haven't decided on the next step.

Then I had a question on the process coming forward on the effective date of coverage of what was anticipated. Is it anticipated that it will be presented at the next meeting for action? Is it substantial revision? If there are substantial revisions, would it be another process where the Board gets time to both consider new language and time to consider that before they vote at maybe a following meeting?

**Dave Iseminger:** Because of the likelihood of substantial changes, we would basically restart the process and re-propose to the Board. We'd keep the same number because the concept is still Resolution 2018-12, but we wouldn't present and ask you to take action in May. We would bring you a new proposed resolution, discuss the stakeholder feedback that led to it, get your new feedback, and ask you to take action at a subsequent meeting, not at the May meeting.

**Julie Salvi:** Okay, and then one other process question. It was mentioned in the work coming forward that the RFP would be issued, it was in the summer months, I believe. I was also curious to know the delineation of work between agency and the Board on this. Presumably, there are policy decisions embedded in any RFP and how would the Board be brought in on those?

**Dave Iseminger:** Previewing next meeting's agenda, we're anticipating sometime in June that the RFP would go out. We're planning to bring to the Board insights and information from the medical RFI responses received last Friday and gather Board insight to be able to work that into the final RFP. We won't present an RFP for ratification or anything like that, but we will ask you and bring up a couple of different

issues that we know you'll want to chime in on. An example of that is: we're planning at the May meeting to bring back that question about an embedded dental within a medical plan that Kaiser Permanente Northwest brought up at the January or March meeting. We want to engage with the Board on that discussion so we can clarify how that needs to be addressed in the RFP. We will then turn around and release an RFP in June, probably before the June Board meeting.

**Julie Salvi:** Okay, thanks. That's all I had today.

**Lou McDermott:** The next meeting is scheduled for May 30, 1:00 p.m. to 5:00 p.m., same location.

**Preview of May 30, 2018 SEB Board Meeting**

**Dave Iseminger:** I just previewed a few things we already know are going to be on the agenda. We'll also follow up on the UMP's specific benefit issues that were identified earlier in this meeting and present about the UMP pharmacy benefit. We'll likely present what we call the Centers of Excellence Program, which is a benefit that Dr. Lessler alluded to in some of his presentations back in November and December. It's a bundle payment, or at least right now, it's set for total joint replacement and we'll explain how that builds upon the Uniform Medical Plan as another benefit option for you to consider.

We'll have the resolutions presented today by Barb and the stakeholder feedback, for your action and we'll present a variety of new resolutions. The timeline between the May meeting and June meeting doesn't fit the typical stakeholder review process. We would be asking you to take action on them in July, but we want to go ahead and start teeing them up in May and June. That way stakeholders still have an ability to provide feedback, but we want to take advantage of that time and begin teeing up issues for your consideration.

We'll also be providing you insights from the RFIs and specifically focus on that medical one so we can get insight from you as we craft the final RFP for release. That's generally what four hours looks like in May.

**Lou McDermott:** Dave, thanks to you and your staff; lots of work. Appreciate it. This meeting's adjourned.

Meeting adjourned at 4:16 p.m.

# TAB 4

Washington State Health Care Authority

# July 30, 2018 SEB Board Meeting Follow-Up

David Iseminger, Director
Employees & Retirees Benefits Division
August 30, 2018

Washington State Health Care Authority

# UMP (PEBB Program) Claim Comparison International vs. Domestic

| US vs. Other | Paid per Claimant | Claimant Count | Claim Count | Paid Claims | Paid per Claim |
|---|---|---|---|---|---|
| US | $4,064.69 | 246,583 | 4,902,225 | $1,002,284,586.43 | $204.46 |
| Non – US | $1,350.07 | 15 | 163 | $20,250.98 | $124.24 |
| Total: All | $4,064.53 | 246,598 | 4,902,388 | $1,002,304,837.41 | $204.45 |

Time Period: 4/17 – 3/18

Washington State Health Care Authority

# Questions?

David Iseminger, Director

Employees and Retirees Benefits Division

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# TAB 5

Washington State Health Care Authority

# K-12 Data Support for Decision Making

John Bowden, Manager
School Employees Benefits Section
Employees and Retirees Benefits Division

Kayla Hammer
Fiscal Information & Data Analyst
SEBB Finance
August 30, 2018

# K-12 Data Support for Decision Making

- Overview of five primary K-12 data sources available to HCA:
  - Where they came from
  - Data elements contained
  - Sample Questions
  - Limitations
- Takeaways on Using Available Data
- Discussion of Data Sets and Questions

Washington State Health Care Authority

# Five K-12 Data Sources

- K-12 Staffing Report
- OIC K-12 Data Collection Results
- K-12 Groups in PEBB Program
- HCA Legislated Data Request
- Fully Insured Medical RFI

Washington State Health Care Authority

# K-12 Staffing Report

- Source: Office of Superintendent of Public Instruction (S-275 Personnel Report)
  - Submitted by school districts, ESDs, and charter schools twice each school year
- Contains data for ***most*** employees:
  - Most recent data from 2016-2017 school year
  - Demographics (gender, race/ethnicity, and age)
  - Job (duties and FTE worked)
  - Compensation (salary and wages)

# K-12 Staffing Report (*cont.*)

- Sample Questions:
  - How many employees are potentially eligible?
  - How many employees are there by job type, full-time vs. part-time, gender, urban vs. rural?
  - How do the demographics of the K-12 workforce compare to other populations (e.g., State Employees)?
- Limitations:
  - Does not include all employees (e.g., substitute teachers)
  - Does not include dependent data
  - FTE has varying denominators

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# OIC K-12 Data

- Source: Office of Insurance Commissioner
  - Collected from school districts and carriers for school years 2012-2013 through 2016-2017
- Contains employee, district, and carrier data:
  - Plan benefits, medical & dental premiums paid, and employer contributions
  - Employee demographics, plan and tier selection, dependents, and employee contributions
  - Large claims by diagnostic categories

# OIC K-12 Data (*cont.*)

- Sample Questions:
  - What types of plans/benefits have employees selected?
  - What have the individual employee contributions been?
- Limitations:
  - Only includes school districts - excludes ESDs and charter schools
  - Aggregated data only
  - No individual demographic detail
  - Focused on medical coverage
  - Two years old

# K-12 Groups in PEBB Program

- Source:  HCA's vendors and contractors
  - Groups are identified via PEBB Program enrollment and linked to plan provided eligibility and claim files
- Contains enrollment and claims data:
  - Over multiple years including partial 2018
  - All health and dental plans offered under PEBB Program
  - 71 school districts and 5 ESDs and approximately 3,600 employees (and 4,700 dependents)

# K-12 Groups in PEBB Program (*cont.*)

- Sample Questions:
  - How does K-12 enrollment within PEBB Program compare to the broader PEBB Program enrollment?
  - What areas of the state are current K-12 groups participating within the PEBB Program?
- Limitations:
  - Not a large enough sample for standalone estimates or projections

# HCA Legislated Data Request

- Source: HCA request collected from carriers in March/April 2018
  - Authorized in HB 2242 (2017) and ESSB 6241 (2018)
- Contains data for all types of benefit offerings:
  - Carrier profiles and benefit packages
  - Claims with limited demographics, diagnoses, procedures, total costs, and employee share

# HCA Legislated Data Request (*cont.*)

- Sample Questions:
  - How does the cost per service vary by region and compare between carriers?
  - What is the relative morbidity of the population?
- Limitations:
  - Variety of data features are difficult to standardize
  - Not representative of future eligibility
  - Unable to tie members' claims with details of benefit coverage

# Request for Information Data

- Source: HCA request as part of fully insured medical RFI in April 2018
- Contains fully insured medical plan data:
  - Only includes carriers potentially interested in SEBB fully insured RFP
  - Demographics/distribution
  - Plan design
  - Non-binding rates

# Request for Information Data (*cont.*)

- Sample Questions:
  - What are possible plan designs?
  - What counties are carriers proposing to cover?
  - What is the range of potential bid rates for the program?
- Limitations:
  - Ability for comparison of non-binding rates is limited to simple population variables
  - Not all current K-12 carriers responded
  - Rates are non-binding and not representative of K-12 population that will exist under SEBB Program

# Takeaways on Using Data

- No data exists for the purpose of evaluating the consolidation into a statewide program
  - Trying to answer questions beyond original intent
  - Not all data is complete, additional data is desired
  - Can't tie data sets together
- Claims data are services employees receive based on what's offered and selected:
  - Differing plan design (covered services and treatment limits); and
  - Patient or Member costs (copays, deductibles, coinsurance)

# Takeaways on Using Data (*cont.*)

- Available data are historical – future "what ifs" can be difficult
- Changes included in SEBB Program to consider:
  - Threshold of 630 hours for full eligibility (no more prorating)
  - All employees pay the same for the same plan and tier
  - Employee's premium for employee, spouse/state-registered domestic partner, and children coverage no more than three time as much as individual premium

Washington State Health Care Authority

# Discussion of Data Sets and Questions

- Questions and clarifications about data sets?
- Eligibility, enrollment, utilization, or benefit questions you'd like to discuss?

Washington State Health Care Authority

# Questions?

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# TAB 6

Washington State Health Care Authority

# Centers of Excellence Program

Marty Thies, Program Manager
Employees and Retirees Benefits Division
August 30, 2018

Washington State Health Care Authority

# Context

The Centers of Excellence (COE) Program is:

- A benefit option that currently overlays the UMP Classic & CDHP plans in the PEBB Program
- Clinically effective and helps control costs
- SEB Board can choose to adopt this COE Program overlay on selected SEBB self-insured plans

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# Centers of Excellence Program

- Part of a national movement toward paying for **quality**
- To address:
  - **Variations in cost**—for certain procedures
  - **Variations in quality and outcomes**, which can result in readmissions and revisions

# Washington State

- 2014: Legislature directed HCA "*to align actions to achieve healthy communities and populations,* ***improve health care quality, and lower costs***"
- 2016: PEB Board approved a resolution for the **Centers of Excellence Program (COE)**, whereby the HCA:
  - Identifies facilities that have adopted Bree standards
  - Incentivizes members to use COEs
  - Improves access to health care quality

Washington State Health Care Authority

# Standards & Best Practices

## 2011: The Bree Collaborative (RCW 70.250.050)

- HCA shall convene a collaborative to "*identify health care services for which there are substantial variation in practice patterns or high utilization trends in Washington State, without producing better care outcomes for patients, that are indicators of poor quality and potential waste in the health care system.*"

- Bree Deliverables:
  - By procedure, identify **best practices** to improve quality
  - Establish methods to collect and report baseline **health data**
  - Work to **increase use of "*evidence-based best practice approaches*"**

Washington State Health Care Authority

# Bree Collaborative

- Lumbar Fusion
- Total Knee and Hip Replacement
- Addiction & Dependence
- Cardiovascular Health
- End of Life Care
- Hospital Readmissions
- Maternity Care
- Spine and Low Back Pain

Washington State Health Care Authority

# Total Joint Replacement

## Why TJR?

- High utilization (650/year in PEBB Program self-insured plans)
- High variability in cost and outcomes

## Bree Standards for TJR:

- Appropriateness: conservative therapy, documentation
- Fitness: BMI, nicotine use, A1c, circulation, opioid use
- Surgery: surgeons perform 50+/year, begin before 5 PM
- Recovery: pain control, PT, return-to-function, follow-up

