School Employees Benefits Board Meeting

April 10, 2019

Washington State Health Care Authority

School Employees Benefits Board

April 10, 2019
1:00 p.m. – 5:00 p.m.

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

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TAB 1

Washington State Health Care Authority

AGENDA

School Employees Benefits Board
April 10, 2019
1:00 p.m. – 5:00 p.m.
Sue Crystal Rooms A & B

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

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

1:00 p.m.*	**Welcome and Introductions**		Lou McDermott, Chair	
1:05 p.m.	**Meeting Overview**		David Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information
1:10 p.m.	**Approval of October, November, and December 2018 Meeting Minutes**	TAB 3	Lou McDermott, Chair	Action
1:15 p.m.	**March 7, 2019 Board Meeting Follow-up**	TAB 4	David Iseminger, Director ERB Division	Information/ Discussion
1:20 p.m.	**SEBB Finance 2019-2021 Update**	TAB 5	Megan Atkinson, Chief Financial Officer, Financial Services Division	Information/ Discussion
2:15 p.m.	**Legislative Update**	TAB 6	Cade Walker, Special Assistant to ERB Division Director	Information/ Discussion
2:35 p.m.	**Break**			
2:45 p.m.	**Policy Resolution**	TAB 7	Rob Parkman, Policy and Rules Coordinator, ERB Division	Action
3:05 p.m.	**Eligibility and Enrollment Policy Development**	TAB 8	Rob Parkman, Policy and Rules Coordinator, ERB Division	Information/ Discussion
3:15 p.m.	**UMP Pharmacy Benefit Proposal**	TAB 9	Marcia Peterson, Manager Benefits Strategy & Design Section, ERB Division	Information/ Discussion
4:00 p.m.	**2020 Final Benefits Design Refinements**		Marcia Peterson, Manager Benefits Strategy & Design Section Dave Iseminger, Director, ERB Division	Information/ Discussion
4:30 p.m.	**Public Comment**			
5:00 p.m.	**Adjourn Meeting**			

***All Times Approximate**

The School Employees Benefits Board will meet Wednesday, April 10, 2019, at the Washington State Health Care Authority, Sue Crystal Rooms A & B, 626 8th AVE SE, Olympia, WA. The Board will consider all matters on the agenda plus any items that may normally come before them.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW. Direct e-mail to: SEBboard@hca.wa.gov. Materials posted at: https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program by close of business on April 9, 2019.

Washington State Health Care Authority

SEB Board Members

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

SEB Board Members

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

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

4/5/19

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

UPDATED SEBB MEETING SCHEDULE

2019 School Employees Benefits Board (SEBB) Meeting Schedule

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

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

March 7, 2019 - 9:00 a.m. – 5:00 p.m.

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

May 16, 2019 - 9:00 a.m. – 5:00 p.m.

June 12, 2019 - 9:00 a.m. – 5:00 p.m.

July 18, 2019 - 9:00 a.m. – 5:00 p.m.

July 25, 2019 - 9:00 a.m. – 5:00 p.m.

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

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

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

Updated 11/27/18

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: November 27, 2018
TIME: 3:36 PM

WSR 18-24-024

TAB 2

Washington State Health Care Authority

SCHOOL EMPLOYEES BENEFITS BOARD BY-LAWS

ARTICLE I
The Board and Its Members

1. Board Function—The School Employees Benefits Board (hereinafter "the SEBB" or "Board") is created pursuant to RCW 41.05.740 within the Health Care Authority; the SEBB's function is to design and approve insurance benefit plans for school district, educational service district, and charter school employees, and to establish eligibility criteria for participation in insurance benefit plans.

2. Staff—Health Care Authority staff shall serve as staff to the Board.

3. Appointment—The members of the Board shall be appointed by the Governor in accordance with RCW 41.05.740. A Board member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.

4. Board Composition —The composition of the nine-member Board shall be in accordance with RCW 41.05.740. All nine members may participate in discussions, make and second motions, and vote on motions.

5. Board Compensation—Members of the Board shall be compensated in accordance with RCW 43.03.250 and shall be reimbursed for their travel expenses while on official business in accordance with RCW 43.03.050 and 43.03.060.

ARTICLE II
Board Officers and Duties

1. Chair of the Board—The Health Care Authority Director or his or her designee shall serve as Chair of the Board and shall conduct meetings of the Board. The Chair shall have all powers and duties conferred by law and the Board's By-laws. If the regular Chair cannot attend a regular or special meeting, the Health Care Authority Director may designate another person to serve as temporary Chair for that meeting. A temporary Chair designated for a single meeting has all of the rights and responsibilities of the regular Chair.

2. Vice Chair of the Board—In December 2017, and each January beginning in 2019, the Board shall select from among its members a Vice Chair. If the Vice Chair position becomes vacant for any reason, the Board shall select a new Vice Chair for the remainder of the year. The Vice Chair shall preside at any regular or special meeting of the Board in the absence of a regular or temporary Chair.

ARTICLE III
Board Committees
(***RESERVED***)

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board's duties. All Board meetings shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW, but the Board may enter into an executive session as permitted by the Open Public Meetings Act.

2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser's Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.

3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.

4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.

5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 24 hours prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. An audio recording (or other generally-accepted electronic recording) shall be made of each meeting. HCA staff will provide minutes summarizing each meeting from the audio recording. Summary minutes shall be provided to the Board for review and adoption at a subsequent Board meeting.

6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board members in the minutes.

ARTICLE V
Meeting Procedures

1. Quorum—Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.

2. Order of Business—The order of business shall be determined by the agenda.

3. Teleconference Permitted—A Board member may attend a meeting in person or, by special arrangement and advance notice to the Chair, by telephone conference call or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the SEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at Board meetings may also occur in conjunction with a public hearing or during the Board's consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.

5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Board members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .

6. Representing the Board's Position on an Issue—No Board member may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.

7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the Chair, or upon request of a Board member, a roll call vote may be conducted. Proxy votes are not permitted, but the prohibition of proxy votes does not prevent a temporary Chair designated by the Health Care Authority Director from voting.

8. State Ethics Law and Recusal—Board members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW. A Board member shall recuse himself or herself from casting a vote as necessary to comply with the Ethics in Public Service Act.

9. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert's Rules of Order Newly Revised. Board staff shall ensure a copy of *Robert's Rules* is available at all Board meetings.

10. Civility—While engaged in Board duties, Board members conduct shall demonstrate civility, respect, and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

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

1. Two-thirds majority required to amend—The SEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.

2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public's health, safety, and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

TAB 3

Washington State Health Care Authority

School Employees Benefits Board
Meeting Minutes

Draft

October 4, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 5:00 p.m.

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

Member Present by Phone:
Wayne Leonard

SEB Board Counsel:
Katy Hatfield

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

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

August Board Meeting Follow Up
Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided updates to Board questions from the August 30 and September 17 meetings.

Slide 2. I believe Terri asked for a copy of the talking points from Kayla Hammer's presentation about the data sets and the chiropractic, acupuncture, and massage therapy limits. The talking points are in bullet format and included in your materials today.

During the same K-12 data description presentation, Pete asked that the Board have access to a complete copy of the data elements within the various data sets. We've

been working on pulling that information together. It proved to be a little more difficult for getting to this meeting, but we will provide it when it's completed.

At the September 17 meeting, we talked about the disability benefit. I will confirm that we have the Employment Security Department, the state agency that's implementing the Paid Family and Medical Leave bill that we talked about in the context of the short-term disability benefit, will be coming to the Board's December meeting. They will provide more information about how that benefit for all employees across the state is being built and to answer some of the questions you had.

Because our September 17 meeting was barely two weeks ago, questions asked about the frequency of Long-Term Disability (LTD) claims, the utilization of the LTD benefit, and taxability provisions with disability payments will be presented to you when we bring long-term disability back to the Board in November.

Collective Bargaining Results

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division and Megan Atkinson, Chief Financial Offer, Financial Services Division, provided an overview of what's in the Collective Bargaining Agreement for SEBB benefits.

This summer we began a journey with the super coalition for statewide collective bargaining on health benefits. As Slide 2 indicates, the statute specified we bargain over the dollar amount to be contributed for school employee health benefits. This process will be conducted in even-numbered years.

Slide 3 – Bargaining Timeline. Under statute, we could officially begin the process on July 1. We had multiple meetings with the super coalition. The state team was led by state Human Resources and chief negotiator, Diane Lutz. HCA and OFM staff were subject matter experts to provide context to the bargaining. We had multiple sessions with the super coalition that resulted in a tentative agreement in mid-September. Then the super coalition went through a ratification process and the tentative Collective Bargaining Agreement was ratified. This past Monday it was transmitted to OFM with all the other Collective Bargaining Agreements that were negotiated over the past summer, for the director of OFM to do the financial feasibility study. The transmittal occurred on October 1. We couldn't send you materials until after the transmittal occurred. That's why you got your Board materials on this particular slide deck on Tuesday, instead of last week with the rest of the materials.

The next steps in the process is that OFM will do the financial feasibility study after the November revenue forecast and then there will be a submission about the financial feasibility for this Collective Bargaining Agreement, as well as all other Collective Bargaining Agreements to lead into the governor's budget, which leads us into the legislative session in January.

Slide 4 – Medical Benefit Funding. There are different provisions within the Collective Bargaining Agreement. The first one highlighted here is funding of the medical benefits. What the super coalition and state ultimately bargained over was an "employer medical contribution" (EMC). This is a funding amount specific to the medical benefit part of the portfolio. There are multiple benefits within the program, but this particular part was focused on a dollar amount called the "employer medical contribution" that the state

would pay out through the school districts, that then funnels to the Health Care Authority for the purposes of the medical benefits. For plan years 2020 and 2021, the EMC is specified as "a dollar amount that will be equal to 85% of the monthly premium for the self-insured plan UMP Achieve."

Megan Atkinson: Achieve 2.

David Iseminger: I'm not sure if it's Achieve 1 or Achieve 2.

Megan Atkinson: Anyway, it will be the 88% AV plan. .

David Iseminger: I'm pretty sure that's Achieve 2. The important part is it's 85% of the monthly premium of the self-insured plan that is an 88% Actuarial Value (AV). The Collective Bargaining Agreement language says the plan that's similar to UMP Classic, 88% AV. This effectively means when the portfolio has plans that have lower AVs, if an individual elects that plan, the state contribution will cover more than 85% of the premium. If an individual selects a plan that's more than 88% AV, the state contribution will cover less than 85%. It is very different from the PEBB world that some of you may have heard about.

On the PEBB side is a tiered weighted average of all plans. On the SEBB side, for at least the start of the program and this collective bargaining process, a flat dollar amount is applied to an 88% AV plan. Part of the reason it's different for the two programs is when collective bargaining started for the PEBB Program, the benefits had been around for 15-20 years. There was a lot of data. People knew everything they were bargaining. There is a chicken and the egg issue for basically everything in the SEBB Program, and this was deemed the best way to move forward with the amount of uncertainty on both sides.

Megan Atkinson: Essentially what we're doing by establishing a set employer medical contribution, 85% of the AV plan, that's essentially the state's bar in terms of providing the state's portion of the medical contribution, a certain benefit level. That's the state's view. Then, if the employee wants a richer benefit, you are essentially putting the employee in a position where they can decide if they want to buy up to a higher AV. Those of you who either make your own decisions around an open enrollment period or who have been more involved in health care purchasing, there is a lot of policy discussion around putting individual consumers in somewhat of an economic situation around the benefit richness of the plan that they choose to enroll in. That's essentially what we have set up now where the state's deal is 85% of an 88% AV plan. The employee has the ability to buy up into the richer plans in the portfolio.

For the plans that have a lower AV, to Dave's point, the employee gets more than 85% of their contribution covered up to a certain floor. We've essentially set up the ability for employees to make economic decisions based on their own family situation, their own preferences, their own risk profiles.

David Iseminger: The third bullet on Slide 4 references the floor. The Collective Bargaining Agreement also indicates there will be an employer contribution on all plans. It sets that employer contribution at no less than 2% of the employer medical

contributions. For example, if the EMC by the state is $500, that means the minimum monthly employee contribution for a plan would be $10, which is 2%.

Pete Cutler: Does the 88% AV value correspond to a gold level plan, if it were on the federal health benefit exchange.

David Iseminger: Yes, Pete, it does.

The last bullet on Slide 4 clarifies the EMC that's paid by the state would be paid across all tiers. Policy Resolution SEBB 2018-14 had the tiered ratio of 1 for a single subscriber, 2 for subscriber and spouse, 1.75 for subscriber and child or children, and 3.0 for subscriber, spouse, and any children. That ratio would be multiplied across the EMC and the EMC would be paid across all tiers.

Pete Cutler: I just want to confirm. Am I right that in prior years the dollar amount that was negotiated was more broadly for insurance benefits and included what would be provided as funding for the dental benefits, etc., whereas this year, it's focused, in the collective bargaining, on the contribution for medical care?

David Iseminger: Pete, I think when you're talking about prior you are really comparing to PEBB?

Pete Cutler: Yes. Thank you for clarifying that.