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# Total Joint Replacement: Design

For members: Incentivizing toward quality

- Voluntary participation
- Available to UMP Classic and CDHP members
- Low to no out-of-pocket costs,* including:
  - Surgery and associated inpatient services
  - Implant and Durable Medical Equipment (DME)
  - Case Management
  - Transportation & accommodations for patient and care companion
- Prospective payment
- 90-day warranty for specified complications

*CDHP members must pay their deductible first, as required by IRS regulations

Washington State Health Care Authority

# The COE-TJR Team

## Center of Excellence: Virginia Mason

- Experience in Total Joint Replacement (TJR) bundling
- Comprehensive, patient-focused approach to providing care
- History of high quality, low complication rate
- Established best practices using Bree criteria
- Current contract renewable through 2026

## Third Party Administrator: Premera

- Intake, customer service, referrals, travel, logistics
- Patient Experience Surveys
- End-to-end member-focused concierge facilitation

# Calendar 2017 COE-TJR

- 122 Referrals to COE in 2017:
- 95 Completed Surgeries in 2017*
- 16 Moving toward surgery
- 11 Did not result in surgery

2 nights Average Length-of-Stay

- COE Participants' counties-of-residence are roughly proportional to State population distribution

*128 completed surgeries from January 1, 2017 through August 11, 2018

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# Summary: Quality & Costs

## Outcomes:

- **Zero readmissions** for members undergoing their TJR at the Center of Excellence
- **Zero complications** indicated in claims data

## Costs:

- **Savings to participating members**
- For the UMP population, TJR surgeries performed at the Center of Excellence **were less expensive** than those performed elsewhere

# Comments from Members

- *" I thought the whole organizing from Premera to VM was well handled, **they did a wonderful job**. It's been a good experience."*
- *"It was **second to none**; [the program] was awesome!"*
- *"**One of the most positive medical experiences I've ever had!**"*
- *"I was very **impressed with the entire process**. The people at Virginia Mason were awesome and [Premera] did a great job setting everything up for me. **You guys made it as easy as possible for me.**"*
- *"Everything about it was amazing: everyone was super helpful and knowledgeable. **Everything about it was great.** I would definitely recommend to friends."*
- *"My recovery went well because **I was taken care of so well that I recovered well from start until end.** They called to see if I had any questions. The staff, the hospital, the facility was excellent. I could not say anything better. My experience there was great!"*

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# PEBB Program Participant Surveys

**Premera**: **69% Response Rate, Scored 1-10**

- My Case Manager was courteous and helpful **9.8**
- I valued the travel benefits **9.7**
- I felt ready for my surgery **9.5**

**Virginia Mason as Center of Excellence:**

- I understood my recovery plan **9.1**
- If I have another TJR, I'd use the COE again **9.7**
- I'd recommend the program to family, friends **9.7**

- **Overall satisfaction with total experience: 9.5**

# Centers of Excellence Program
# Spinal Fusion

Washington State Health Care Authority

# Benefit Design

## Benefit Design:

- Using the Bree Criteria
- Little to no out-of-pocket
- Travel expenses
- Start-to-Finish concierge case management
- Using COEs is incentivized but optional

Washington State Health Care Authority

# Spinal Fusion Centers of Excellence Procurement Timeline

- RFP was released in **February 2018**
- Responses were due in **April 2018**
- Site visits conducted in **June 2018**
- Two ASBs awarded early **July 2018**
- PEBB Program benefit launch **January 1, 2019**

Washington State Health Care Authority

# Next Steps

- COE follow-up presentation on October 4
- Propose a resolution for adoption to include COE benefits for 2020 launch
- SEB Board action on November 8

Washington State Health Care Authority

# Questions?

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# TAB 7

Washington State Health Care Authority

# Policy Resolutions

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

Washington State Health Care Authority

# SEB Board Policy Resolutions

- SEBB 2018-28 Eligibility for the Employer Contribution Based on Stacking of Hours
- SEBB 2018-33 Returning school employees with uninterrupted coverage
- SEBB 2018-34 Eligibility when moving between SEBB Organizations

# 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;

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

**Resolved that,** a school employee may establish eligibility for the employer contribution toward SEBB benefits based on stacking of hours within one SEBB Organization.

# Policy Resolution SEBB 2018-33 Returning school employees with uninterrupted coverage

**Resolved that,** a school employee returning to the same SEBB Organization who is anticipated to work at least 630 hours in the coming school year, and who was receiving the employer contribution in August of the prior school year, will receive uninterrupted coverage from one school year to the next.

# Returning school employees with uninterrupted coverage Example

## **Example:** Certificated Employee (teacher)

The school employee works for a SEBB Organization for the 2020 to 2021 school year and was receiving an employer contribution in August 2021. The school employee will continue to work for the SEBB Organization in the 2021 to 2022 school year in a position anticipated to work at least 630 hours in the school year.

- Is there a change in the eligibility for the employer contribution between school years? **No.**

# Policy Resolution SEBB 2018-34 Eligibility when moving between SEBB Organizations

**Resolved that,** a school employee will have uninterrupted coverage when moving from one SEBB Organization to another within the same month or a consecutive month if the following conditions are satisfied:

- The employee was eligible for the employer contribution toward SEBB benefits in the position they are leaving; and
- The employee is anticipated to be eligible for the employer contribution toward SEBB benefits in their new positon.

# Eligibility when moving between SEBB Organizations Example #1

**Example:** Certificated Employee (teacher)

This school employee works for SEBB Organization "A" as a teacher and is eligible for the employer contribution toward SEBB benefits. She takes a position at SEBB Organization "B" as a teacher where she is also anticipated to work at least 630 hours in the upcoming school year. The school employee's **last day with "A" is August 31, 2021** and the school employee's **first working day with "B" is September 7, 2021.**

- When is she eligible for the employer contribution toward SEBB benefits through "B"? **September 1, 2021.**
- When does SEBB coverage begin? **September 1, 2021.**

# Eligibility when moving between SEBB Organizations Example #2

**Example:** Certificated Employee (teacher) to Administrative (principal)

This school employee works for SEBB Organization "A" and is eligible for the employer contribution toward SEBB benefits. He takes a position with SEBB Organization "B" as a principal where he is anticipated to work 52.5 hours a month in July and August. He is also anticipated to work at least 630 hours in the upcoming school year. His **last day with "A" is June 30, 2021** and his **first day with "B" is July 1, 2021.**

- When is he eligible for the employer contribution toward SEBB benefits through "B?" **July 1, 2021.**
- When does SEBB coverage begin? **July 1, 2021.**

# Next Steps

- Incorporate the policy resolutions into SEBB Program rules

Washington State Health Care Authority

# Questions?

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Washington State Health Care Authority

# Appendix

Washington State Health Care Authority

# Proposed Policy SEBB 2018-28 (as presented May 30, 2018) 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 2018-33 (as presented July 30, 2018) Returning school employees with uninterrupted eligibility get uninterrupted coverage

A returning school employee anticipated to work at least 630 hours in the coming school year and who was receiving the employer contribution in August of the prior school year will receive uninterrupted benefits from one school year to the next.

# Proposed Policy SEBB 2018-34 (as presented July 30, 2018) School employee's eligibility when transferring SEBB Organizations

SEBB benefits coverage is effective the first calendar day of the month in which a school employee transfers from one SEBB Organization to another if the following conditions are satisfied:

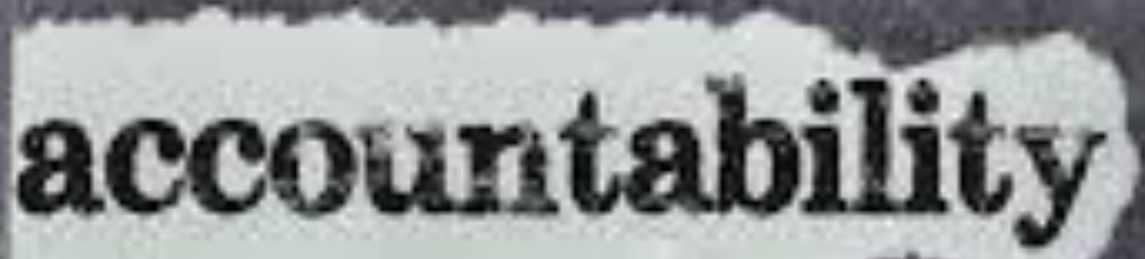
- The employee was eligible for the employer contribution toward SEBB benefits in the position they are leaving; and
- The employee is anticipated to be eligible for the employer contribution toward SEBB benefits in their new positon.

# TAB 8


GOT
ETHICS ?

# Why do we have the Ethics Act?

Holds us accountable to the public for:




Access to Confidential information

Use of public equipment

Use of technology

Our time

# Executive Ethics Board

# Complaints and Investigations

- Public
- Agency
- Whistleblower investigations
- Co-worker

# Conflicts of Interest

Conflicts of interest involve the concepts of Benefit and Bias.