David Iseminger: The structure of this Collective Bargaining Agreement is similar to the PEBB Collective Bargaining Agreement. In PEBB, there is a section about the medical. It's not expressly called the employer medical contribution in that Collective Bargaining Agreement, but the first provision of the health section of the PEBB Collective Bargaining Agreement is about the part the state is providing for medical. That's where it refers to a tiered weighted average of 85% of the medical plans. Then, there is a separate provision, which I'll go through on a different slide, about the other benefits that are 100% fully paid by the state. There is a parallel structure between the two programs' Collective Bargaining Agreements. They were separately described in PEBB and they continue to be described separately in SEBB.

Pete Cutler: Thank you.

David Iseminger: Slide 5 – EMC Concept Illustration. We used round numbers that would be easy to digest. Don't get these numbers stuck in your head. I've tried to model Megan's request to not use numbers that are so close to reality that it starts to stick in people's minds. This illustration is just to show exactly how the employer medical contribution works and the relationship between the EMC and that floor threshold of an employee contribution. And, apparently, here's the confirmation that it is indeed Achieve 1, the 88% AV plan.

Megan Atkinson: Or we're consistently incorrect.

David Iseminger: At least we're consistent in our slide deck. The top of the slide reminds you of the four different tiers. The tiered ratio is in the grey row near the top of the slide and that is the tiered ratio from the resolution from several months ago. And

then, by plan. We're simplifying it and showing you the two Achieve Plans, as well as UMP Plus and not showing the CDHP Plan at this time. It shows how the math would work, what the employer medical contribution would be, how that represents an 85% split, and how it multiplies across, exactly what it would look like. These illustrations would be the employee contributions for those plans. This was just an illustration showing you the math of how those provisions would work out in real time.

Megan Atkinson: This allows you to see that the EMC, that middle row in each one of the larger rows, remains the same across the different plans, whether $200, $400, $350, $600. You can see as you change the actuarial value of the plan, the employee contribution, the bold row, changes as well. If you look at the employee only column, you've got an employee contribution going for $15, $35, or $25. We're showing these all in terms of the UMP products, but this holds true if an employee chooses a managed care option. If we use these numbers in this example, the employer medical contribution of $200, if an employee enrolls in a managed care product, that $200 would also apply to the managed care product program.

Sean Corry: I noticed when I was scanning across these imaginary premiums that the cost for a family is not the same number as it would be if we added up the components of the family. Could you explain why that is? When we add, for the top line, $430, $376, and $215, it doesn't total $645. There are variations in that. I've seen this before in commercial business and that might be helpful to explain why a family rate with dependent children or spouse or partner, the premium's not the same as the total of the individual parts.

David Iseminger: Essentially, the answer to your question is, again, why the Tier 4 ratio is set at 3.0 instead of 2.75 because if you added up the sum components, you would get to 2.75 instead of 3. At the time, when we brought the Board the resolution related to the tiered ratio, I remember very clearly Megan saying there is no perfect tiered ratio. What you're really talking about is how different parts of the population are subsidizing each other. I believe we presented some information about if you compress the tier ratio for the fourth tier at 2.75, like it is in PEBB, we described before your vote about what that additional compression would look like. Our recommendation to the Board at the time was, because there's no perfect number and there's already a lot of shock that's going to go in the system because of all the changes, and the statute allows the Board the discretion up to 3.0, that we recommended going with 3.0 for that ratio. Even though, as Sean's pointing out, it is more than the sum of the parts. Are there things that I missed, Megan?

Megan Atkinson: I think Dave did a good explanation. The math isn't additive math across the tiers. It's multiplicative math using the single employee only amount times the tier ratios. To Dave's point, the obvious ones are if you have a single employee of 1.0 and you have employee plus spouse or partner, essentially a single employee is one adult, employee plus spouse or partner, two adults. That's the easy, logical one that makes sense to everyone. You've got 1.0 for employee only. It is 2.0 for two adults, employee plus spouse. When you get to the next two, the employee only as the only adult plus child or children, and then the employee, partner, spouse, and child/children, those two tiers are where some of the data, the science, and the art comes in on how you want to set up the tier ratios.

I don't know if you recall that information, that conversation, around the child load in PEBB on the employee plus child/children versus that fourth tier and how that looked. We talked about you can chase the data and try to get really exact, but the reality is, you're chasing the data. Also remember that the tier ratios aren't changing the total cost of providing the plan benefit. They help you allocate the cost, the employee's contribution to the cost across the population, and how you segment that population into the different tiers or different segments.

Making the distinction of a 1.75 and a 3.0, it's not intended to exactly replicate the costs associated with each one of those tiers. It's helping you set the relativity of how, from your tier with the fewest number of people in terms of individual subscribers, the fewest number of people per subscriber as your single employee, that's only a 1.0 to your tier that has the most number of family members per subscriber, your employee, spouse/partner, child/children tier and how much distance you spread between those. How much the single employee is subsidizing or not subsidizing that latter tier. Again, for tier ratios you need to use some data in establishing them. They don't change the total cost of the plan that you need to provide. It's helping you distribute that cost, and setting that relativity across the tiers. So, Sean is correct. They won't add up. But the math should work as you multiply across.

Lou McDermott: Megan, just for simplicity, we know that as we move the tier numbers around we're going to have winners and losers, to put it bluntly. If we go from a 3.0 to a 2.75, describe the winners and losers.

Megan Atkinson: If you went from a 3.0 to a 2.75, the employees that enroll in that fourth tier would pay lower than they would have otherwise. Your other tiers would pick up that cost because, again, the total size of your cost would be covered, regardless.

Pete Cutler: Changing the topic. Under the column that deals with the actuarial value that lists the different UMP Plans, they are listed in the order that they're increasing in actuarial value, 82%, 88%, 90%, and the first two make sense that the employee contribution for the one where you have more out-of-pocket cost is lower premium to the employee because they pick up more. When you get the Achieve 1, you're going to pay more premium because you have lower out-of-pocket costs. But then, when you get to UMP Plus, with a 90% AV, your costs as an employee go down. My guess is this has to do with the accountable care networks and there's an assumption that there'll be significant savings from those aspects of the plan that will offset the fact that there's less point of service. I just sense intuitively, for somebody without a further explanation, it seems counter-intuitive that employee cost would go up and then down. I just would like to confirm that's what's driving that reaction, or that outcome.

Megan Atkinson: I actually want to go back and double check with the staff. When we pulled this together, we were trying to do an illustrative example. There's a possibility we might have illustrated this and not got it quite right. As soon as you started talking about it, I realized you have a very good point. Setting aside the numbers on this chart, there are obviously certain things we're trying to achieve for the portfolio, with the plus offering. That is around both increases in quality and the value proposition for the members. Dave, do you want to talk more about that.

Lou McDermott: I can probably take a swing at that, too.

David Iseminger: Let me say one thing before you do, Chair McDermott. I don't think that the slide's wrong because in the PEBB portfolio, the UMP Plus Plan does have a lower employee cost share than UMP Classic, which is the PEBB's 88% AV plan. A lot of that has to do with the contractual risks and rewards built into the network contracts with the Puget Sound High Value Network and the UW Accountable Care Network. Part of how this benefit is funded is the assurances of hitting certain financial metrics. That funds a lower premium to make it attractive for members to go into and have that coordinated care. I do believe that the illustration is illustrating a correct phenomenon that is counter-intuitive.

Megan Atkinson: I think part of what we wanted to illustrate with this, though, is how the Collective Bargaining Agreement works. Setting aside the uniqueness of the UMP Plus offering, as we were explaining initially, as a member chooses to move into a higher AV plan, a higher AV plan is going to have a higher premium associated with it, and the employer medical contribution will not float as an employee selects either a higher or a lower AV plan.

Pete Cutler: Thank you. It helps to have that discussion on the record.

Wayne Leonard: I want to check my understanding on a couple of points. One is the follow up to what Pete asked. The EMC only relates to the medical benefit, is that correct?

David Iseminger: The employer medical contribution is specifically for the medical benefit part of the portfolio. There's a separate provision that I'll go into where the employer covers 100% of specified other benefits. The EMC that we're talking about is specific to the medical part of the portfolio.

Wayne Leonard: I'm trying to make the leap between our current K-12 world and what you're talking about. Right now we get an allocation that covers the entire basic benefits package with pooling. Our out-of-pocket expenses are determined afterward. But, with this plan, pooling goes away, but we're still getting some allocation that's covering the entire basic benefits. But, right now you're just referring to the medical portion of it?

David Iseminger: Wayne, for the purposes of the Collective Bargaining Agreement, there are separate provisions for medical and other benefits. What you're describing, I believe, is the funding rate that the Legislature puts in the budget that is then pushed through the mega model that goes to OSPI, to the school districts, and eventually to the Health Care Authority. It’s a rollup of a lot of different components. One of those components will be the EMC. Other parts of that funding component in the state budget will be the allocation for the other benefits. We’re just starting to describe the separate components of what will eventually be a rolled up into the funding rate number that is in the state budget. We're only describing a component of what you're currently receiving and then we'll move on and describe other components.

Wayne Leonard: Okay. The reason I ask is that in the last several meetings there's been discussion about increasing the life insurance benefit or the long-term disability benefit. And I just want to clarify that it's all included in the same manner. If we

increase benefits in one area, there's no effect on cost in other areas. I just want to interject my understanding of that.

Megan Atkinson: Wayne, to underscore what Dave's talking about, I think we have been talking globally about the total benefit package and then the total cost proposition for the state that will be presented to the Legislature. That's really going to be the total cost of the Collective Bargaining Agreement, the impacts of the FTE and head count hiring decisions that happen in the school districts. But, for the Collective Bargaining Agreement, to Dave's point, we had the employer medical contribution, which, again, is medical. It's medical and pharmacy but it's a medical benefit. Then, we have the other components that Dave's going to talk about next. Those costs for the benefit offering plus costs associated with the agency administration, building reserves, the loan repayment that has to happen for the start-up costs that were fronted to the SEBB Program, those total costs of operating the program. They get rolled up into a funding rate. And that, I think, is what you're used to seeing, that's specified in the budget bills and then rolls out through your apportionment.

Wayne Leonard: Correct. And will you be touching on whether this overall funding rate includes the K-12 remittance?

David Iseminger: Yes, we will. And the answer to that question is yes, it does.

Wayne Leonard: Okay. Thank you.

Sean Corry: Just to reinforce a point that's come up again, which is that all of the decisions that we are pondering now and will ultimately make as recommendations for funding lead us to the point that the funding request and the funding amount is not yet fixed. It's not yet a zero sum game, when we're considering alternative levels of coverage, for example, on life and disability insurance. If that becomes the ask, that becomes the ask. So, understanding how a zero sum game works, if you take a buck, you have to take a buck from some place to spend it in another place. But we're not quite there yet, because we don't have the fixed dollar amount. So, I'm encouraging the Board to remember that when we're considering what I would think to be, in my view, what will be moderate, maybe modest, changes in life and disability benefits compared to PEBB. But, even still, dramatic deductions in life and disability benefits that are enjoyed by virtually a huge percentage of school employees now.

David Iseminger: I've a little bit of additional context for that piece, but I want to get to it after I get through the 100% portion of the Collective Bargaining Agreement. I'll pick up on that thought in a moment.

On Slide 6, the second part of the Collective Bargaining Agreement is describing benefits that the state will pick up 100% of the premium cost. It includes both dental and vision. The language in the Collective Bargaining Agreement is, "…any offered standalone vision…," because at the time a tentative agreement was reached, the Board had not yet taken action on having a separate vision. Therefore, if the Board hadn't carved out vision, it would have been embedded in the 85% medical because vision would have been with medical. But, since it's carved out by your action, it will now be 100% paid by the state, along with dental. And, because not all districts were used to having the employer contribution paid across all tiers, the language in the

Collective Bargaining Agreement is clear that for dental and vision, it is all tiers picked up 100% by the state, regardless of how many dependents are included on the plan.

Pete Cutler: Dave, just to be clear. There's certain positions. There will be some that will be funded by employers rather than from state money.

David Iseminger: Yes. I am sorry for oversimplifying that. Thank you for correcting me. The other part of this employer paid benefits is 100% of the cost of the basic life and basic LTD benefit. This is saying that the overall funding allocation that would go to the state includes 85% of an 88% AV medical plan and 100% of dental, vision, basic life, and basic LTD. Although there is not something that gets you to a specific dollar amount as on the employer medical contribution, the financial underpinnings, and my understanding of how this will be assessed as part of the feasibility. Although, I'm obviously not OFM, my understanding is that the starting point for the financial feasibility on these benefits is the same allocation that will be spent on PEBB as in SEBB. There will be underpinning assumptions within the financial feasibility that OFM has to complete about the total cost of the entire Collective Bargaining Agreement, which includes assumptions about the payment of the 100% premium for these various benefits.

Slide 6 – Wellness. For the Wellness Program, there was an agreement to have a wellness program that you'll get a presentation shortly about that is built off of the wellness program that the agency has and administers for the PEBB Program. Effectively, it sets up a point-based system for people to engage in overall health well-being, including physical, mental, financial, emotional, work, it's a whole person wellness program. By completing certain requirements, and we will go through some of the decisions you'll need to make along the way about this wellness program, individuals would be eligible for a $50 reduction in either their deductible or deposit into an health savings account (HSA) if they're enrolled in a qualified high deductible health plan. They would earn that $50 incentive first for plan year 2020, the launch of benefits, based on doing a well-being assessment in the program during the 2019 open enrollment.

After that first year, for plan year 2021, the incentive would be $125, either, a deductible reduction or a deposit into a qualified high deductible health plan associated with an HSA. We will talk more about the exact mechanisms for this in the next presentation and start that process with you. Essentially, the Collective Bargaining Agreement has a total of $175 in wellness incentives across the two plan years that we're talking about under the CBA. That should tee up for you why there are no plans that anyone will be offering that have lower than $125 deductible, because, foreshadowing that this was coming, you could get in certain plans down to a zero dollar deductible by participating in the wellness program. So, no deductibles will come in under $125 so that there's not a negative deductible situation.

Pete Cutler: I have a question about this. My understanding is state law says that this Board establishes a cost sharing like deductibles for the school employee plans. This wellness program is not something that was part of what this Board is putting together, and yet it's in the actual Collective Bargaining Agreement. To me, there's a disconnect there. How can the Collective Bargaining Agreement establish provisions related to cost sharing the deductibles, etc., in SEBB Program plans if those decisions are in

theory statutorily assigned to this Board? It would be a different thing if it was just a proposal, but here we have a Collective Bargaining Agreement that assumes it as a given fact. I'm also curious, are we going to see dollar amounts about how much these deductible, whatever it's called, the reduction deductible, the HSA contributions -- how much those cost? And if they're not offered, how that would impact, frankly, the ability to fund other aspects that the Board might feel are higher priorities. Is that type of analysis going to be presented to the Board at some point?

David Iseminger: A couple of different things to unpack in your question, Pete. We have a lot of wellness reports that go to the Legislature about the wellness program on the PEBB side that describes some of the cost impacts that you're describing. As we go through the wellness development process with the Board, we can describe some of those impacts, because we're used to describing them in other contexts. The short answer to your question is yes, we'll work on describing some of the potential fiscal impacts. I do want to make sure the Board is aware that in the Board's statutory authority, there are references to wellness. They are in RCW 41.05.740. There are references to the Board's authority to related to the concept of a wellness benefit.

Another important piece with regards to the authority is this Board's authority is statutorily delegated from the Legislature. The Legislature also has its important role whether or not to fund and accept the Collective Bargaining Agreement. There are always things delegated to the Board. For example, sometimes the Legislature pulls back and says, “thou shalt, SEB Board, and all fully insured plans including those under 41.05, cover X” or “won't cover Y.” Just because there is authority to this Board doesn't mean that the Legislature also doesn't have overlapping higher authority to add different parts and dictate different components of the authority that it's delegated to the Board. As long as the Legislature funds the Collective Bargaining Agreement, it's stepping into that role in the same way when it mandates a benefit that's covered. There are overlapping authorities.

Pete Cutler: Just for the record, I am, more than anything else, a legislative staff person over my career and I have quite an appreciation of the importance of deference to the policy setting role for the Legislature. But we're not talking here about something where the Legislature has delegated some authority to some other entity, that I’m aware of. I may be wrong. There may be statutory language I'm not familiar with and that's fine if there is. But, off the top of my head, if there is no such provision for how the wellness program explicitly providing for the collective bargaining process, or OFM, or the Health Care Authority to establish wellness programs that impact the cost sharing arrangements of plans offered to school employees, the lawyer in me wonders where the assumption is that that could be done. Be that as it may, I will look forward to the information about the financial status of the current wellness program with the state employees. I'll look forward to getting more background information. We don't have to make any decisions right now.

Megan Atkinson: Pete, are you focusing in on the connection that Dave made between the wellness benefit that's in the Collective Bargaining Agreement and that being the floor on a plan deductible?

Pete Cutler: No. Just the flat out -- I mean, frankly, when I was on legislative staff, we had questions about does the state actually get back in benefits, in terms of just from a

fiscal point of view, the reduction in claims costs, or reduction in employee absences, or whatever from having a wellness program that we spend, for its administrative costs, for these reduced deductibles, and the contribution to the HSA accounts. At that point, that was when the programs were first being considered. It was very much still, and my guess is that whole area of wellness programs is still in flux, but there was no real data. It was just a guess. It was a, “we think it'll help - we think this will lead to changes in behavior that will lead to reduced cost long term and not so much short term, but long term.” The budget part of me is still really curious about can you really make the case that reducing the deductibles, which increases the premium cost for the employees, no it reduces, it increases for the employer. Right?

Megan Atkinson: This is an employer provided benefit.

Pete Cutler: Right. If the employer wants, would we as a Board prefer that the employer spend that amount of money on something else that we think would be more beneficial to school employees than these incentives? I haven't made up my mind, but it just seems I wouldn't want to take it as just a given that, well, because the state offers this particular program we're just going to automatically sign up, because it does. If it didn't involve employee deductibles or the plans then it'd be, well, it's something that the state administers and it's, you know, not directly related to matters under the Board's authority. But in this case, as long as it deals with and impacts deductibles, it impacts areas under this Board's authority. So, I'd really want to know what is the case for doing this?

Megan Atkinson: Okay, so you're interested more comprehensively in the cost benefits of a wellness program?

Pete Cutler: Yes.

Megan Atkinson: Okay, thank you.

David Iseminger: And just to preview, Pete, you're probably not going to get the answers to your questions in 20 minutes when we move on to that presentation but we will work on bringing more information as we go on the wellness journey with the Board.

Pete Cutler: That'd be fine, thank you.

David Iseminger: Slide 8 – Benefit Allocation Factor (BAF) describes another component of the Collective Bargaining Agreement. If you think about the conversion factor that exists within the K-12 financing mega model, the model used to push money out via the allocation process to the districts, there is an adjustment factor that exists currently in the mega model. This is, in the Collective Bargaining Agreement, an agreement as to what that multiplier will be separately for classified and certificated staff. I'm probably going to oversimplify it, but this is the answer to the FTE to head count conversion question that we've been teeing up and describing for the Board since the first couple of Board Meetings.

Megan Atkinson: One of the things that we have talked a lot about is the benefit funding currently provided to the school districts goes out on essentially an FTE basis. Within the budget bill, there's an additional multiplier used to take those FTE, increase

them by more than one, and drive out allocations to address the issue that there's more bodies out there than FTEs working in the school districts. What the Collective Bargaining Agreement does is, we have that factor now identified as a benefit allocation factor (BAF) which calculates separately for classified versus certificated staff. As you well know through your experience in the districts, you usually bring in more part time classified staff than you do certificated staff. And, again, with eligibility set at 630 hours, you're going to have a certain part of the head count coming in and eligible for benefits.

One of the concerns raised repeatedly by the Board, and when we've gone out and talked with district folks, like WASBO, really any conversation that you end up around SEBB is how are we going to address that head count issue. The Collective Bargaining Agreement does specify two different benefit allocation factors applied to the certificated and the classified staff. As the K-12 model rolls up the number of state recognized FTE, and I want to underscore that because this is state recognized FTE, it will take the state funding, multiply it by these factors, and that drives out the total amount of funding that the state is providing to the districts. There will still be the district hiring practices that drive out district funded staff that won't be addressed in the state funding. These factors were calculated based on information OFM had available on how the hiring practices are currently. That's where the 1.43 and the 1.02 were calculated off of the state funded or state recognized FTE and head count that are in the system currently. These may not be the right factors for the district-funded staff. But, again, they are specified in the Collective Bargaining Agreement and they will be used in driving out the state funding.

Sean Corry: A request for clarification on these factors which came out of the grand bargaining, which was with bargaining units. Essentially in proportion to their heft. But I don't understand. Did district administration get involved in this conversation too? Because I know that administrators across the state were calculating what it's going to cost districts to meet that 630 hour low threshold for all those employees that are not funded by the state. Could you explain how administrators were involved, if at all, in determining what these factors might be?

David Iseminger: In general, with the collective bargaining process, administrators weren't in the room, so to speak, as the negotiations were happening. But, OFM did have a separate consulting committee, if you will. I don't remember the exact word for it, but there was a group convened by state human resources with a set of administrators and they served as another kind of SME for the collective bargaining process, even though they weren't in the room. That's unfortunately the best I can describe as context, Sean. But I can follow up with more information if you'd like.

Sean Corry: No, that’s okay.

Pete Cutler: Just to confirm, this 1.43, it will be applied to all districts regardless of what nuances they have in terms of their HR approach?

Megan Atkinson: That's my understanding, yes.

David Iseminger: Slide 9 – Other Agreements. To Wayne's question earlier, there's a provision describing that employers versus employees will contribute 100% of the K-12 remittance. The funding amount that's paid will be the same, regardless of what type of employee you are in the K-12 system. Everyone is treated the same from a funding

perspective. There is also a brief acknowledgment about the spousal and tobacco surcharge as the state budget provision from the current operating budget requires there be language about the surcharges in the Collective Bargaining Agreement. There's nothing that's different about those surcharges than what was previously presented to the Board. It is just mirroring the language of the budget provision.

Pete Cutler: I'm embarrassed to admit it but I know we discussed those surcharges. Did we actually vote them in? Or did we actually adopt policies adopting them?

David Iseminger: Yes, Pete, the Board did adopt several policies related to surcharges like the definition of tobacco products; the definition of tobacco use, exempting ceremonial religious use; as well as a 60-day look back; and a default if an individual does not attest to the tobacco surcharge, they are assumed to attest to it.

Pete Cutler: I remembered a lot of discussion. I knew we were well briefed on it, it's just with our bifurcated process of discussing topics and then at later meetings voting on them, I have to admit I forgot whether we got to stage two.

David Iseminger: I believe you got to stage two at the June meeting, and it's somewhere around Policy Resolution SEBB 2018-16 through 2018-19.

Pete Cutler: That's way better than I could ask, thank you.

Sean Corry: I want to go back to something we all heard a few minutes ago about, in some way, a general intent to have funding for PEBB equal to, or very nearly equal to, the funding for SEBB out of the Legislature. It brought to mind what I think we've discussed without certainty in past meetings and outside of meetings, that it looks as if the cost and risk associated with insuring school district employees is actually better than feared, and perhaps maybe less than what PEBB costs will be. Is that leaning still part of our thinking, that the costs for school district employees and their families is going to be lower than PEBB employees? And, therefore, does that free up money? How do we work with different costs of care, so to speak, with respect to benefit payments with different groups of employees and families, if the funding is flat across both groups?

Megan Atkinson: I want to clarify something. When Dave made that statement, he was talking about the next step in the Collective Bargaining Agreement, which is a financial feasibility certification that comes out through OFM. OFM is currently coming up with costing associated with the Collective Bargaining Agreement. In areas where you are still defining the benefit package, they are making assumptions about the benefit cost associated with the agreement. Dave was talking about the assumptions on the life and LTD. OFM is taking the cost associated with the benefit packages and mirroring the PEBB cost for the SEBB population on that. There is not a requirement that they need to be equal. In fact, I can't remember the exact language in the statute right now around the funding rate, but there is language around the funding rate comparison between PEBB and SEBB. Dave was talking about the assumptions being used to cost out the Collective Bargaining Agreement because, again, OFM has to make a certification on financial feasibility.

David Iseminger: Related to what I've described previously at meetings as kind of "horse trading," and some of the later presentations in this slide deck, and, in fact, the life insurance and prior slide decks, describes the relationship and starts with that assumption -- the funding for these other benefits is generally the same. You're right, there are some demographic differences. In fact, we saw that pan out in what we presented to the Board on the long-term disability benefit. If you take the same amount of money that's spent in PEBB and apply it to the demographics of SEBB, it's not a $240 a month benefit, it's a $400 a month benefit. That's not probably the number everybody wants, but it is a representation of how the same money and demographics results in a different benefit design. We've described with that starting assumption, these benefits, dental, now vision, life insurance, and disability all represent a similar pot of money as under the Collective Bargaining Agreement, it's a 100% employer contribution. That represents an ability to say there's the zero sum game to play within and how do you trade and spend the same amount of money across the different benefits?

Slide 12 – Legislative Change Clause. Under the terms of the agreement, if the Legislature makes a change in either statute or budget that impacts matters that were bargained, either party can then request to meet and negotiate about the impacts. If something gets changed by the Legislature that impacts the Collective Bargaining Agreement in next session, everybody comes back to the table and talks about it.

This represents our overview of the Collective Bargaining Agreement. I do want to say, during our break, that I believe yesterday, the super coalition released a press release about the Collective Bargaining Agreement and I have a copy of that for everyone on the Board. We'll also set out extra copies for the public as well. It has a lot of quotes from each of the members of the super coalition that really talk about the positive aspects of this Collective Bargaining Agreement. I wanted to make sure the Board got a copy.

Megan Atkinson: There is also information available on the OFM website around their costing of the Collective Bargaining Agreement.

David Iseminger: We will send those links to the Board as a follow up.

<u>SEBB Wellness Program</u>

Justin Hahn, Washington Wellness Program Manager. Dave and Megan talked a lot about the Collective Bargaining Agreement's language for the SEBB Wellness Program. Today I want to begin to describe what the SEBB Wellness Program could look like. Your feedback is important, as at some point in the future, you could be voting on SEBB Wellness Program policies related to eligibility timelines, etc. This is a get to know you presentation about the wellness program idea, referencing the PEBB Program experience.