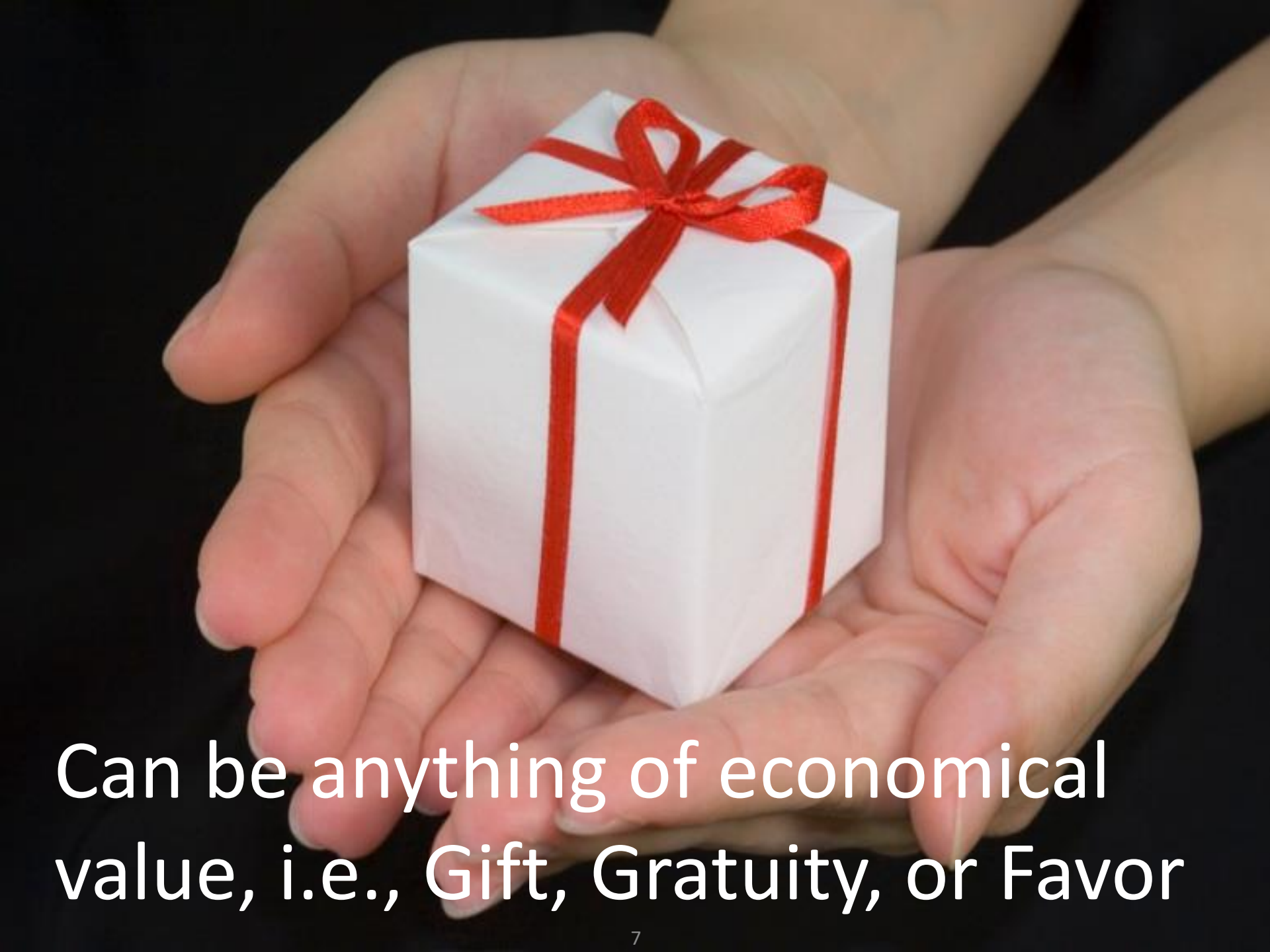
# MANAGING CONFLICT OF INTEREST

**Abstain**

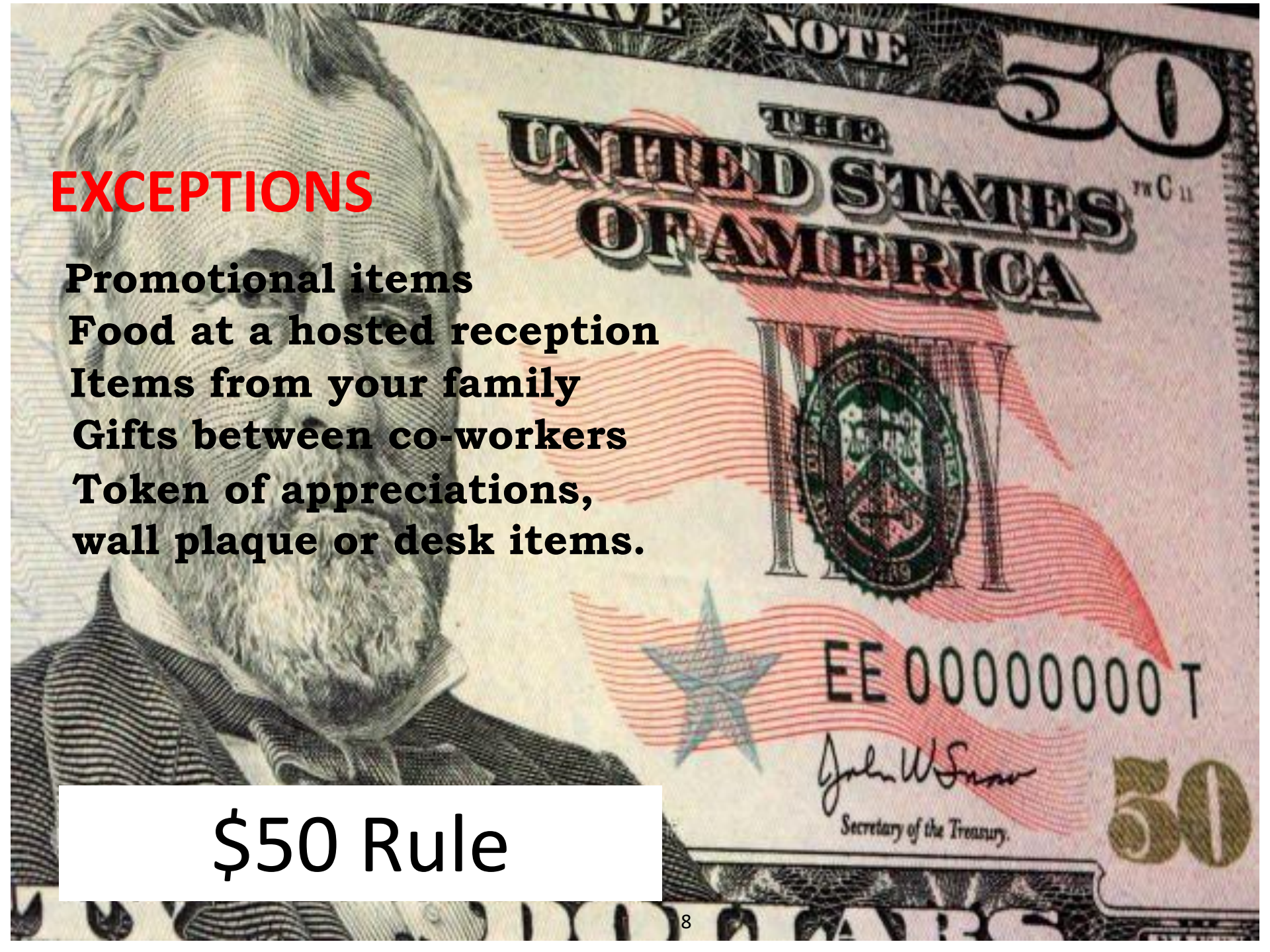
**Disclose**

**Procedures**

**Screening Memo**



Can be anything of economical value, i.e., Gift, Gratuity, or Favor




# EXCEPTIONS

**Promotional items**
**Food at a hosted reception**
**Items from your family**
**Gifts between co-workers**
**Token of appreciations, wall plaque or desk items.**