Slide 2 – Worksite Wellness Programs. The quote on this slide is from the American College of Occupational Environmental Medicine: "many employers have added wellness programs…to their benefits health plans and there is growing evidence for their benefits." Employers can have a positive role influencing the health behaviors of their work force.

Slide 3 – Why School Employee Wellness? These bullet points are from the Alliance for a Healthier Generation and the Robert Wood Johnson's Foundation at Pennsylvania State University. It's recognized that not just teachers, but all school employees, experience high rates of turnover and burn out, and by prioritizing wellness, schools can help staff feel more valued and appreciated. When we did our original survey of school district benefits a year ago, we found evidence that some school districts did offer benefits already in the wellness area. But we were unable to learn what those programs looked like specifically. Worksite wellness programs in the school can help reduce stress, boost morale, in addition through role modeling, can directly have impact on student health as well.

While the focus of the SEB Board is to help design benefits for the school employee population, we know that healthcare itself is only one of the factors that determine a person's health status. There are also your age, sex, inherited genetic factors, your social and physical environment, and your own individual behavior, such as how well you take care of yourself. Slide 4 – What determines Health? is a public health model showing ways that these factors influence health status. Specifically, today, we are going to look at a proposal for a worksite-based wellness program that can influence individual behavior toward improved health status.

Slide 5 – Worksite Wellness Programs – History. Worksite wellness programs began in the 1980s and focused on smoking cessation, stress management, and nutrition. Research began to show the programs that focused only on high cost populations were not effective. So, they started with some big issue items and started to become more nuanced as they moved forward and discovered more as they evolved.

As they evolved, wellness programs began to focus on reducing health care claims costs and getting positive return on investment. It was also discovered that a limitation of this approach was to ignore additional factors that can play a role in employee health, including stress, employee engagement, job satisfaction, fitness, nutrition, sleep, etc. By 2010, there began to be a broader focus on well-being in a more holistic manner. We describe the four overall factors as emotional, physical, financial, and work/life balance.

In 2013, Governor Jay Inslee signed Executive Order 13-06 that established the Worksite Wellness Program and directed the HCA to administer the program. HCA contracted in 2014 with a wellness vendor called Limeade, to provide an online wellness portal to encourage and track participation in wellness activities. In a nutshell, eligible employees register for SmartHealth online. They're recognized through an eligibility file and complete a 200-question well-being assessment. By going through the assessment each year, we're able to tailor the experience to the individual. A good example of that is providing your top three strengths and your top three weaknesses, with regards to this holistic way of defining well-being. If that individual subscriber earns 2,000 points by the end of the incentive deadlines, borrowing from the PEBB example, they qualify to receive a $125 discount by way of a health plan deductible reduction or a deposit in their Health Savings Account, in the following year.

Pete Cutler: When did the program actually get rolled out for active state employee participation? Was that in 2014 or was it not until 2015?

Justin Hahn: The contract was signed in 2014. January 2015 is when it first started.

Pete Cutler: So, the state has three, four years experience with the Limeade program, 2015, 2016, and 2017. And we're in the fourth year.

Justin Hahn: Fourth year right now currently. Correct.

David Iseminger: Pete, a little more context. There was a pre-portal wellness program launched in 2014. There was a requirement to implement a wellness program in 2014 itself. There was an attestation-based wellness program for about six months, and then the online portal was launched in 2015.

Also, the PEB Board actually changed the eligibility requirements and deadlines, between 2015 and 2016. It's not a complete apples to apples data comparison for that first year versus the second and third years. The original deadline was a six-month deadline in the PEBB Program. It became a nine-month deadline for employees in 2016. We're in the midst of the third year of stable eligibility requirements for the program, but we do have three full years of data. Just wanted to make sure it was clear that there were slight differences from the first year to the second year.

Justin Hahn: Slide 8 – The Use of Incentives. The incentives are specifically financial. The Affordable Care Act allows employers to use financial incentives to encourage participation in wellness programs. They tend to result in higher rates of engagement, but the downside is that they are not enough for a sustained improvement of health.

The goal is to get them hooked by what we refer to as intrinsic incent. What interests them and what do they find meaningful? We do things beyond the extrinsic or financial incentives to get people over the hump with sustained behavior change, and sustained engagement in the program. The point is to activate employees to engage in the program, change behaviors, and develop some healthy habits that can be sustained over time. The area of financial incentives is a regulatory moving target and very complex, to say the least. It involves multiple federal agencies, such as HIPAA nondiscrimination, Americans with Disabilities Act, the Genetic Information Nondiscrimination Act, etc. The idea is to influence positive health status, but not use financial incentives to discriminate against people based on their health status. We walk that line to make sure we're getting the best for our members and leaving off the potentially negative aspects of it.

Slide 9 – Proposal for How Wellness Benefit Would Work Within the SEBB Population. During the 2019 open enrollment we will provide an online health and wellness portal to eligible SEBB Program subscribers who can register, complete the well-being assessment (WBA), and receive points for participating in activities. By completing that well-being assessment, you receive 800 points. Subscribers who complete the WBA will be eligible for a $50 reduction in their medical deductible or Health Savings Account deposit in 2020.

Beginning in January 2020, subscribers who miss the 2019 open enrollment window can register or complete their WBA and participate in activities. The early adopter subscribers that started in January who complete 2,000 points by the deadline of 2020

and are still enrolled in a SEBB medical program the following year will receive $125 reduction in their 2021 medical deductible or Health Savings Account deposit.

Patty Estes: When we're talking about eligible employees, how many plans with PEBB, because I know that this is with PEBB, have the SmartHealth eligible?

Justin Hahn: It works for all PEBB plans.

David Iseminger: Patty, the other way to describe it is the eligibility for the wellness program and wellness incentive is based on being a benefits-eligible employee. It's not dependent on being enrolled in a specific medical plan.

Patty Estes: Perfect, thank you.

Terri House: What's the percentage of PEBB employees currently participating?

Justin Hahn: The eligible population, as of yesterday, was 142,518 persons. Registered was 66,541, or approximately 47% of eligible. For 2018, we have close to 40,000 PEBB-eligible subscribers, of which approximately 28% have completed the well-being assessment.

Pete Cutler: Do you know how many have reached the 2,000 point threshold to qualify for the reduction in the deductible for next year?

Justin Hahn: I do know that. I did not write that down, so I'm going to have to get back to you on that.

David Iseminger: But of course, Pete, it's a subset of the well-being assessment. The PEBB Program deadline annually is September 30, so we just crossed that threshold. I think Justin was trying to get the data but it usually comes out a week after. We'll follow up with that.

Pete Cutler: I fully understand. I'm actually one of the people that gets those messages. I do have other questions.

From my experience, back when I was working with these issues, there was widespread agreement that if you could motivate people to exercise regularly, to get more exercise in, to watch their diet, to stay active, that it could significantly reduce health care costs and improve the health of those individuals. Those were worthwhile goals to promote. At the same time, when I left working in the field at the end of 2015, to the best of my knowledge, no program had shown a material ability to motivate people to actually do those things. There were all sorts of ways that people had strategies for trying to engage people, but at the end of the day, for sustained periods of time, it was very, very hard to get people who were not used to being active, to become active, or who were not used to watching their diet, to watch their diet. That would be my question, does the state have evidence that its program is actually being effective in motivating people to take actions that they would not otherwise take and that then it's leading to healthcare savings. That would be, for me, the $64,000 question for this kind of program.

David Iseminger: Pete, we will follow up. As we continue talking about wellness with the Board, we'll bring some information about what we've been providing. I think we've produced six legislative reports since the wellness program began that are all publicly available. We will synthesize some of the information that's in those reports that hit on the questions you're asking.

Pete Cutler: Thank you.

Justin Hahn: Slide 11 – SEBB SmartHealth Financial Incentive Eligibility. There are three basic steps for the primary SEBB benefits subscriber to qualify and receive a financial wellness incentive. The first one is meet the SEB Board's criteria for SEBB medical plan eligibility. For example, 630 hours or more per year. The second step would be to qualify for the SmartHealth incentive by completing wellness activities before the incentive deadline. For PEBB, it's September 30.

David Iseminger: And for this Board, we'll talk with you about the appropriate deadline. This is describing the framework, and then Justin a little bit later will describe some of the decisions you'll have to make. One of them is the incentive deadline.

Justin Hahn: There is a two-step process for receiving the incentive. It's qualifying, getting it registered, and qualifying for the incentive by participating in the program, meeting the requirement by the deadline, but also, you must be enrolled as a primary subscriber in a SEBB medical plan the following year, when the financial wellness benefit is rewarded. For instance, I'm a subscriber. I completed the incentive before the September 30 deadline. I earned 2,200 points and I'm the primary subscriber on my UMP Plus. In the beginning of January, how it works for PEBB, if I am still the primary subscriber on a PEBB medical plan, I will receive $125 off of my medical plan deductible because I don't have a Health Savings Account.

David Iseminger: But if you left state employment in December, you aren't enrolled in a plan come January, then no incentive for you because you're no longer in a medical plan under the PEBB Program.

Justin Hahn: There's no place for the $125 to go.

Sean Corry: Justin, this implies, and I just want to have it clear for us, that there is no incentive for dependents, spouses, for example. Can they participate anyway? Is there any rule? Of course spouses incur claims costs, too. I don't know, maybe the rate is even higher.

Justin Hahn: On the PEBB side, the spouse/domestic partners have access to the portal, the SmartHealth Program. They have access to all the website and signing up for activities, gaming points, the game-ification, all that sort of behavior change model, but they are not eligible for extrinsic incentives.

David Iseminger: And we would envision a similar model on the SEBB side, that there would be access, but not incentive abilities for those folks.

Justin Hahn: Okay, and as Dave prognosticated a little bit earlier, the PEBB experience with SmartHealth included decisions on eligibility and financial incentive

deadlines. We anticipate that, moving forward, the SEB Board would be viewing additional wellness presentations, having conversations, getting more feedback from you to help inform decisions on how you feel about the whole idea, about policy, such as eligibility, deadline, etc. This presentation has been at a higher level. There's more information to come, based on the feedback.
I would like to direct your attention to one of the screens because we are going to play a demo that our partners at Limeade put together to walk through a Smart Health subscriber's experience. (SmartHealth video demo played.)

Justin Hahn: Slide 15 – Secure. Private. Confidential. We follow stringent HIPAA privacy standards. Data from groups with fewer than 20 people is never revealed. When HCA gets data reports, we get aggregate data reports that are not personally identifiable. Federal law prohibits disclosure of personally identifiable health information to the employer. That means this personal health data is never shared with the employer or HCA staff. The only information that we see is anonymized and at the aggregate level.

David Iseminger: In the presentation, you heard that sometimes there will be data reports that can be used to help influence, encourage, and shape a strategy on wellness. What's being described is this aggregate data reporting would be able to come back at a school district by school district level, as long as the school district has at least 20 employees. For those school districts that have at least 20 or more employees, they would get aggregate information and determine what they want to promote based on their results.

Justin Hahn: I'll just add a friendly addendum to that. This also applies to the subgroups within that. If you have an employer group of 20, then they'll show up as an employer group of 20, but once you start to break that down, it falls within the no-go zone, as far as reporting.

Pete Cutler: My recollection is they have very strict password requirements and I've been curious from day one of why is it so important to have such a high, strict password standard when I don't see myself interacting with any personal information on the website. I'm not quite sure why Limeade is afraid that somebody else might use my name to somehow go on to my account. My account pretty much to my vague recollection, may show some activities I've been involved in, but it was primarily "here's 1,500 different things you could do." I'm just curious about why? What's the rationale behind having a really strict standard for accessing in terms of security?

David Iseminger: Pete, there are at least two things that I'm thinking of with that question. First, in the well-being assessment itself, you're answering some questions that relate to your mental health status, as an example. There are also how much you feel sad in a given time period, or indications of potential depression. Also, at the end of the well-being assessment is an opportunity for you to input results of your blood work. You can put in what your A1C level is for your sugar. What your most recent blood pressure is. It's optional to put that in, but some people do put in those lab report type examples. That's another protective measure.

In general, as our office has been bringing up more systems, I can't remember what OCIO stands for, but there are pretty stringent IT requirements as we bring forward new

systems. There is a very robust password requirement that goes through a lot of the things you're used to seeing when you were making your password for the Limeade portal. As more systems are coming up, higher password requirements are being required across all state systems to ensure accurate security. It does things like require length of password, resets every 90 days, working towards two-factor authentication like many of us have when we access our bank accounts. Those are things that are being rolled out as a standard security measure across platforms.

Pete Cutler: Actually, I was not aware that after I did the health assessment at the beginning that I had any access to those answers. My impression was that it got launched somewhere to Limeade folks who then had suggestions for strengths and areas to focus on. But I did not think of it as data that I would access. I could understand how that would be considered sensitive information. Your observation about the general state move towards very strong password protection for online access sounds pretty familiar. Okay. Thank you.

David Iseminger: And that means we have feedback to help members understand how they can access their old well-being assessment answers. Because I know personally that you can do that because I have done it recently.

Justin Hahn: You will have further opportunity for discussion. But if you have questions in the meantime, contact Marcia or me. Our contact information is on Slide 16.