## $50 Rule

# Section 4 employees may NOT accept

**Flowers**

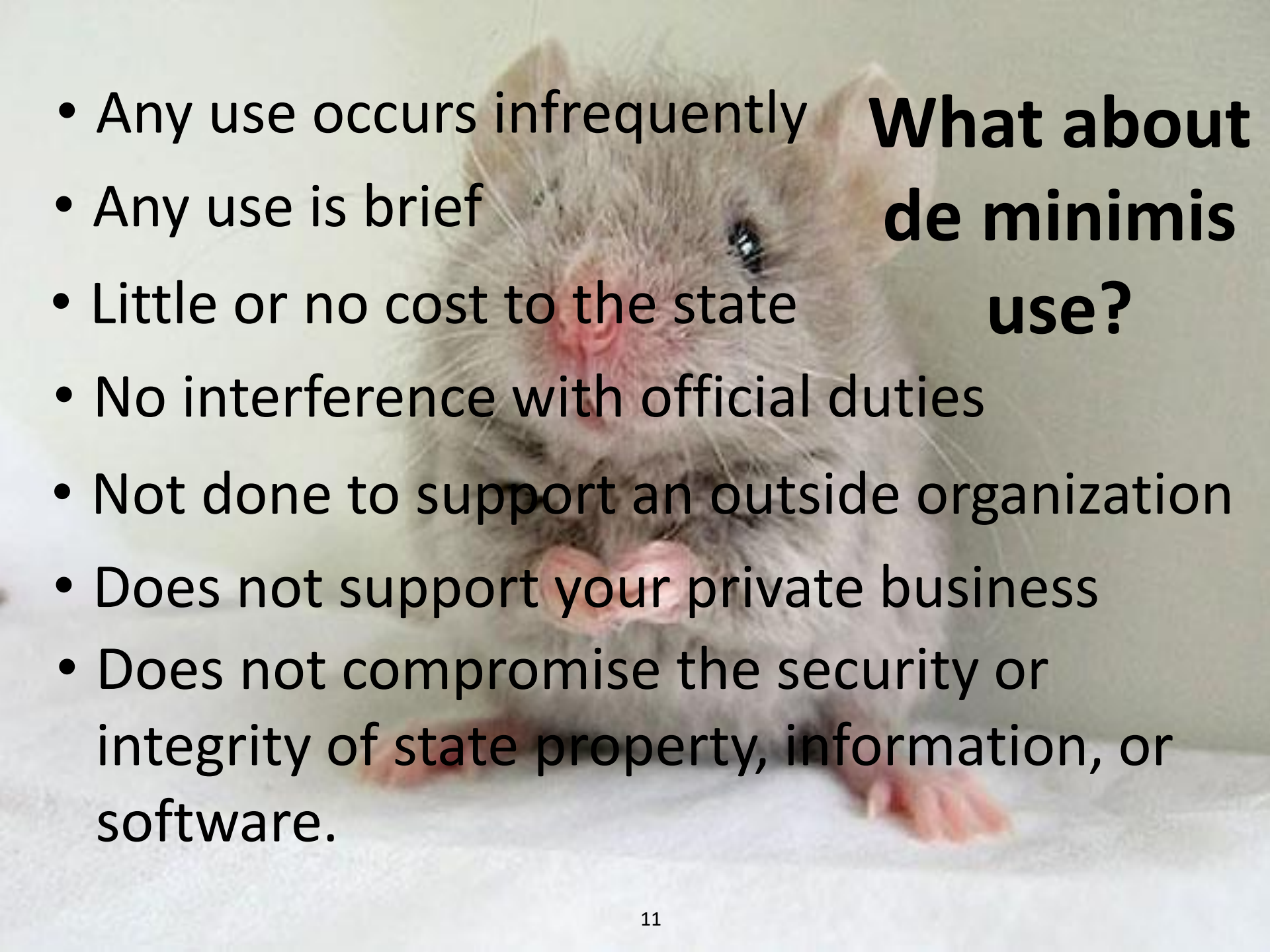
**Travel expenses**

**Food & beverages**

# Use of State Resources

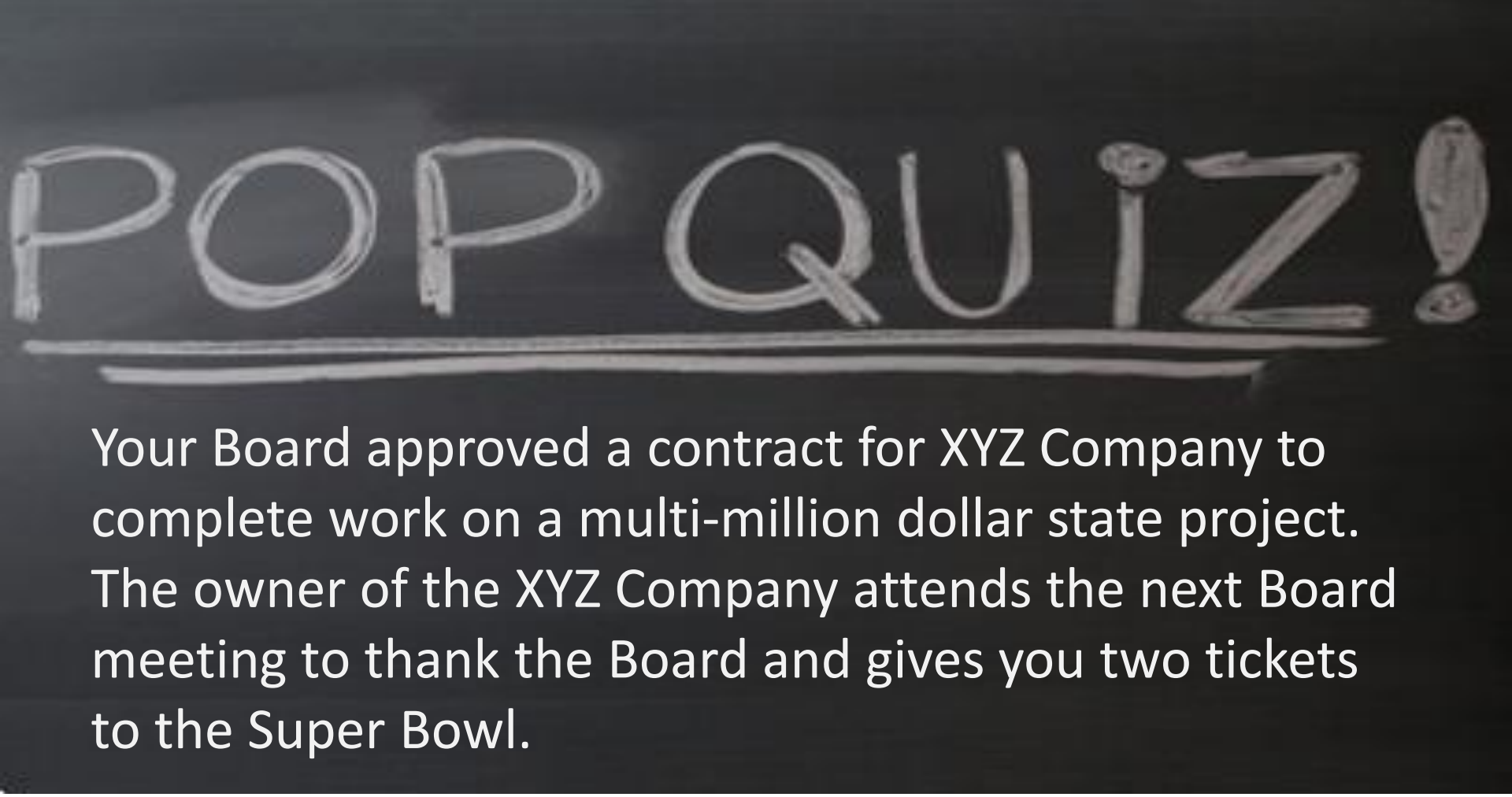
RCW 42.52.160(1) – Use of persons, money, or property for private gain, states:

No state officer or state employee may employ or use any person, money, or property under the officer's or employee's official control or direction, or in his or her official custody, for the **private benefit or gain** of the officer, employee, or another.



# What about de minimis use?

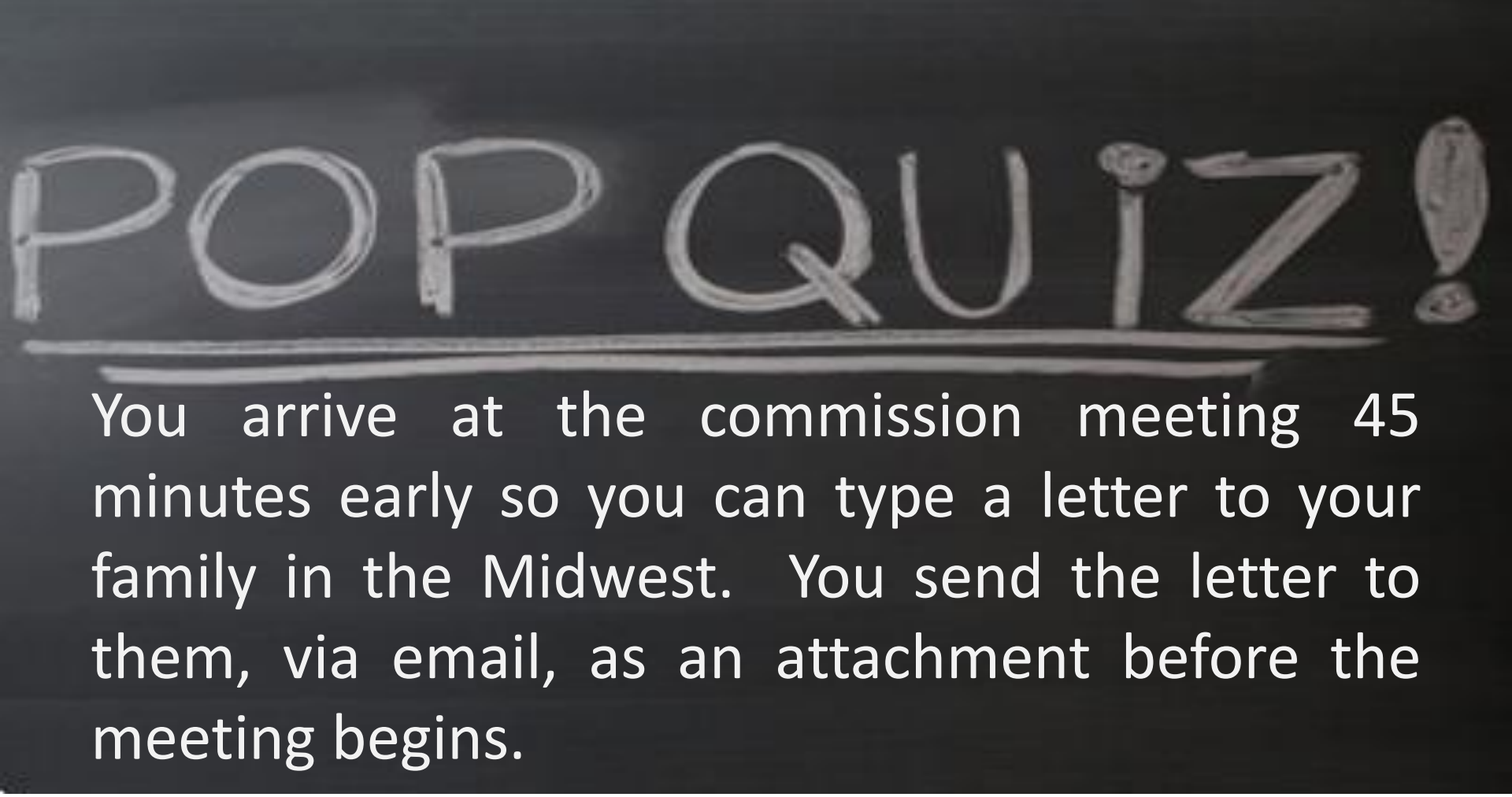
- Any use occurs infrequently
- Any use is brief
- Little or no cost to the state
- No interference with official duties
- Not done to support an outside organization
- Does not support your private business
- Does not compromise the security or integrity of state property, information, or software.




Your Board approved a contract for XYZ Company to complete work on a multi-million dollar state project. The owner of the XYZ Company attends the next Board meeting to thank the Board and gives you two tickets to the Super Bowl.

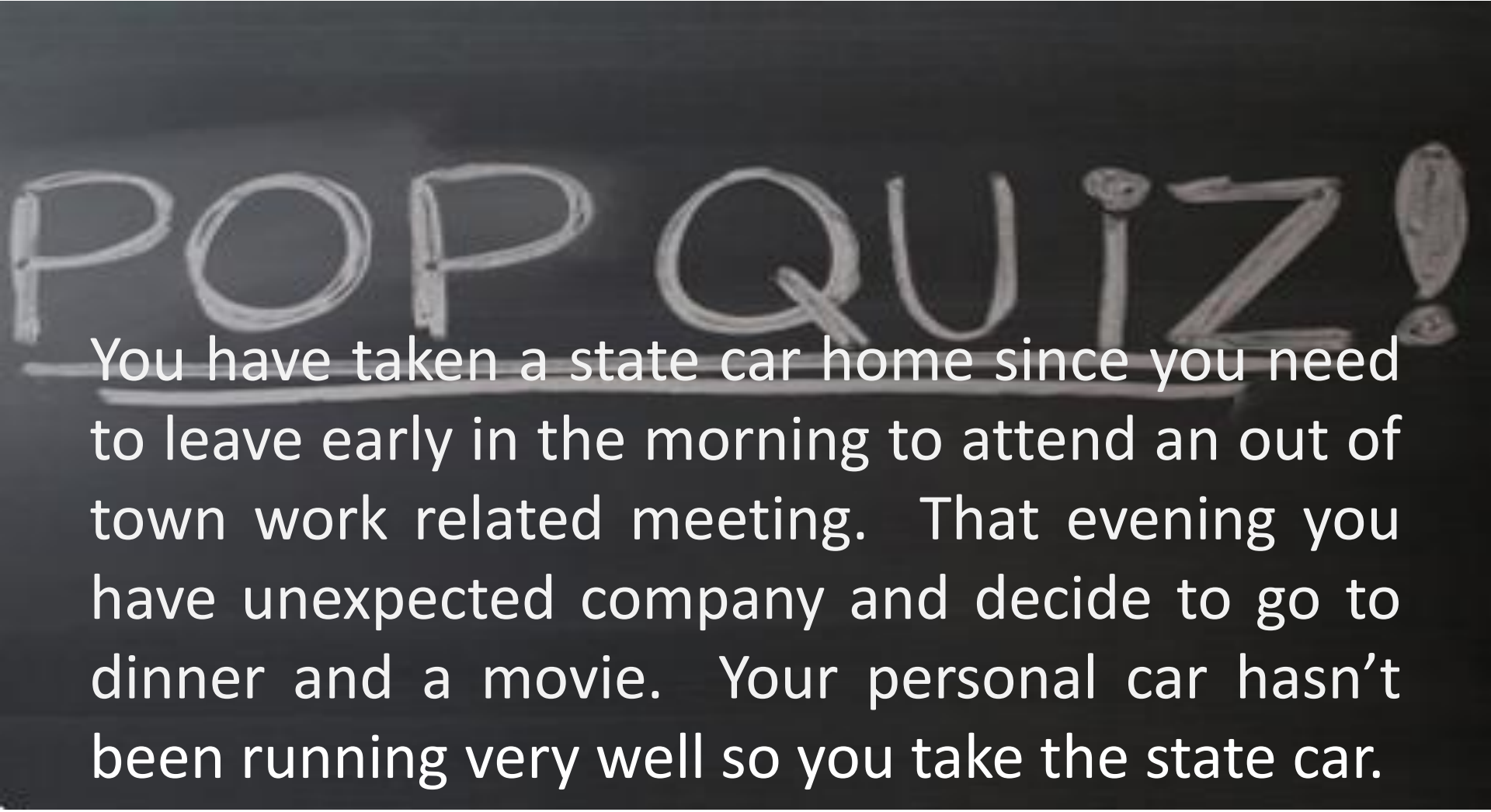
# Violation?

Yes.




# Violation?

Probably not.



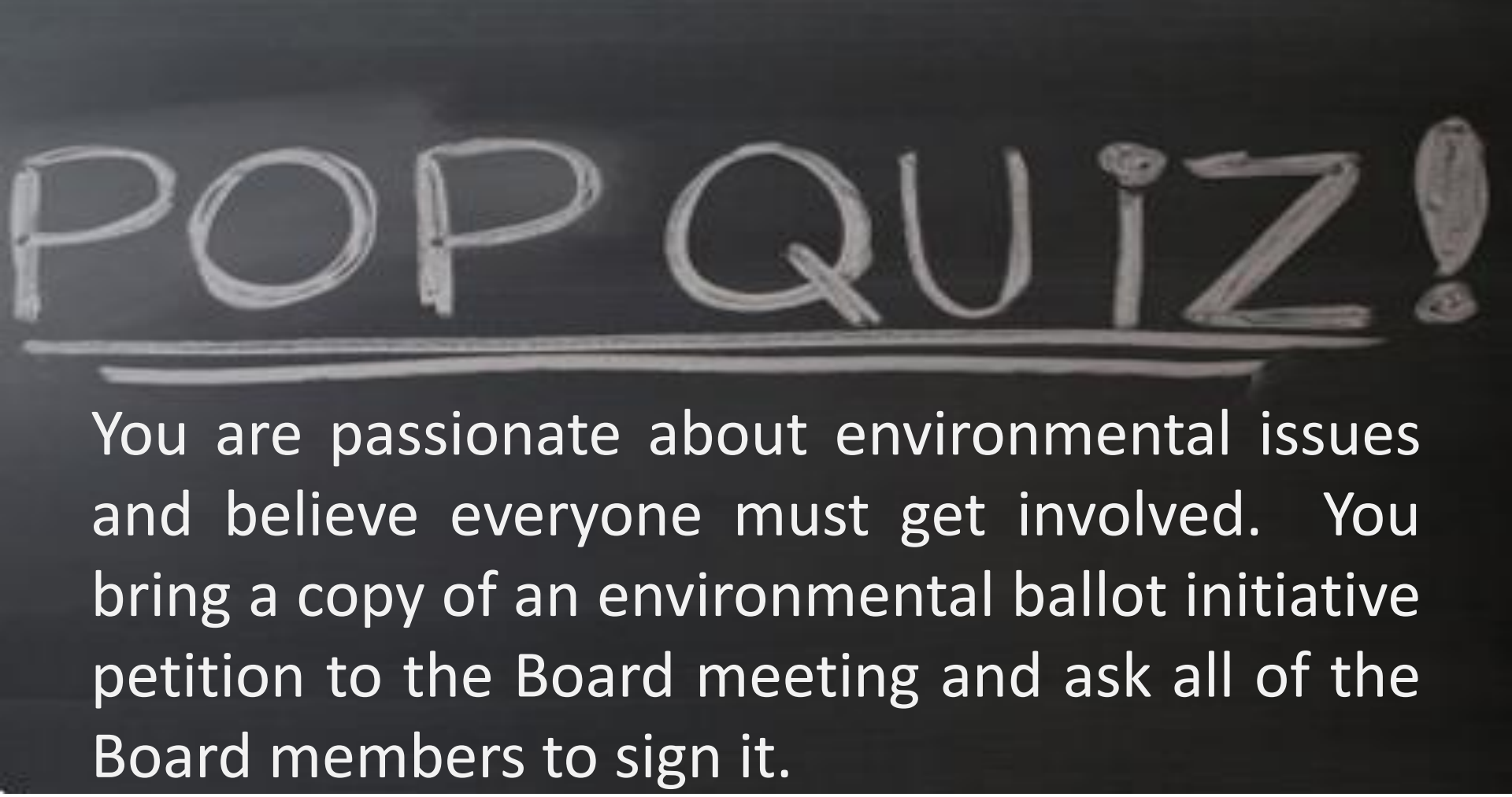

You have taken a state car home since you need to leave early in the morning to attend an out of town work related meeting. That evening you have unexpected company and decide to go to dinner and a movie. Your personal car hasn't been running very well so you take the state car.

# Violation?

Yes.


# No use for political campaigns

Test Your knowledge Page 27 and 28




You are passionate about environmental issues and believe everyone must get involved. You bring a copy of an environmental ballot initiative petition to the Board meeting and ask all of the Board members to sign it.

# Violation?

Yes.


You're asked by a local politician for your support in their upcoming campaign and they want to use your name and commission title. They come to the commission HQ and take a picture of you standing in front the commission sign to use in their flyers and on Facebook.

# Violation?

Yes. Use a disclaimer.


PUBLIC
TRUST



19

# Questions



20

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# TAB 9

Washington State Health Care Authority

# Group Vision Plan(s) Procurement Updated

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

# Status

- Eight proposals submitted
- Three Apparently Successful Bidders (ASBs) will enter into negotiations for a potential contract(s): Davis Vision, EyeMed, and MetLife; MetLife will negotiate to offer only a fully insured plan(s) (they did not submit a bid for a self-insured plan)
- Additional next steps:
  - Board to take action on Policy Resolution 2018-35 to establish a separate group vision plan(s)
  - Contract negotiations
  - Work on plan design and rates

Washington State Health Care Authority

# ASB Response Highlights

- **Coverage may include:**
  - Comprehensive eye exam
  - Prescription lenses
  - Frames
  - Contact lenses
  - Other lens options, such as ultraviolet coating, transition lenses, scratch-resistance, etc.
  - Online or in-person purchasing for hardware
  - One year warranty for prescription lenses and/or frames
- **Customer Service available 7 days a week (for all three ASBs)**

# ASB Network Key Takeaways

**Geographical coverage includes:**

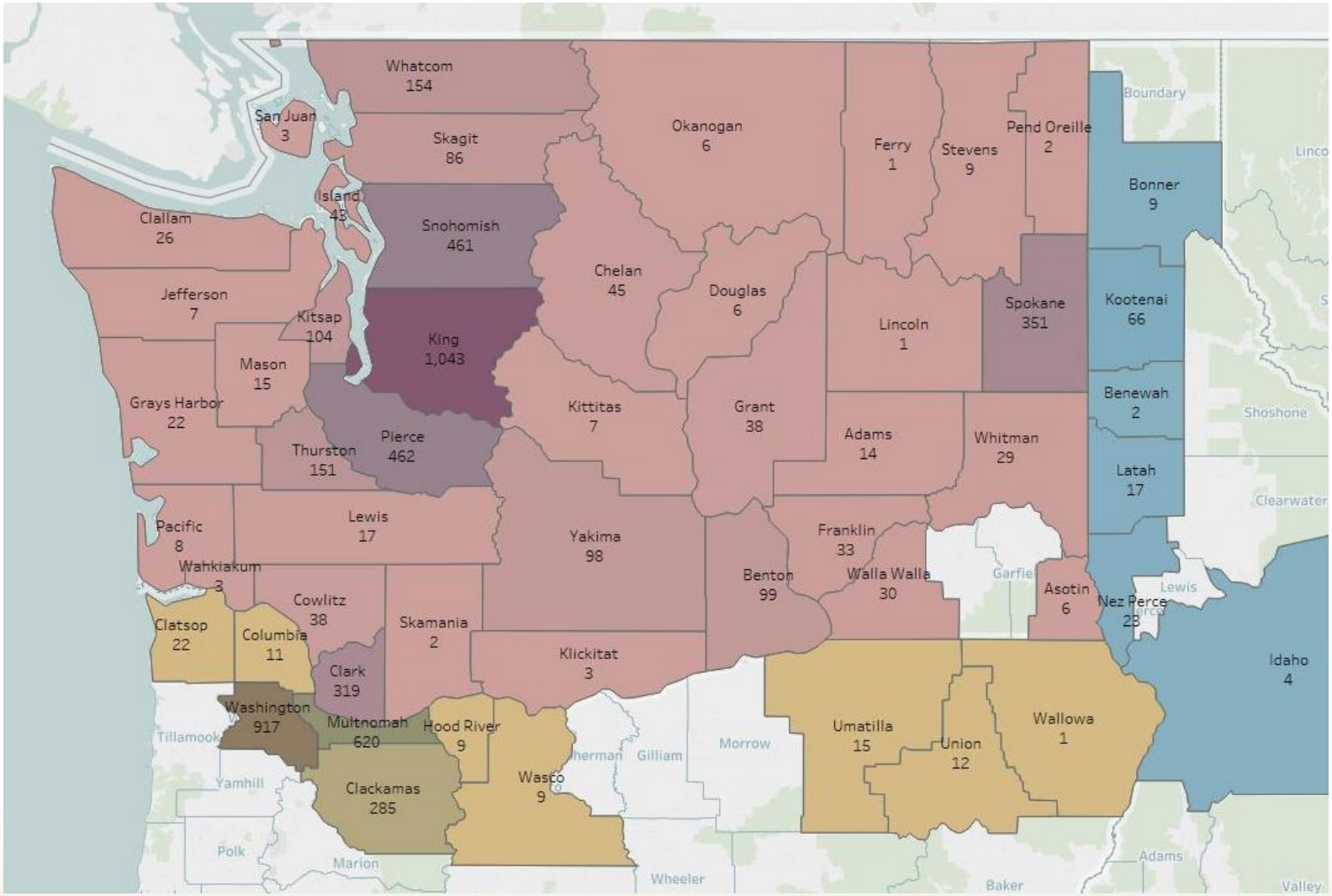
- Potential for vision provider coverage in thirty-seven (37) Washington counties
- Provider coverage in the other forty-nine (49) states
- Coverage in Washington, D.C., Guam, Puerto Rico, U.S. Virgin Islands
- Out-of-network coverage accessible outside of the United States

**Provider Contracting:**

- Credentialed providers
- Increasing rural access for members through provider contracts and online hardware purchasing options
- Optical retailers, may include, but not limited to: Costco, Pearle Vision, America's Best, LensCrafters, Vista Optical

Washington State Health Care Authority

# ASB Proposed Provider Locations



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# Considerations

| Group Vision Plan |
| --- |
| Carriers who specialize in providing vision benefits |
| Purchasing hardware online using in-network benefits |
| Possible set copays for benefit options after allowance is met |
| School employees are already familiar with separate vision benefits |
| More purchasing option without the member submitting a reimbursement form |
| Higher visibility into plan costs and utilization |
| Mitigates future Cadillac Tax responsibilities under existing federal law |

| Embedded Vision Benefits |
| --- |
| Regardless of service type, the provider bills one carrier for all services provided |
| Potentially more contracted provides (depending on the carrier) |
| Eye health services more likely to be integrated and managed with medical services |

# Proposed Policy Resolution SEBB 2018-35
## Group Vision Plan(s)

Offer a group vision plan(s) beginning January 1, 2020 that is separate from the medical plans.