Group Vision Plan Benefit Designs

Lauren Johnston, SEBB Procurement and Account Manager. Slide 2 – Objective, to propose vision plan designs for Board action at the November 8, 2018 meeting. The next few slides are what the member will pay; out-of-network coverage, what the member will be reimbursed up to.

Slide 3 – Proposed Vision Plan Designs In-Network Coverage. These are the proposed vision plan designs for in-network coverage for Davis Vision, EyeMed, and MetLife. For a routine eye exam, one exam is covered every 12 months, and the member pays zero dollars. For frames, one pair of frames is covered every 24 months. All three of the plans have zero dollar coverage up to $150. Then, the member will pay 80% of the balance over $150. Davis Vision has a little bit more in their plan design where, if you purchase a pair of glasses from Vision Works or they purchase glasses from the Davis Vision frame collection, the member will pay zero dollars.

Sean Corry: I have a quick question that relates to a slide that's coming about locations. We have different sets of benefits, essentially. There are variations in benefits for the three likely candidates, but they're not each in every place. I just wonder about the fact of that, and what will become, I guess, obvious from the question, is that some employees will have access to certain benefits that others don't. How do you deal with that with respect to enjoying better benefits from Davis, for example, in the way they've proposed plans for us.

David Iseminger: There are a couple of different pieces. First, all three networks were asked to work on their provider networks, and we're expecting a check-in with them on what the status of their provider network is in February. That's to give us a better sense

as to what the provider network is looking like, especially as were trying to align different pieces with where we need to give information to the Legislature on the financial model. As provider networks could impact finances, we wanted an update on their provider networks. Also, with regards to vision, we're still evaluating this, but because it's about the location of the provider, it doesn't necessarily mean that an individual could only enroll in this vision plan if they resided where the provider resides. Although MetLife may have a provider network that goes in more counties than the other two, as it stands today , that doesn't mean that an individual who lives in a county where there's only a MetLife provider under contract, couldn't enroll in the other plans. From the vision plan, although there would be travel associated with that, and that would be part of their calculus in the plan that they select, we're: a) working on provider network, and b) we're not envisioning at this point that there would be a limitation for vision benefits based on where you live.

Lauren Johnston: For lenses with Davis and EyeMed, the member will pay zero dollars. For MetLife, there will be a $10 copay. For progressive lenses, the copay ranges are listed, as well, which are all in the same area.

David Iseminger: Lauren, for progressive lenses on MetLife, it shows zero dollars. Correct me, but my understanding is that's for the most basic lens. As you get into more complex progressive lenses, the cost shares more closely align with the other plans.

Lauren Johnston: Correct. With progressive lenses, there are different tiers, standard, premium, and custom. The zero dollars could be up to $175 for MetLife. Some of their providers have deeper discounts. It depends on what provider you see to get your progressive lenses.

Slide 4 is a range of copays by carrier, and then by the different lens options a member could select when purchasing their lenses. These are all a copay range as well, and the same comment for MetLife, for anti-reflective coating, scratch resistance, polycarbonate, transitions, and tinting, those are all "up to." If the member sees a provider that has deeper discounts for those specific areas, it could be less than $41, $17, $31. It depends on the provider's discounts.

Pete Cutler: The numbers shown on Page 4, do they correspond to the range on Page 5 for the progressive lenses? Or do they stack on top of each other?

Lauren Johnston: They stack on top.

Slide 5 shows what the member will pay for contact lenses. For Davis and EyeMed, zero dollars up to $150, and then 85% on the balance over $150. For MetLife, zero dollars up to $150, and then 100% of the balance over $150. For disposable and conventional lenses, Davis Vision has an additional plan design that, if you purchase four boxes from their collection of lenses, you receive those four boxes within the $150. You don't pay anything else for those four boxes. The medically necessary lenses is zero dollars for all three.

Pete Cutler: Can I ask when are contact lenses considered medically necessary, compared to glasses?

Lauren Johnston: Yes. If you have cataracts or you just had surgery. Those could be a reason why you would need medically necessary contact lenses.

Pete Cutler: Contacts instead of the glasses?

Lauren Johnston: Yes. Usually it's in cases where you can't wear glasses or you can't wear other types of contact lenses. The only thing you can wear to improve your vision is through medically necessary contact lenses.

The next few slides are for out-of-network benefits. They are the same slides you saw with in-network benefits. Slide 6 – Proposed Vision Plan Designs Out-of-Network. For the routine eye exam, the member reimbursement is up to $40, $84, or $45, depending on which plan they are in. For frames, the member reimbursement will be up to $50, $75, or $70. You can go down the list and see reimbursements for each of the lenses all of which have a different cost that for reimbursement. For the out-of-network benefit for lens enhancements, Davis Vision does not reimburse for any of the options, whereas, EyeMed reimburses $55 for scratch resistance and polycarbonate and zero for the others. MetLife is between $30 and $100. The single bifocal, trifocal, lenticular, and progressive, whatever lens options you select would go towards that $30, $50, $65, and $100.

Slide 8 is contact lens coverage. Member reimbursements up to: Davis is $105, EyeMed is $150, and MetLife is $105, depending on contact lens selection.

Sean Corry: Going through and hearing this, it reinforces what I thought when I was briefly looking at it yesterday, there is a pretty significant variation in benefit levels through the slides. It implies to me that it's that way because they need it to meet a financial target and the adjustments that were made were in the benefits. Because, the agency could have said, "this is the set of benefits we want you to offer, price it out." Am I seeing that correctly? That's the different benefit levels from these proposed carriers are really a function of needing to meet a financial request?

David Iseminger: I would say that was certainly a factor, but it wasn't the only piece. We asked the carriers to present to us, based on their experience within school districts, what they thought was the benefit offering that would be most attractive to school employees. We described to them what we thought the claims experience was for vision expenditures if the product would have been embedded with the self-insured and fully insured plans based on prior information we've gotten over the years from the PEBB side of the house. We SEBBified that, now a word in my vernacular, SEBBify, we SEBBified that with the SEBB assumptions and then said here's a general expenditure framework, and within that, show us what you propose.

We'd heard from this Board that there is interest in providing choices for people about different types of coverage levels. Knowing that this benefit is ultimately going to be 100% paid by the state, there is that high-level piece that sets a ceiling. We didn't want to specifically impose on all three carriers to only have $100 for contacts, only have $150 for frames. If this Board wants more uniformity across the plans, we will certainly go back to the carriers and indicate the Board has instructed that they want more uniformity. Our understanding and impression from the Board was variability is

desirable. We asked for some variability but we didn't want there to be so much variability that there is significant adverse selection across the products.

Sean Corry: Thank you, Dave. And for me, the driver on that would be school district employees and family members having access to the choices.

David Iseminger: And that gets back to, Sean, where I'm saying we aren't envisioning, at least for the vision product, enrollment on the plan would be based on the county in which you live. As a school employee, you would know that the provider network for Davis requires you to go to the neighboring county sometimes if you wanted to go for a certain benefit design versus one that's closer to you that has a different benefit design.

Lauren Johnston: But the goal is to get them in every county.

David Iseminger: Except for Columbia and Garfield because there are no providers in those counties.

Lauren Johnston: Slide 9 – Other Member Savings, shows some of the additional member savings each of the carriers provided. These are savings to the member. If a member were to purchase an additional pair of glasses, they would get 30% off of those through Davis, up to 40% off through EyeMed, and 20% off through MetLife. There are discounts for Lasik surgery, as well.

Slide 10 – Considerations. These are considerations for the Board when you vote on the plan designs at the November 8 meeting. Included are the members' purchasing experience and their out-of-pocket costs. This could include independent retail or online purchasing and what the member pays versus member reimbursement. There are two distinguishing factors between fully insured and self-insured plans. Premium tax paid on fully insured plan premiums. Additional reserves needed to provide a self-insured group vision plan.

David Iseminger: Our recommendation to the Board is three fully insured products, one from each of the three carriers on Slide 11. We did the analysis of a self-insured plan, with two of the carriers, they were announced as apparently successful bidders for potential self-insured plans. We got pricing from them, compared that to the fully insured, and to use a rather simple analogy for purposes of making up time, the juice wasn't worth the squeeze in pushing toward launching a self-insured plan. You overlay that with needing to build up reserves for the self-insured plan, although it's not nearly at the scale of a fully insured medical plan, self-insured reserves would still be required to be able to cover those claims expenses. We went forward and brought to you a recommendation for three fully insured products, but it was a very worthwhile exercise initiated by the Board when we originally presented the draft RFP information in June. Before it was released, I believe it was Sean that asked some questions as to whether or not we were looking at a self-insured plan. It was a very fruitful exercise to go through, but at the end of the day, the juice wasn't worth the squeeze.

Lauren Johnston: And the plan designs are the same, so regardless of if a fully insured plan or self-insured plan, when it comes to what the carrier benefit is, it's the same for both. It's not a different experience for the member, depending on whether or not it's fully insured or self-insured.

Pete Cutler: Is the premium tax 2%?

Lauren Johnston: I believe so.

David Iseminger: We'll follow up with exactly what the premium tax is.

Pete Cutler: And that, as far as you know, is the only major obvious additional expense that's levied just on insured plans?

David Iseminger: Correct.

Lauren Johnston: Slide 11 – Recommendation. HCA's recommendation is to offer fully insured group vision plans for benefit-eligible school employees, through Davis Vision, EyeMed, and MetLife. Now moving into the resolutions.

Slide 12 - Proposed Policy Resolution SEBB 2018-40 - Fully Insured Vision Plan (Davis Vision). Beginning January 1, 2020, the SEBB Program will offer a fully insured vision plan by Davis Vision as presented at the October 4, 2018 Board Meeting.

David Iseminger: Before Lauren moves on to the other resolutions, I want to set up the structure of the resolutions. On the self-insured plan and medical, we had you vote on different co-insurance levels. One slide said, “match the cost shares for the UMP Classic,” and another one had bulleted voting on different specific cost shares. When it comes to fully insured products, you're buying the whole bundle of sticks. If you have a question or you want more uniformity in the plan, you give that direction publicly. The carriers, who are all on the phone, presumably, as they've been instructed, are listening. They start that guidance, they run and sharpen their pencils, and they get going until Lauren gets back to her desk and says, "Did you hear what the Board just said? We need to work on these changes." The Board doesn’t get to pull a stick out of the bundle and say, "I don't want that stick." You buy the whole bundle of sticks.

When we present resolutions to you on the fully insured products, we're asking you ultimately at the end of next year to endorse rates. That rate comes with an implicit ratification of the underlying benefit design. Here, you're seeing that play out where we're saying endorse the plan. We don't have rates for you yet, but at the end of the day you'll vote on rates, for example, in the fully insured medical plans and that will be your endorsement and an offering of a plan with the benefit design that comes with those rates. That’s how it works over time. It also plays out this afternoon when you see the fully insured plans and it says, "endorsing a benefit design for purposes of going into rate development." You can continue to refine those benefits and ask questions of the carriers, and have the agency work with the carriers to refine benefit design for purposes of modifying the rates. At the end of the day, you would pass rate resolutions that ratify the benefit design that underlies them.

Lauren Johnston: Slide 13 - Proposed Policy Resolution SEBB 2018-41 - Fully Insured Vision Plan (EyeMed). Beginning January 1, 2020, the SEBB Program will offer a fully insured vision plan by EyeMed as presented at the October 4, 2018 Board Meeting.

Slide 14 - Proposed Policy Resolution SEBB 2018-42 - Fully Insured Vision Plan (MetLife). Beginning January 1, 2020, the SEBB Program will offer a fully insured vision plan by MetLife as presented at the October 4, 2018 Board Meeting.

David Iseminger: Is there any direction by the Board to alter plan designs?

Pete Cutler: The question I have has to do with the networks. I understand you're asking them to expand their networks, but I don't feel like I -- and maybe it was presented prior -- but my recollection is we haven't seen the number of providers split out by the three different proposed successful bidders by county. I certainly would feel a lot more comfortable if I could get a sense, even if we had to go with the networks they have today, what kind of coverage is there?

David Iseminger: Pete, at the August 30 meeting there was an updated slide that has de-duplicated provider counts by county. It's in the appendix of Lauren's presentation. It does not show them separated by carrier, but we can provide that if you like.

Pete Cutler: I think that'd be relevant. I'd also be curious what we know about, for the school employees currently, they have access to a variety of vision plans, standalone vision plans and networks. It keeps coming down to that. Will they be able to go to providers that they're used to going to? And so, some kind of reassurance about there being a very large amount of overlap between what they are able to do now and what they'd be able to do, or where they'd be able to go, if we adopt these three plans would certainly be reassuring for me.

David Iseminger: We'll work on giving you the carrier county provider amounts, as well as what we can provide about potential provider disruption.

Sean Corry: Following up on Pete's question. We have these resolutions lined up and there's a shell in each of them, but we don't yet have information about what provider access each of the plans will provide to school district employees and family members across the state. Nor are we yet fixed, apparently, on what the benefits are actually going to be because there's some variability there. I'm wondering, on behalf of my fellow Board Members, how do we go about reassessing? Once we've passed these resolutions, once we've said “these are the three we're going to do business with,” when we run into issues we've talked about, how will we go about assessing that? When will we learn that we have a problem here or there, so that we can perhaps revisit?