# Questions?

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# TAB 10

Washington State Health Care Authority

# Life and AD&D Insurance

Beth Heston, Procurement Manager
Employees and Retirees Benefits Division
August 30, 2018

Washington State Health Care Authority

# Objectives

- Provide additional information about the proposed Basic Life and Accidental Death & Dismemberment Insurance (AD&D) benefits
- Take action on Resolution SEBB 2018-31

# Basic Life and AD&D Insurance Summary

- On July 30, 2018, the Agency recommended benefit levels of:
  - $35,000 basic life insurance
  - $5,000 basic AD&D insurance
- An increase or decrease of $10,000 in basic life insurance is estimated as ~$1.00 per subscriber per month (pspm)

# Stakeholder Feedback & Responses

- Requests for increases coverage amounts ($50k-$100k)
  - Employer paid life insurance exceeding $50,000 requires imputing taxable income to employees under Internal Revenue Services (IRS) requirements (26 U.S.C. 79)
    - The income imputed as taxable income is an age-banded per $1,000 amount for employer-paid life insurance that exceeds $50,000 (IRS Table in Appendix)
      - Example: For an $80,000 employer-paid life benefit, a 55-year old school employee would have $154.80 of imputed taxable income for the tax year
    - A few narrow exceptions to imputing income exist
    - IRS requirement does not apply to employer-paid AD&D

# Stakeholder Feedback & Responses (*cont.*)

- Benchmarking Insights
  - MetLife provides Life/AD&D insurance benefits for 10 "non-PEBB benefits participating" school districts
    - Average benefit for employer-paid Life/AD&D is $14,200
    - High of $50,000 (one district) and a low of $10,000
    - Most common benefit is $10,000
  - MetLife provides life insurance benefits for the Federal Employees Group Life Insurance Program (FEGLI)
    - The life benefit is one times the salary rounded to the next $1,000, plus an additional $2,000
    - The average benefit is ~$83,000; however, the plan is only 1/3 paid by the government, so the employer-paid portion of the plan is ~$27,400

# Stakeholder Feedback & Responses (*cont.*)

- For some school districts life insurance is embedded in medical premiums
  - Under the SEBB Program, employee medical premium contributions will generally be taken as pre-tax deductions
  - When life insurance benefits are paid with pre-tax funds, taxes will likely be owed by the beneficiaries (value of benefit changes based on then existing tax rules)

# Stakeholder Feedback & Responses (*cont.*)

- Could an employee's current life insurance amount above the new plan's guaranteed issue be grandfathered?
  - HCA and MetLife are discussing a possible transition opportunity related to honoring some existing coverage amounts
- In some districts employee groups are able to have different employer-paid life insurance coverage amounts
  - Under the statewide risk pool for life insurance, the employer-paid benefit level cannot vary for different types of employees

# Proposed Resolution SEBB 2018-30 Basic Term Life Insurance and Accidental Death and Dismemberment Insurance

The employer paid life insurance provided to eligible employees beginning January 1, 2020 will be a $35,000 death by any cause benefit, and a $5,000 accidental death and dismemberment (AD&D) benefit, unless modified in a subsequent resolution by the Board.

# Basic Benefit - Next Step

- Action on Resolution SEBB 2018-30 is scheduled for the October Board meeting
- If the basic life benefit exceeds $45,000 rates for both basic and optional coverage it will be re-evaluated, but the optional benefit design would not need to be reconsidered

Washington State Health Care Authority

# Recommended Supplemental Life Insurance Plan

| Employee Paid Supplemental Insurance | |
|---|---|
| **Insurance Type** | **Supplemental** |
| Employee Supplemental Life | • **Guaranteed Issue** Up to $500,000 in $10,000 increments up to a maximum of $1,000,000<br>• EOI** required for amounts over $500,000 |
| Supplemental Spousal Term Life (Tied to Employee Coverage Amount) | • Up to 50% of Employee's Supplemental<br>• **Guaranteed issue** of $100,000 Guaranteed Issue in $5,000 increments<br>• EOI required for amounts over $100,000 |
| Supplemental Dependent Child Term Life | • **Guaranteed Issue** $10,000 to $20,000 in $5,000 increments<br>• For dependents 2 weeks to 26 years |
| Supplemental Employee, Spousal, and Child AD&D* | • **Employee:** $30,000 to $250,000 in $10,000 increments<br>• **Spouse**: $30,000 to $250,000 in $10,000 increments<br>• **Child**: $10,000 to $25,000 in $5,000 increments |

*All AD&D coverage is **Guaranteed Issue**

**EOI = Evidence of Insurability

Washington State Health Care Authority

# Supplemental Employee and Spouse Rates

| Non-Smoker | | Smoker | |
|---|---|---|---|
| Age Band | 1/1/2020 Rates | Age Band | 1/1/2020 Rates |
| <25 | $0.038 | <25 | $0.050 |
| 25-29 | $0.042 | 25-29 | $0.060 |
| 30-34 | $0.046 | 30-34 | $0.080 |
| 35-39 | $0.058 | 35-39 | $0.090 |
| 40-44 | $0.088 | 40-44 | $0.100 |
| 45-49 | $0.128 | 45-49 | $0.150 |
| 50-54 | $0.188 | 50-54 | $0.230 |
| 55-59 | $0.346 | 55-59 | $0.400 |
| 60-64 | $0.534 | 60-64 | $0.630 |
| 65-69 | $0.962 | 65-69 | $1.220 |
| 70+ | $1.438 | 70+ | $1.988 |

*All rates guaranteed for five years (plan years 2020-2024)*

Washington State Health Care Authority

# Supplemental Child and AD&D Rates

| | Premium Rate per $1,000 per month |
|---|---|
| Supplemental Child Life | $0.124 |
| | |
| Supplemental Employee AD&D | $0.019 |
| Supplemental Spouse/State-Registered Domestic Partners AD&D | $0.019 |
| Supplemental Child AD&D | $0.016 |

*All rates guaranteed for five years (plan years 2020-2024)*

Washington State Health Care Authority

# Example Supplemental Premium Calculations

- 35-year old smoker, $200,000 supplemental employee and $100,000 for spouse
  - $18.00 per month for supplemental employee
  - $9.00 per month for supplemental spouse

- 50-year old non-smoker, $150,000 supplemental employee and $75,000 for spouse
  - $28.50 per month for supplemental employee
  - $14.25 per month for supplemental spouse

Washington State Health Care Authority

# Example Supplemental Premium Calculations

- $20,000 Supplemental Child Life
  - $2.48 per month for supplemental child life
- $250,000 Supplemental employee or spouse AD&D
  - $4.75 per month for supplemental employee *or* spouse AD&D
- $25,000 Supplemental Child AD&D
  - $0.40 per month for supplemental child AD&D

# Resolution SEBB 2018-31
# Supplemental Term Life Insurance Plans

- **Resolved that**, beginning January 1, 2020, the voluntary employee paid supplemental life benefit will include:
  - An employee supplemental death from any cause life insurance benefit of $500,000 guaranteed issue (GI), up to a maximum of $1,000,000 with medical underwriting for amounts over $500,000;
  - An employee supplemental AD&D benefit of $30,000 up to $250,000 GI;
  - A spouse or state-registered domestic partner death from any cause life insurance benefit of up to 50% of the employee supplemental elected amount with $100,000 GI and amounts over $100,000 with medical underwriting;
  - A spouse or state-registered domestic partner AD&D benefit of $30,000 up to $250,000 GI;
  - A child death from any cause life insurance benefit of $10,000 up to $20,000 GI; and
  - A child AD&D benefit of $10,000 up to $25,000 GI.

Washington State Health Care Authority

# Questions?

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Washington State Health Care Authority

# Appendix

IRS Section 79 – Table 1 Uniform Premiums for $1,000 of Group Term Life Insurance Protection

| Age Bracket | Cost per $1,000 of Coverage per Month |
|---|---|
| Under 25 | $0.05 |
| 25–29 | $0.06 |
| 30–34 | $0.08 |
| 35–39 | $0.09 |
| 40–44 | $0.10 |
| 45–49 | $0.15 |
| 50–54 | $0.23 |
| 55–59 | $0.43 |
| 60–64 | $0.66 |
| 65–69 | $1.27 |
| 70 and above | $2.06 |

# TAB 11

Washington State Health Care Authority

# Dental Benefits

Beth Heston, PEBB Procurement Manager
Employees and Retirees Benefits Division
August 30, 2018

Washington State Health Care Authority

# Resolution SEBB 2018-06
## (As passed by SEB Board at the 3/15/18 Board Meeting)

- **Resolved that**, beginning January 1, 2020, the School Employees Benefits Board Program will offer fully insured dental plans leveraging the fully insured dental plans offered under the Public Employees Benefits Board Program
- **Resolved further**, that the Board will evaluate in 2020 whether the SEBB Program should pursue a fully insured dental plan procurement to consider additional or different offerings.

# Resolution SEBB 2018-07
## (As passed by SEB Board at the 3/15/18 Board Meeting)

**Resolved that**, beginning January 1, 2020, the School Employees Benefits Board Program will offer self-insured dental plan that leverage the features from the Uniform Dental Plan such as covered benefits, clinical policies, and provider networks, subject to financing determinations

Washington State Health Care Authority

# ERB Dental Plans

# Overview of ERB Dental

ERB has three dental offerings

- **DeltaCare Dental Plan**
  - Managed care (restricted network) plan - 27,652 members
- **Uniform Dental Plan (UDP)**
  - Wide-ranging preferred dental provider organization (PPO) administered for HCA by Delta Dental of Washington (DDWA)
  - 226,687 members
- **Willamette Dental Plan**
  - Managed care (restricted network) plan - 32,166 members

# Proposed SEBB Self-Insured Dental Plan

- Administered by Delta Dental of Washington
- Claims paid from SEBB Funds (subject to financing decisions)
- Subscribers may see any provider that accepts Uniform Dental Plan (Preferred Provider Organization)

Washington State Health Care Authority

# Proposed SEBB Self-Insured Dental Coverage Map

Washington State Health Care Authority

# Proposed SEBB Self-Insured PPO Option

| SEBB Uniform Dental | |
|---|---|
| Annual Maximum | $1,750 |
| Deductible | $50 individual/$150 Family |
| General Office Visit (after deductible) | Covered at 100% |
| **Diagnostic and Preventative** | |
| Routine And Emergency Exams (X-Rays, Teeth Cleaning, Fluoride Treatment, Sealants, Periodontal Evaluation) | Covered at 100% |
| **Restorative Dentistry** | |
| Fillings | Covered at 80% |
| Porcelain-Metal or Stainless Steel Crown | Covered at 80% |
| **Endodontics and Periodontics** | |
| Root Canal | Covered at 80% |
| **Oral Surgery and Orthodontia** | |
| Routine or Surgical Extraction | Covered at 80% |
| Dental Implants | Covered at 50% |
| Local Anesthesia | Covered at 80% |
| Orthodontia | 50% of costs until the plan has paid $1,750 for PPO, out of state, or non-PPO; then any amount over $1,750 in member's lifetime. |

Washington State Health Care Authority

# Considerations

- Statewide coverage option
- Comparable rates to PEBB Program Self-Insured plan
- Orthodontia coverage included
- Competitive benefit structure (see Appendix)

# Proposed Resolution SEBB 2018-37

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 Dental Plan (UDP) 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 UDP benefit under the PEBB Program.