David Iseminger: A couple of things. I want to make sure it's clear. We have provided to the Board at previous meetings information and we always have this debate as to how much of the previous presentations do we put in an appendix and all of your materials to have right in front of you in these meetings. But we have provided an overall county by county combined provider map de-duplicated for the three carriers. We'll provide the additional provider context that was requested today, to give insight on that as well as potential provider disruptions that we can dig out of the claims data that we received back in April from the carriers.

I do want to be clear that the resolutions here would be an endorsement of the slides and the benefit design that Lauren presented between Slides 3 through 8. The question I had whenever we shifted to the last part of the presentation was are there things that

you want us to bring to you differently? If there are things you want us to bring to you differently, then we would work with the carriers between now and November 8 to refine Slides 3 through 8, put them in your slide decks for November 8, and modify the resolution to say, "as presented at October 4 and modified on November 8." This is a specific benefit design proposal that you would be ratifying by passing Policy Resolutions SEBB 2018-40, SEBB 2018-41, and SEBB 2018-42. I want to make sure that's clear.

Unless you want something changed within those slides, that's the benefit design you are saying you're offering through these three carriers. It's the three carriers with the benefit design that's being proposed to you right now. As I've said a couple of times over the journey with the Board, we're leading up to having up to 90% of your homework done. After the funding comes in and we know what the true funding rate is from the legislative session, we'll come back to the Board right after the funding rate is in the operating budget, whether that's April, May, or June. We'll come to you with information about what that funding rate is, how it stacks up with the entire suite of benefits that you've previously presumably endorsed by the end of the November meeting, and say, "There's a little more funding than we expected. Here are ways you could spend it in the different benefit pieces." Or, "The funding is lower than the benefit designs that have been negotiated with the carriers. Here's the way to make up the gap." We would give you different options along the benefit portfolio to show how you can make up that gap and where you would go back and refine different pieces of each of the benefit designs.

I've said you're the lead and the anchor in the relay race when it comes to the benefit design piece. We're asking the Board to endorse, at least for purposes of the rate development, and to go into the legislative session to say, “here's generally what could be bought with the money that looks like it's on the table.” On the back end, once the dollars are locked in, do some refinement benefit by benefit. That's how it would come up on the back end, Sean.

Fully Insured Dental Benefits

Beth Heston, PEBB Procurement Manager. Slide 2 – Objective. Today I will share proposed fully insured dental benefits for Board action at the November 8 Board meeting. Slide 2 – Policy Resolution SEBB 2018-06. In March you passed a resolution to leverage the existing PEBB fully insured dental plans, and you would evaluate in 2020 whether SEBB should pursue a fully insured dental plan procurement.

Slide 4 – HCA Fully Insured Dental Plan Contracts. We currently contract with Delta Dental of Washington, who is also the administrator for our Uniform Dental Plan, and Willamette Dental for our fully insured plans. Those plans differ from the self-insured plan in that the claims are paid and risk assumed by the vendors. The carrier is fully responsible. In these plans, they're like an HMO. Subscribers have to see in network dentists in order to have their care covered by the plan, except in cases of emergency.

Slide 5 – Proposed Fully Insured Dental Plans. This chart should look familiar. We've been showing you these categories of care and costs for the self-insured plan and here is the comparison between the fully insured plans. They're very much alike in coverage. No annual maximum, no deductible, general office visit is zero, preventative and

diagnostic care covered at 100%. We have copays to go along with the actual care in other categories.

David Iseminger: Beth, before you go on, can we go back to the previous slide? I do want to make sure it's clear that there is an embedded orthodontia benefit within the fully insured dental. I know that is not common within the K-12 districts at this time in their coverage. It's usually separate/standalone. But, just as there's an orthodontia benefit that was in the proposed self-insured design, there is embedded in the fully insured dental. Beth, is there a difference between the self-insured and fully insured dental -- orthodontia benefits?

Beth Heston: Orthodontia benefits, yes. In the fully insured dental, the entire cost of orthodontia is $1,500. In the self-insured plan, it is a lifetime maximum of $1,750.

David Iseminger: So, to clarify, on the self-insured side, there is a capped amount paid by the plan. On the fully insured side, there is a capped amount paid by the member and anything above that the plan covers. That is a key difference in the orthodontia benefits between the two products. I am sure there are countless examples of it in the audience, but what I hear over and over again is people will switch to the fully insured plans when they know their kids are about to get braces, and then they have more coverage for orthodontia. I wanted to call attention to the orthodontia benefit because I know it is of keen interest to school employees.

Sean Corry: I know that many school districts do not offer orthodontia benefits because it frees up money for other things. I'm actually looking forward to that conversation here so we can see the cost of orthodontia benefits and weigh that with other benefits in other areas. Whatever that cost is going to be. I know that Seattle, for example, did a survey some years ago of employees and got a very high response rate to the survey. A substantial percentage, majority, said “no, let's not add orthodontia.” I mean, there's those circumstances where it comes at a cost. And it may not be a cost that's wanted by the majority of the employees who are going to get this. I'm just pointing out that this may be an area that we could put money on the table for something else, maybe within the dental plan or elsewhere.

Beth Heston: These are the choices that the PEB Board made in the past to have it included in all of their benefits. But certainly, even though the resolution was that you would be leveraging similar benefits, we certainly can take that back and look at it.

David Iseminger: We did have some conversations with the carriers about that, and we'll get into some horse trading insight later in this slide deck.

Beth Heston: Slide 6 – DeltaCare Coverage Map by County. Slide 7 – Willamette Dental Coverage Map by County. Slide 7 has has been before you a couple of times in different variations. It is also different from the one that was printed for the public to pick up out on the table in the hall. The difficulty that we had was that we want to show you which counties Willamette Dental Group has clinics in. In the past, we were using where they have subscribers. Their feeling is that any person eligible for benefits may enroll. But the dark blue counties on this map is where they actually have brick and mortar clinics. I wanted to make that very clear.

David Iseminger: This is a good illustration, similarly, for vision. This is describing the same thing where a member knows up front where the network is. If they want this plan, where they would have to travel to for providers, yet everyone in the state could enroll in this plan. Again, your Board booklets in front of you have the correct map. Slide 7 is the correct map. The one that's printed out for the audience is the wrong map. And the one that's online that people can access has been updated to be the correct map. So, everybody's is correct except for the stack of papers in the hall.

Pete Cutler: No, actually that was very helpful. Otherwise, I would have not interpreted the map correctly. But with your explanation, it came into focus and was very helpful. And I think it is good to show both. A question in terms of the number of providers and the number of providers taking new patients for both of these, is that what they're called, managed care?

Beth Heston: Yes, managed dental care.

Pete Cutler: Managed dental care. Do we have information on how many providers there are and especially distinguish between providers who are actually taking patients? There's been some controversy in the past, maybe more with medical organizations, but sometimes dental, where somebody will be listed and then you contact them and find out they have a contract, but not taking patients anymore.

Beth Heston: Yes. And both of these plans offer coverage through WEA and other school districts.

Pete Cutler: Fair amount of overlap. Great, thank you.

Beth Huston: But we'll get you the numbers of dentists accepting patients in both plans and as much information as we can about that.

David Iseminger: I know everyone doesn't remember all the meetings and resolution numbers as well as I tend to, but I would be remiss if I didn't remind the Board that back when you passed the resolutions in March, Kaiser Northwest came forward and had some concerns about provider disruption in southwest Washington. We have done some provider disruption overlap and many of the providers, I believe, are in one of these networks.

That discussion was more about how well it could be integrated with a medical plan or not. It does not seem that there would be as big of a provider disruption because we did more analysis.

Beth Heston: If I remember correctly, there are only 26 dentists that were not overlapped between Delta Dental network and Willamette network or DeltaCare network.

Slide 8 – Fully Insured Compared to Self-Insured. This is a comparison to juxtapose the two kinds of dental plans. In a fully insured dental plan, the member has to choose a contracted dentist within the network before receiving services. On the self-insured side, you choose your own dentist, who may participate at varying levels in the network. They may be fully in, they may be partly in, or they may be out-of-network, but you can

still see them and get coverage. On the fully insured side, that's not the case. We have a lot of "dental confusion" in PEBB, because people don't understand that they are in a managed care plan, or they choose the wrong plan because they confused the names. But these are the basic differences between fully insured and self-insured. Predictable out-of-pocket costs, because it is copay not coinsurance.

On a self-insured plan, coinsurance is a percentage of the cost and the total cost depends on the provider. It is possible that, on the self-insured side, you might pay less than the copay on the fully insured side. It depends upon the provider. Also, there's no annual maximum under a fully insured plan, and we know that under the self-insured plan there is an annual benefit max. Fully insured orthodontia covered completely with a copay, self-insured orthodontia partially covered with a separate lifetime maximum. Fully insured available clinics and providers may be limited by geography. On the self-insured side, our current TPA has 94% of state dentists participating in their network.

Those are the basic considerations. Why you would choose to offer a fully insured plan compared to a self-insured plan? Many people like the choices in a fully insured plan. That's why the PEB Board decided to offer both.

Slide 9 – Recommendation. Our recommendation is that you offer the fully insured dental plans through Delta Dental, called DeltaCare, and Willamette Dental, called Willamette Dental Group.

David Iseminger: This would be a supplemental to the self-insured plan previously recommended and are asking the Board to take action on later in this meeting.

Beth Heston: The proposed policy resolutions are much like the vision resolutions. Except, in this case, they say with the same coverage services and exclusions, the same provider networks, same clinical policies, and same copays as the existing DeltaCare plan under PEBB. And the next slide says the same thing for the Willamette plan under PEBB. And this, I believe, gets back to Sean's question earlier about orthodontia.

Slide 12 – Dental Portfolio Alternative Benefit Design. We looked at some alternative benefit designs. We could, for the purposes of horse trading, reduce the dental annual benefit maximum from $1,750 to $1,625. And we could increase the employee share to 30% on Class II restorations. In other words, the plan pays 70%, not 80%. We could also adjust the fully insured dental plans to introduce copays for office visits and increase the copay on fillings and/or crowns. And those combined changes could generate some annual premium dollars that could support increasing the long-term disability benefit to around $800 per month. I believe the magic chart from Betsy's presentation is in the appendix to this, if you want to look again at that.

David Iseminger: Beth is correct, Slide 16 is the chart you received at the September 17 meeting that showed some of the incremental costs and expenses that would lead to higher basic LTD benefits. I know that we have tried to present to you the context of a horse trade for LTD benefits because we heard from the Board pretty clearly that, if there was a way to increase that benefit, that was an area to focus on. We could certainly describe horse trades in other directions, but it seemed, based on Board comment, that it was primarily focused on how could we do a horse trade to make the

LTD benefit higher than $400 if the same per subscriber per month (PSPM) was spent as in the PEBB Program. That's one reason why it's described the way it is, to describe the trade in the context of long-term disability.

We went through a variety of different options, many of them I will say more Draconian than the one that's before you. We didn't want to show too many different ways, but if there are other ideas you want us to look at we will, and I'm sensing we'll probably be asked what orthodontia looks like, if orthodontia was altered. I want to get a little more feedback from the Board on the types of changes in that area. We can bring that back to the Board in November. This was one example of how you can change the entire dental portfolio. You couldn't pick just the changes in uniform dental or just the changes in fully insured dental because that would create too many adverse selection issues between the portfolio. One of the challenges is, because the fully insured doesn't have an annual benefit maximum, there has to be something that's changed differently for them. And that's where, in partnership with our carriers, the ideas of introducing an office copay, or similarly increasing copays on fillings and/or crowns, led to having something that would offset the difference across the portfolio from an adverse selection standpoint.

We also put an example here that showed a higher increment you could do from life insurance. When we get to life insurance after lunch, you'll be reminded about the potential horse trade of taking the life insurance benefit from $35,000 to $25,000. That trade could get you a $600 basic LTD benefit.

I wanted to give a little bit more context for what this benefit design is. It's not our recommendation, but of course, if you want to make this type of trade, you could. I'll be interested to hear more about other things you're interested in, including details about orthodontia.

Pete Cutler: I specifically would like you to check on what the savings might be and the feasibility, vis-à-vis the insurers limiting the orthodontia coverage in the insured plans to the dollar maximum that applies in the self-insured plan. So, if it's $1,750 or whatever it is, just having that.

David Iseminger: So, having it align to the same plan maximum coverage instead of an area where the plan picks up everything after a dollar amount?

Pete Cutler: Correct.

David Iseminger: Because I get stuck in this trap, it's not really right to call it savings. It's really lower projections on claims expenses. It's lower projected expenses, and then trying to think about how to appropriately account for those potential lower projected expenses, and how they can be converted to premium dollars that are paid in LTD. That is another layer of this. I've been reminded that it’s not “savings” so I want to make sure that’s clear for the Board.

Sean Corry: Two things. One, I want to thank you for beginning to show us this kind of information because it's helpful for us to know that we have choices in this way. But I still want to push back, at least for my own benefit, continue to remember that this type of analysis, “this can buy that” within our benefit package, implies a fixed dollar amount

which is not known yet. I just want us to know that the funding for what benefits we would like to have for our fellow employees and school districts is not known yet. It's still not yet a necessary zero sum game. So, we could have both. We could have orthodontia and better life benefits, knowing that it's going to cost $20 a month per employee, to make up a number. It could be that's what we want to have happen and that could be what we ask for. So, I'd like to have us continue to understand that's a path that we could pursue as opposed to continually just fixing on a number that we don't know as the amount of money that we have to spend.