# Next Steps - October

- Board action on Resolution 2018-37
- Presentation of Fully Insured Dental Options

Washington State Health Care Authority

# Questions?

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Washington State Health Care Authority

# APPENDIX

Washington State Health Care Authority

# Dental Portfolio Overview

| | Health Care Authority (PEBB Benefits) | Lynden Public School District | Seattle Public School District | Spokane Public School District | WEA Select Plans |
|---|---|---|---|---|---|
| **Portfolio of Dental Benefits** | **UDP**: 1 PPO plan<br><br>**Delta Care**: 1 Managed Care plan<br><br>**Willamette**: 1 Managed Care plan | **Delta Dental**: 1 PPO plan | **Delta Dental**: 2 PPO plans | **Delta Dental**: 1 PPO plan<br><br>**Delta Care:** 1 Managed Care plan<br><br>**Willamette**: 1 Managed Care plan | **Delta Dental:** 4 PPO plans 2 Managed Care plans<br><br>**Willamette**: 2 Managed Care plans |

*Source Appendix: Page 49*

Washington State Health Care Authority

# Dental Benefits Ranges Comparison

| | Health Care Authority (PEBB Benefits) | Lynden Public School District | Seattle Public School District | Spokane Public School District | WEA Select Plans |
|---|---|---|---|---|---|
| **Annual Deductible** (The amount the member must pay before the plan begins to pay for covered services) | $0 – $50 Individual<br><br>$0 – $150 Family | $0 | $0 – $50 | $0 | $0 – $50 Individual<br><br>$0 – $150 family |

*Source Appendix: Page 49*

Washington State Health Care Authority

# Dental Benefits Ranges Comparison (*cont.*)

| | Health Care Authority (PEBB Benefits) | Lynden Public School District | Seattle Public School District | Spokane Public School District | WEA Select Plans |
|---|---|---|---|---|---|
| **Coinsurance/ Copayment** (The member's share of the costs as %/ Fixed dollar amount member pays for services) | **UDP members:**<br>Restorative Crown (Porcelain)<br>50%/50% split<br><br>Preventive Screening<br>$0<br><br>**Managed Care members:**<br>Restorative Crown (Porcelain)<br>$100 – $175<br><br>Preventive Screening<br>$0 | Restorative Crown (Porcelain)<br>100% paid – 70%/30% split<br><br>(dependent on incentive level)<br><br>Preventive Screening<br>100% – 70%/30% split<br><br>(dependent on Incentive level) | Restorative Crown (Porcelain)<br>100% paid – 50%/50% split<br><br>Preventive Screening<br>100% paid – 70%/30% split | Restorative Crown (Porcelain)<br>$50 – 50%/50% split<br><br>Preventive Screening<br>100% | Restorative Crown (Porcelain)<br>$47 – $250<br>*or*<br>80%/20% split – 50%/50% split<br><br>Preventive Screening<br>100% paid – 70%/30% |

*Source Appendix: Page 49*

Washington State Health Care Authority

# Orthodontia Coverage for PEBB Dental Plans

| Uniform Dental Plan* | DeltaCare** | Willamette Dental Group |
|---|---|---|
| **Member pays after deductible:** | **Member pays:** | **Member pays:** |
| 50% of costs until the plan has paid $1,750 for PPO, out of state, or non-PPO; then any amount over $1,750 in member's lifetime. | Up to $1,500 copay per case | Up to $1,500 copay per case |

** Uniform Dental is self-insured and administered by Delta Dental*
*** DeltaCare is a managed care plan administered by Delta Dental*

# TAB 12

Washington State Health Care Authority

# Eligibility & Enrollment Policy Development

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

# Introduction of Policy Resolutions

- SEBB 2018-36 Eligibility presumed based on hours worked the previous school year

# RCW 41.05.740(6)(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;

# Proposed Policy SEBB 2018-36
# Eligibility presumed based on hours worked the previous school year

A school employee is presumed eligible if they:

- worked at least 630 hours in the prior school year; and
- are returning to the same position (teacher, paraeducator, food service worker, custodian, etc.) or combination of positions with the same SEBB Organization.

A SEBB Organization rebuts this presumption by notifying the school employee, in writing, of the specific reasons why the employee is not anticipated to work at least 630 hours in the current school year and how to appeal the eligibility determination.

# Eligibility presumed based on hours worked the previous school year Example

**Example:** Classified Employee (part-time custodian)

This school employee was not anticipated to work 630 hours or more during the 2020-2021 school year. In March of 2021, he actually worked 630 hours and earned eligibility for the remainder of the school year.

- Is the school employee eligible for the employer contribution toward SEBB benefits when he returns to work in the same custodian position for the 2021-2022 school year? Yes.

# Next Steps

- Incorporate Board feedback in the proposed policy
- Send the proposed policy to stakeholders *(after today's meeting)*
- Bring a recommended policy resolution to the Board to take action on *(October 4, 2018)*

# Questions?

Barbara Scott, Manager

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# TAB 13

Washington State Health Care Authority

# SEBB Program Rule Development Plan and Process

Rob Parkman
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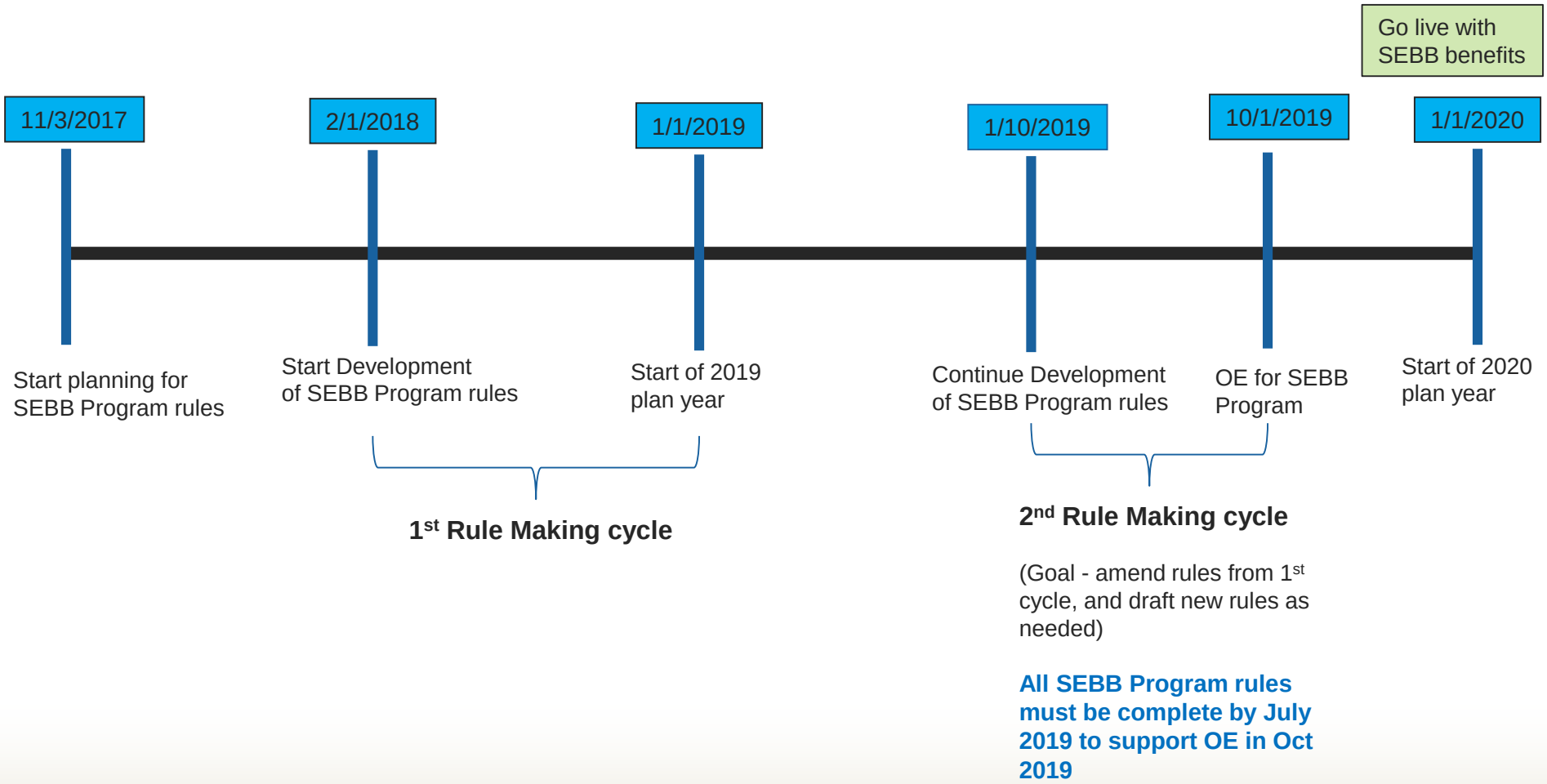
August 30, 2018

Washington State Health Care Authority

# Agenda

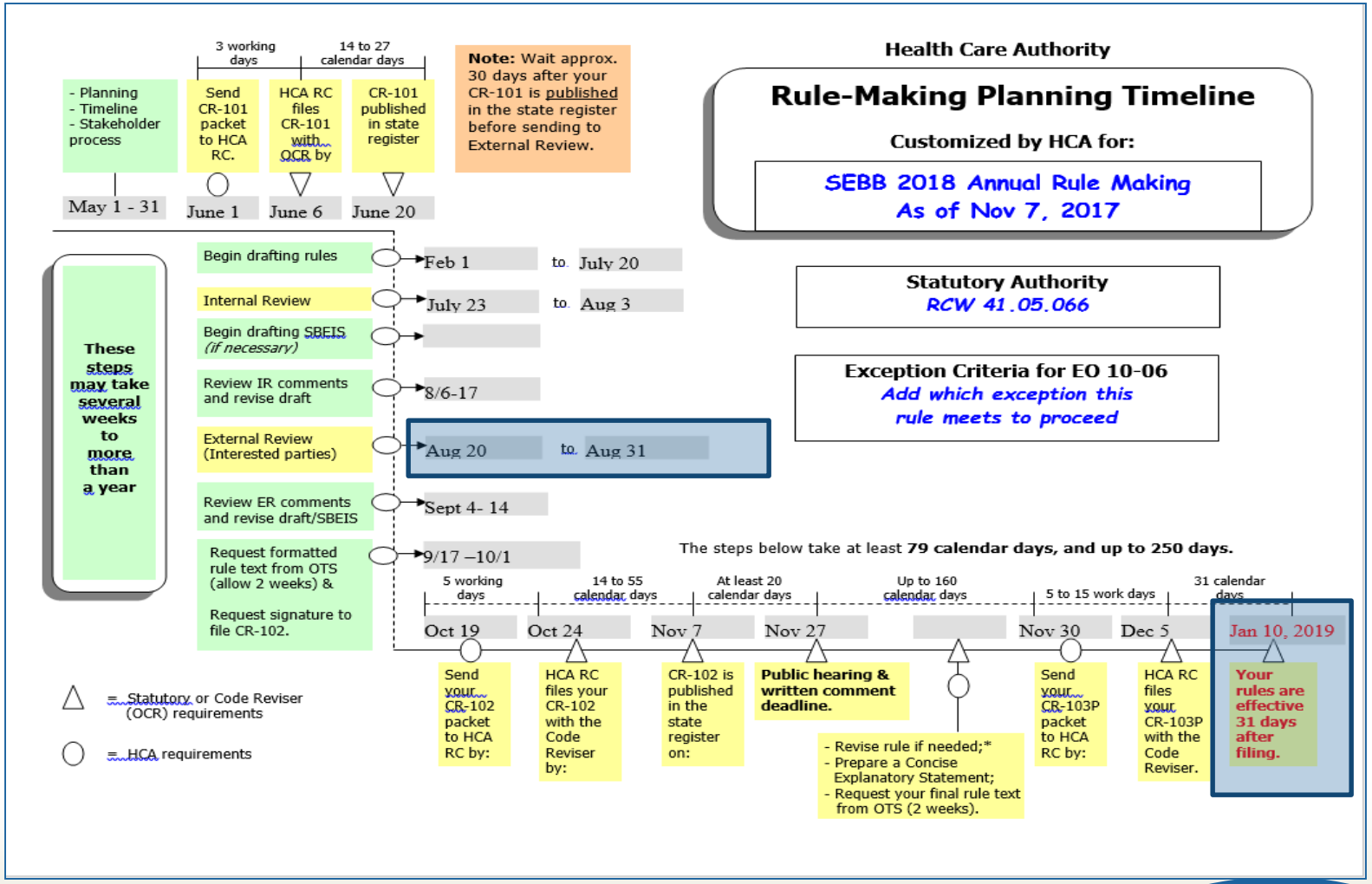
- SEBB High-level rule making plan
- 2018 SEBB rule making plan
- 2019 SEBB rule making plan
- SEBB Program Rules High-Level Authority
- SEBB Program Rules Development
- Questions