David Iseminger: For the Board, we will talk more in Executive Session about the financial picture, some things that we can only share in Executive Session. I would just remind the Board that there are assumptions throughout state government about building the financial cost of this program. I alluded to this in the collective bargaining piece, that OFM is doing a financial feasibility of the Collective Bargaining Agreement and a starting assumption for the cost of the fully employer paid benefits is the amount of money that's spent in the PEBB Program. There is, at least, a reason for the assumption that we kept bringing to the Board about a zero sum game using PEBB dollars. The Board can agree or disagree with that assumption, but that is the basis for the assumption. I want to make sure that everyone is clear about the basis for that assumption.

We're definitely going to talk with the carriers about capping the orthodontia benefit in the fully insured plans to match the cap that's within the self-insured plans, and bring back the incremental projected cost savings of what that would do to the fully insured plans. Are there other benefit design pieces that the Board is interested in? For example, are you interested in not having orthodontia coverage at all? That could be something that is currently what many K-12 employees experience as a separate option. If the Board's interested in us pulling orthodontia out completely, that's something we could look at.

Pete Cutler: I was going to say I thought I heard Sean at least ask that we have the financial analysis done of what would be the savings, and if he hasn't asked, I'll add that to my request as a second option.

David Iseminger: I wanted to be clear if that is a request, to fully pull out orthodontia.

Sean Corry: And see the cost impact.

David Iseminger: The cost impact of eliminating orthodontia. We will do two analyses, one of which is capping orthodontia at the same benefit as the proposed self-insured dental plan, and pulling orthodontia out of both fully and self-insured. Just to be clear, as we go forward this afternoon asking for a vote on self-insured dental, it would include the benefit design of having orthodontia in, but we could certainly, if the Board wants to make that trade in November on the fully insured plans, we could bring another resolution back to modify the self-insured dental resolution, assuming it passes today, to change that part of the benefit design structure. I'll count that as Sean's request. Pete asked for capping, Sean asked for the analysis if it were taken completely off.

Beth Heston: Just to reassure you, both plans are present in the meeting so they've heard exactly what you're asking for.

David Iseminger: They already have their homework assignment is what Beth is saying.

Beth Heston: Slide 13 – Next Steps – November. For the November Board Meeting, we will take action on Policy Resolution SEBB 2018-43 and Policy Resolution SEBB 2018-44. We will include all the analysis and present it to you at that time so resolutions can be modified.

Pete Cutler: I want to congratulate Beth because you managed single handedly to take us from being 30 minutes behind schedule to being back on schedule, so thank you very much.

Lou McDermott: The Board will meet in Executive Session during the lunch period, pursuant to RCW 42.30.110(1)(d), to review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs; and pursuant to RCW 42.30.110(1)(l), to consider proprietary or confidential non-published information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026.

Self-Insured Dental Benefit

Beth Heston, PEBB Procurement Manage. I am back to talk about our self-insured dental benefit. We discussed this at the August 30 meeting. Today the resolution is up for action. The plan is administered by Delta Dental of Washington. Claims will be paid from SEBB funds subject to financing decisions. Subscribers may see any provider that accepts the Uniform Dental Plan, which is a preferred provider organization. About 94% of the dentists in Washington State participate in the UMP network. It is statewide coverage, with coverage also across the United States and internationally.

Slide 4 – Proposed SEBB Self-Insured PPO Option. We want to correct a few things. First, when we presented the crowns in August, we had them covered at 80% and they are actually covered at 50%. That's why the red ink on the chart. For orthodontia, we promised that we would clarify that 50% of the costs are paid until the lifetime maximum $1,750 is met. That is a different $1,750 from the annual plan maximum. There is an annual maximum of $1,750; and for orthodontia, a separate lifetime maximum of $1,750. The considerations for offering this, again, statewide coverage, comparable rates to the PEBB Program self-insured plan, orthodontia coverage included, a competitive benefit structure. You asked us to look at incentive plans in comparison. What we've discovered was that many incentive plans, after two or three years, have greater coverage. However, our plan has better initial coverage because Class I and Class II are covered. Class I is covered 100%. Many of the incentive plans do not have 100% coverage from the beginning, you have to earn upwards.

Dave Iseminger: They have a lower coinsurance that's covered initially. Somewhere around 70% or 80%. After three or four years, it becomes 100% coverage. Whereas, the proposed plan starts immediately. Everybody has 100% coverage of preventive services Class I.

Beth Heston: Crowns would be treated as Class III compared to many dental incentive plans that offer opportunities for a higher coverage.

Dave Iseminger: That's the flipside of what I just said. The incentive-based plans, there are often opportunities to have a higher coinsurance coverage by the plan and less for the member in subsequent years for crowns. There are tradeoffs and we wanted to be clear about those different tradeoffs.

Beth Heston: Right, because members would be entering at year one. In incentive plans, they would not have that coverage until they had earned in a couple years. The proposal before you is a popular and rich plan. It has great coverage. Our recommendation is that you offer the self-insured dental benefit design as proposed at the August 30 meeting.

Dave Iseminger: There is one piece I want to make sure we add on the record. We did go through the same stakeholder feedback with this resolution like we do with all the other. We received three comments. One was checking on who the administrator of the plan will be. Beth has already clarified it's Delta. Another comment from WASBO was supporting the motion as written. The third comment, "This benefit design is different from what some school employees experience. I hope you communicate it well." We agree that's going to be the challenge of communicating all the benefits because of the variability that exists in this system. We acknowledge the need for great communication.

Pete Cutler: I want to re-confirm that we have asked for a cost analysis of what would happen if we dropped the orthodontia benefit or capped it off. I guess the insured one was about capping off. Even if we adopt this, the understanding is it could be amended in the near future, i.e., before the end of the year if we so decided. Great. Thank you.

Sean Corry: Just a comment. I do want to point out that, at least for the school district clients that my firm has, this is actually a noticeable and substantial reduction in benefits. The vast majority of employees in Seattle Public Schools, for example, are at the 100% on the incentive benefits, not just incentive in Class I. That's an example of what will be a noticeable change in benefits.

Lou McDermott: **Policy Resolution SEBB 2018-37 – Vision Benefit**

Resolved that, 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.

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-37 passes.

Basic Life and AD&D Insurance

Beth Heston, PEBB Procurement Manager. The objective today is to take action on Policy Resolution SEBB 2018-30, originally presented at the July 320 Board Meeting. In July, we recommended employer-paid benefit levels of $35,000 basic life insurance, $5,000 basic AD&D insurance. We are now presenting to you the information that a decrease to a $25,000 basic life insurance benefit could generate annual premium dollars that could support an increase in the basic long-term disability benefit to approximately $600 a month. We had a lot of stakeholder feedback that's contained in the appendix to this presentation.

There was one outstanding Board question. We presented MetLife's findings for the ten non-PEBB benefits participating school districts that they had. Someone asked how many total employees they covered. The answer is 3,887 total employees.

Dave Iseminger: Slide 9 in the appendix has information benchmarking insight from MetLife and that's what Slide 4 relates to. It's the information originally presented in August when we were answering stakeholder questions and that's where that question was generated.

Pete Cutler: First of all, I want to confirm that this is similar to the dental benefit resolution we just passed, that if down the road we decided to go with a lower, say the $25,000 amount rather than $35,000 that's proposed, that we could make that adjustment there again sometime before this gets locked in. Beth is nodding her head yes.

Dave Iseminger: In fact, Pete, you could do that today. If you wanted to amend this motion and change it today, you could. If you did that, the direction of the agency would be when we bring back the LTD benefit resolution in November, we would automatically move that to $600 because of the decision you could make today. Or you could do it later. As a reminder, it’s in the last clause of the resolution, “unless modified in a subsequent resolution by the Board.” We don't write it over and over again in all the resolutions. But the reality is, all of them are subject to another one. At the time we were presenting this, there was a fair amount of concern from the Board about the veracity of that statement. So we put the words on the page. They're true whether they're there or not.

Pete Cutler: Thank you for pointing that out. I'm not ready to lock in on a decision, but I do think the long-term disability benefit is especially one of concern, and even the $35,000 is a low number. But a month or two from now, I think we may have a more information and be in better position to know what, if anything, at least, that I would support for a change. So, thank you for answering that question. And once more, just for the record, if it were up to me, I would eliminate the accidental death disability benefit because I think it doesn't really make much policy sense. But I will not let that hold me back from supporting the life insurance benefit.

Lou McDermott: Your position is noted. [laughter] Does the rest of the Board concur with leaving the $35,000 for now? Okay.

Policy Resolution SEBB 2018-30 – Basic Term Life Insurance and Accidental Death and Dismemberment Insurance.

Resolved that, 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.

Katy Henry moved and Dan Gossett seconded a motion to adopt.

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-30 passes.

Dave Iseminger: Wayne Leonard has a lot of pressures on his time today and needs to leave the meeting since we have completed the action items on the agenda.

Wayne Leonard: Thank you, Dave. Bye.

Eligibility & Enrollment Policy Development

Barb Scott, Manager, Policy, Rules, and Compliance Section. I am going to introduce two policy resolutions you today, SEBB 2018-32 and SEBB 2018-36. Staff have included the original resolutions for these two policies in the appendix.

Proposed Policy SEBB 2018-32 is being reintroduced because it changed significantly as we went through stakeholder feedback. The policy was originally introduced to address stakeholder concerns related to 12-month employees hired in full-time positions beginning July 1. When we first talked to stakeholders, they indicated that they hire principals, superintendents, and a number of 12-month type positions hired for whatever reason, July 1 based on their business needs. The policy was constructed around that. Since then, we've been asked to look at not just 12-month employees, but the nine- to ten-month employees. That's why you're seeing significant change from where we started to where we are today.

The policy was expected to allow for employees to begin benefits in July when they're hired if they were anticipated to work 630 hours in the next school year. Where the biggest change occurred is in how we address the number of hours that are needed during the remainder of the year once they're hired mid-year. It will provide eligibility to employees hired late in the year. The Board's eligibility can't be more restrictive than to require an employee be anticipated to work 630 hours within the school year. This particular policy is more generous than that eligibility.

With that, we received stakeholder feedback around the title. We originally had in the title the word "positions." We've removed that because it's not position-based. It's based on what the employee is expected to work hour-wise. Stakeholders wanted us to recognize that school employees work somewhere between nine and ten months rather than nine months, which is what we originally had. You'll see that in the policy before you today, we've changed that to nine to ten month school employees. One stakeholder was concerned that it would be difficult to administer two different monthly standards.

We have gone back and forth between a 52.5 hour standard per month and a 70 hour per month standard for employees. Stakeholders were also concerned that the requirement for a set number of hours per month would be problematic for specifically the months of April due to spring break, May due to Memorial Day, and June, mainly because it's a short month for your nine to ten month employees. One stakeholder suggested using the 52.5 hour per month standard and another stakeholder suggested addressing the concern by prorating the 70-hour standard.

Another stakeholder suggested the prorated number of hours should be a weekly standard of 17.5 hours, which is what you see on the proposal before you today. For the 17.5 hours, we took the 3.5 hour daily standard times five. When we worked it out, it comes out to the higher 70 hour a month standard. The policy resolution itself would cause the employee to have to meet, depending on which type of employee they are, one of the two standards. It proposes a single standard so it's easier to administer, which was important to stakeholders. It also allows us to fix this for both types of employees. It doesn't matter whether you're a 12-month employee or a nine- to ten-month employee. If you're hired mid-year, there's a way you could become eligible mid-year even if it's late in the year.

Staff included a number of different examples to help you see how this would be applied.

Katy Henry: Can you talk about how you determined six of the last eight weeks and the use of the word "partial" and "full?

Barb Scott: Yes. As we went through this with stakeholders, we struggled with looking at certain weeks on the calendar. Some folks saw those as full weeks and some saw them as partial weeks. This was especially noticeable when we looked at the week of Memorial Day. It really is a partial week. Monday is typically the holiday. It also was something that came up when we looked at the month of June for the nine- to ten-month employees. We wanted to be clear that it doesn't matter if it's a partial week or if it's a full week. That week would count in the calculation.

Dave Iseminger: The way you would think about this is to go to your school district calendar and determine the last day of school. That's week eight. Count back on the calendar to one. Look at those eight weeks and determine if the employee worked 17.5 hours in at least six of those eight weeks. That's how we got to eight. We looked at about a dozen school districts and did some examples. We know there's a lot of shifting at the end of school because of how school started in some districts, and exactly when school started, so we came to realize if you did an eight week look back, starting with the week that has the last day of school, in no instance did we hit and leapfrog over spring break.

The whole scenario then always describes a post-spring break employment anticipated-to-work world. We thought that would be easier to administer because in some school districts, if you lept over spring break, sometimes you're looking at March. Sometimes you're looking at April. There was a lot of calendar counting that went into this seeing if we could get a reasonable amount of time and that ended up being eight weeks. We settled on the recommendation based on different pieces that we heard as concern from stakeholders. Let's give people two bye weeks, one of them in many instances will be

the last week of school just by sheer nature of sometimes it's a one-day week, some days it's a four-day week. And then another bye week, depending on your employment status because of Memorial Day. We tried to add some flexibility.