# High-Level Rule Making Timeline

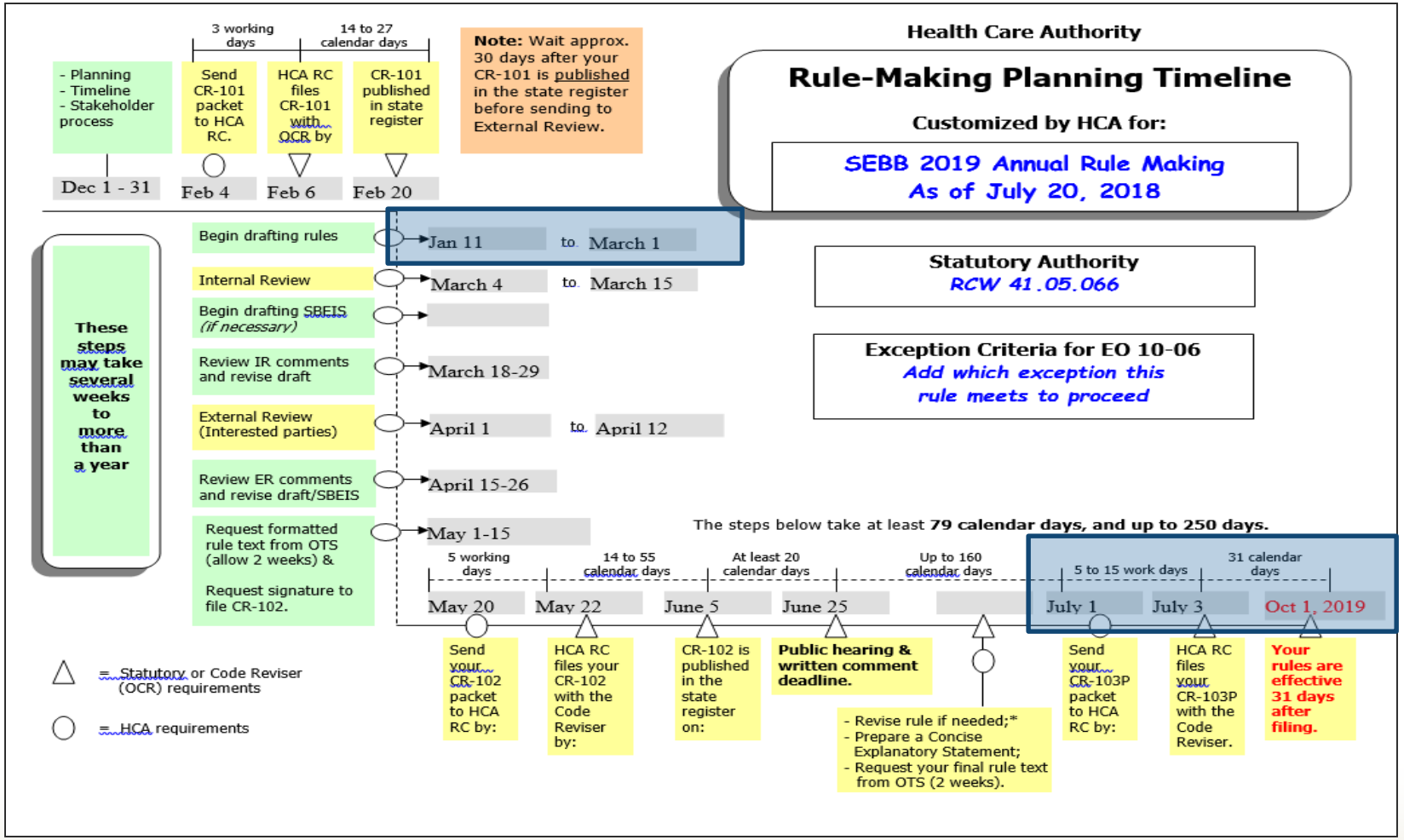


Washington State Health Care Authority

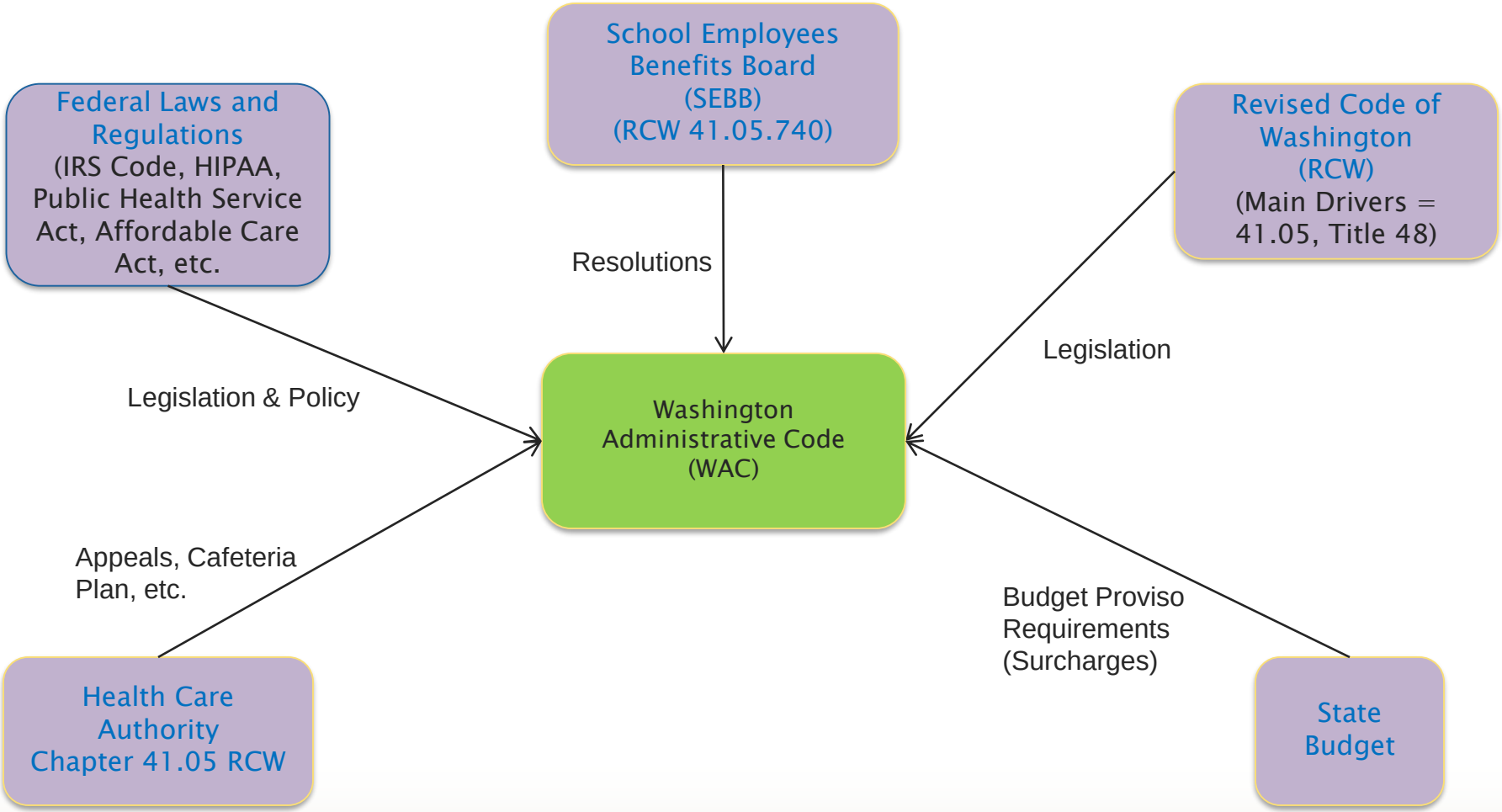
# 2018 SEBB Program Rule Making Plan



# 2019 SEBB Program Rule Making Plan



# SEBB Program Rules High-Level Authority



# SEBB Resolution Tracking

| SEBB Resolution # | Description of SEBB Resolution | Status of Resolution | Date Passed | Comments |
|---|---|---|---|---|
| 2018-12 | Effective Date of Coverage Following Hire | Active | (6/13/2018) | Used within WAC 182-31-040 |
| 2018-26 | SEBB Eligibility for the Employer Contribution Based on a Revision to the School Employee's Anticipated Work Pattern | Active | (7/30/2018) | Used within WAC 182-31-040 |
| 2018-27 | SEBB Eligibility for the Employer Contribution Based on Actual Hours Worked | Active | (7/30/2018) | Used within WAC 182-31-040 |

Your SEBB resolutions are tracked and included within rules.

Also used for history to show when resolutions supersede each other.

# Draft SEBB Program Rule

**New Section**

**WAC 182-31-040**

**How do employees establish eligibility for the employer contribution toward school employees benefits board (SEBB) benefits?**

(1) Eligibility for a school employee whose work circumstances are described by more than one of the eligibility categories in subsections (3) (a) through (e) of this section shall be determined solely by the criteria of the category that most closely describes the employee's work circumstances.

(2) All hours paid to an employee in their capacity as a school employee, within one SEBB organization, must be included in the calculation of hours for determining eligibility.

(3) School employee eligibility criteria:

(a) A school employee is eligible for the employer contribution if they are anticipated to work at least six hundred thirty hours per school year;

(i) If the school employee's 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, they are eligible for the employer contribution on the first day of work.

(ii) If the school employee's first day of work is at any other time during the school year, they are eligible for the employer contribution on the first day of the month following the day the school employee establishes eligibility for the employer contribution toward SEBB benefits.

(b) A school employee who is not anticipated to work at least six hundred thirty hours in the school year, becomes eligible for the employer contribution the first day of the month following the date they actually worked 630 hours.

(c) A school employee who is not anticipated to work at least six hundred thirty hours in the school year, becomes eligible for the employer contribution the first day of the month following the date their work pattern is revised in such a way that they are now anticipated to work 630 hours.

# SEBB Program Rules Structure

as of Aug 10, 2018 *

- Washington Administrative Code (WAC)
  - Enrollment Chapter
    - 182-30-010 through 182-30-120 (12 total sections - 9 sections this year)
  - Eligibility Chapter
    - 182-31-010 through 182-31-190 (18 total sections - 11 sections this year)
  - Appeals Chapter
    - 182-32-010 through 182-32-470 (45 total sections – 44 sections this year)
  - Total SEBB WAC sections – 75 sections
    - This year rule making cycle – 64 sections

*Sections may be added and removed as these move through the two year process

# Questions?

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