Barb Scott: We’ve got it in our heads as we walk through these examples, that to have a standard like 17.5 hours per week works in this particular policy because it's more generous than the required eligibility. To apply a 17.5-hour standard beyond this policy, we would have to look at each instance separately because you could cross over into being more restrictive, which you're not allowed to be. The reason you're seeing a weekly standard here, and not necessarily in other places in policies that I bring before you, is because this is more generous eligibility than what is required by the statute.

Example #1 is a school employee who's a new principal, not anticipated to work 630 hours during the current school year because of the time of year they're hired. They are anticipated to work at least 630 hours during the next school year. In this case, the principal's first day is July 1, 2020. They are going to work at least 17.5 hours per week for at least six partial or full weeks in the last eight weeks, which would be during the months of July and August 2020. The question is, when are they eligible for SEBB benefits. Their eligibility begins July 1, 2020. Based on Policy Resolution SEBB 2018-12, paragraph two, coverage would begin August 1, 2020 because that policy resolution says for a new employee, coverage begins first of the month following the date of hire.

Example #2 is a bus driver who's not anticipated to work at least 630 hours during the current school year because of the time of year hired, but they are anticipated to work 630 hours during the next school year. Her first day of work is April 20, 2020 and she's anticipated to work at least 17.5 hours per week in six partial or full weeks of the eight weeks before summer break, which begins for this district June 18, 2020. The employer contribution towards SEBB benefits is April 20, 2020. Coverage begins May 1, 2020 based on paragraph two of Policy Resolution SEBB 2018-12.

Example #3 is a new teacher who's not anticipated to work 630 hours during the current school year. The first day of work for him is April 1, 2020. He is anticipated to work at least 17.5 hours per week for at least six partial or full weeks in the last eight weeks before summer break, which, for this district is June 16, 2020. He is eligible for the employer contribution towards SEBB benefits April 1, 2020 and coverage begins on May 1, 2020 based on Policy Resolution SEBB 2018-12 paragraph two.

Typically when we bring the resolution back to you, we include the examples and I let you know whether or not I've made any changes. We will be adding an idea in the resolution itself, which is these would be looked at as compensated hours, which is different from hours worked, which is what we're using every place else because, again, hours worked is what comes from the statute. Because we are in the world of being more generous than what is required by statute, we've included the concept of compensated hours. You may not see us use compensated hours any other place. But because we're in the world of more generous eligibility, you're seeing it here.

Pete Cutler: Just to be clear, would that suggest that for this resolution, if a person is paid for a holiday, or sick leave, or whatever that those would be compensated hours? They would count as hours whereas they might not be counted as hours under when you're talking about hours worked?

Barb Scott: Correct.

Dave Iseminger: I also thought of another answer to Katy's question from earlier of where eight weeks came from. For many school administrators, if you go to the end of the school year, August 31, and count back eight weeks, you hit the 4th of July. If you do a number greater than eight, you're counting hours and weeks before many people are hired. We learned that a lot of school administrators are hired and start around July 1. We were also trying not to leapfrog back into June so that you were somehow penalized for hours before you were an employee.

Barb Scott: You're seeing us use compensated hours here, which is very different. And that's because it's also our understanding that superintendents and principals are hired effective July 1 and immediately put on leave. They are using vacation leave right away. They have to come to work based on the way their annual work actually plays out.

Proposed Policy Resolution SEBBf 2018-36 – Eligibility Presumed Based on Hours Worked the Previous School Year. This policy is intended to address concerns that certain employees whose hours hover around the 630 mark will automatically be presumed ineligible at the beginning of each year but will actually work the 630 hours and receive eligibility late in the year resulting in an annual gap in eligibility. It will also address the concern that substitutes will always be presumed ineligible at the beginning of the year even if they've worked 630 hours or more year after year. The policy's being reintroduced with the addition of a two-year look back.

Following the last Board meeting, I talked to a number of you and there was a concern that substitutes needed to be carved out. We struggled with that and looked at a number of different methods to try and achieve that. This policy resolution began with the idea of addressing substitutes and these employees who hover right around the 630 hours, addressing their eligibility and trying to alleviate this gap that could occur annually. We've reintroduced this with a two-year look back. And we believe that that will help to mitigate the concerns brought to us last time around. In addition, we had a good amount of stakeholder feedback.

Dave Iseminger: Barb, just to clarify, feedback on the prior version, this same concept but the prior wording?

Barb Scott: Yes, this concept but the prior version wording, correct. A stakeholder was concerned that the presumption is not being granted to employees who have control over the number of hours they work in a school year. A stakeholder was concerned that certain employees will have a gap in coverage year after year even though they meet the annual requirement.

Example #1 is a part-time bus driver who's earned eligibility in April during each of the prior two school years and is returning to a part-time bus driver position for the third year. She is eligible for the employer contribution towards SEBB benefits when she returns to work in the same bus driver position for the third school year, unless the SEBB organization informs the bus driver in writing of the specific reason why she would not be anticipated to work 630 hours in the current school year.

Example #2 is a part-time food service worker who earned eligibility in April during each of the prior two school years and is returning to a part-time food service worker type position for the third year. He is eligible for the employer contribution towards SEBB benefits when he returns to work in the same food service position for the third school year unless the SEBB organization informs the food service worker in writing of the specific reason why he is not anticipated to work at least 630 hours in the current school year.

Dave Iseminger: We're being very clear about the need for in-writing reasons that comes with appeal rights. That is really true for any negative employee eligibility benefits determinations. Any time an employee is told that they aren't eligible for benefits, they have appeal rights. We've been working on the appeal rights because that's under the jurisdiction of the agency's authority. And this was a clear tie to make sure that those individuals who may believe that they are eligible, get definitive written explanations they could challenge on appeal if they so felt. I wanted to be very clear about that tie to the appeal world.

Pete Cutler: That's exactly what I was going to ask about. I was surprised words about how to appeal the eligibility termination were not included in examples because I think that's an important component of the notification. But clearly, the agency plans to incorporate that in its rule making. I think that's a really important aspect of it. Thank you.

Barb Scott: Yes. And the requirement to provide those appeal rights to employees is required under statute. I don't have the RCW number in front of me but it is in 41.05 series. Statute itself requires them to provide the employees with appeal rights related to their eligibility decisions. If you have no feedback, I will bring these back to the November Board Meeting for you to take action.

Dave Iseminger: But in the intervening month, it will undergo stakeholder review.

Barb Scott: Yes, these will go to stakeholders early next week.

Dual Enrollment

Kim Wallace, SEBB Finance Manager. The purpose of this presentation is to present some background information and to provide the opportunity to discuss SEBB-SEBB dual enrollment as the Board prepares to consider a policy resolution included in this deck. There will be a request for a vote at the November 8 Board Meeting.

Slide 3 – What is Dual Enrollment? SEBB-SEBB dual enrollment occurs if one SEBB member, an individual person, adult, or child, was enrolled under two SEBB medical plan accounts, two SEBB dental plan accounts, or two SEBB vision plan accounts. Contrasting with that in bullet two, SEBB-PEBB dual enrollment, we are not going to discuss at length today but we did want to acknowledge it’s on the minds of a number of people. SEBB-PEBB dual enrollment would occur if a SEBB member was enrolled under a SEBB medical plan account and a PEBB medical plan account, or dental, or group vision as well. Today, we're going to continue the discussion of SEBB-SEBB dual enrollment.

Slide 4 – Example of SEBB/SEBB Dual Enrollment. This example focuses on two employees who are married and both are SEBB benefits eligible, the most basic scenario that comes to mind when we think of dual enrollment. In this example, a benefits eligible employee enrolls as the subscriber in one of the medical plans offered to her as an employee, UMP Achieve 2 or UMP Achieve 1. Her spouse, who is also a SEBB benefits eligible employee, enrolls as the subscriber in one of the medical plans offered to him as an employee. It could be the same plan or it could be a different plan. Bullet three is where the dual enrollment occurs. One or both of them *also* enroll the other as a spouse dependent on *their* plan. Regarding the monthly premiums, per Policy Resolution SEBB 2018-14, which established a tiered premium structure for SEBB medical plans, this creates a Tier 2 employee, plus spouse enrollment scenario. Under Tier 2, the employer and the employee pay their premium contributions for both the employee and the spouse. You remember Tier 1, we talked about the medical contribution earlier. Under Tier 2, that gets multiplied times two and the employer pays that amount and the employee also pays their premium contribution times two. In this dual enrollment situation, now the employer and the employee are essentially paying premium contributions twice conceivably for both individuals.

Slide 6 – Benefits: How are Claims Paid? We’ve all have heard about coordination of benefits and many of us have participated in this. There are a couple of general points to be made. The plan determined to be primary pays its share of the cost first. The general rule is that an employee's own plan is the primary. Rules for Coordination of Benefits (COB) do vary. But generally, if there is any remaining amount owed by the member after the primary plan has paid, the secondary plan processes the claim and may cover some or all of the rest, in knowing that the member will not receive coverage for more than 100% of the allowed cost.

Slide 7 – Financial Considerations. Financially, if SEBB-SEBB dual enrollment is allowed, the employer, as I stated earlier, will pay premiums for an individual employee twice; once to cover their enrollment as an employee and once more to cover their enrollment as a spouse. The SEBB bullets on this side simply repeat what I already mentioned about the employee owing. If the employee owes part of the monthly premium, they pay twice as well, or two times.

Dave Iseminger: I want to interject one piece because I had this conversation with a lot of folks over time. It's important to remember that in the state world when the employer makes a contribution for medical, the same contribution is then paid out across the tiers for the dependents. That is not necessarily how many employers do it or how many employees experience it. When we talked earlier this morning about the Collective Bargaining Agreement and we described how the employer contribution is paid across all tiers, that's really what Kim's describing. I was thinking about it sitting here and I went back to the collective bargaining slides and pulled out the EMC concept illustration (TAB 4, Slide 5). Essentially what's being described on that slide is if you looked at the 82% AV plan, if the employer medical plan contribution is $200 at the employee only level and somebody has enrolled their spouse, the state is putting forward $400. They're contributing that for the husband and their wife on one account and they're also paying that same $400 on the other account where the wife is the subscriber and the husband is the dependent. Essentially $800 in employer contribution is being put forward into the system, whereas if dual enrollment is prohibited, only $400 is put into the system. The same applies for the employee side. For example, on the scenario

that I was just describing from the earlier slide, normally, it would be $15 at the employee level and $30 in the illustration. The employee would pay $60 instead of $30. But there would be $60 worth of employee contributions collected versus $30.

Kim Wallace: Correct. I think in terms of round numbers to consider, an employer medical contribution is not going to be $200. It will be more than that. And so you start to multiply and it adds up fast. If you want to think about a dental premium and the same dynamic happening under dental, you remember that the employee is not going to be paying any of that premium. The employer is covering maybe $40 to $50 times two and then perhaps $40 to $50 times two again.

Speaking of dental, Delta Dental of Washington, a carrier with currently over 200,000 K-12 enrollees, shared with us that they see at least 5% of that membership are currently dually enrolled in dental plan coverage. We asked them that question because we were trying to understand how often that happen. How many people would be dual enrolling in medical coverage, in dental coverage, in vision coverage? Delta Dental provided this estimate to us. We do have another source who suggested that they felt it would likely be at least 5% and that it could be about 10%. If you have any information about that from your experience in your work, that would be fabulous to hear about as well. But if we use the 5% to 10% estimate, it really does have a significant impact.

If dual enrolment were allowed, it would increase the cost of launching the SEBB Program. The employers would be covering that increased premium cost at the Tier 2 level instead of Tier 1 for every additional adult who enrolls in this dual situation. We didn't speak a lot about the children, but of course, a similar dynamic happens there as well in that we would be moving then not just to Tier 2 but we'd be moving into Tier 3 or Tier 4. And again, as Dave mentioned, there is an increase in the employer contribution as you move to Tier 3 and Tier 4, as well. We want to share that to the degree dual enrollment is allowed to be present in the SEBB enrollment rules, it will create pressure on the Legislature to consider how to address that cost. We know that the assumptions and the understanding to date from the Legislature, and in our conversations with OFM, is that the working assumption has been, and therefore, our modeling has followed this, that there will not be SEBB-SEBB dual enrollment allowed. Neither is PEBB-PEBB dual enrollment allowed in the PEBB Program. That creates this precedent for people's working assumptions going forward.

That said, this conversation and this presentation is definitely meant to provide you with information and food for thought.

Dave Iseminger: I know you're probably looking for what is the dollar amount it costs to buy this, because if the working assumption from all parts of the authorizing environment are like PEBB, dual enrollment would be prohibited within the Program. The natural question is how much does it cost? I'll point out, without getting into too many details, that we talked about general costs during the Executive Session. Anything related to the increase cost for this would be on top of that discussion that we had during Executive Session. We've tried multiple ways to come up with a dollar range to provide to you and they all have significant challenges and significant issues with the assumptions that are necessary. But it is clear, especially because of how we've described the results of the collective bargaining, that it would be a significant additional cost on the state side because it's 85 cents of every dollar on medical and 100% of

every dollar on dental and vision. When I said $400 goes into the system or $800 goes into the system, and we know those are artificially low numbers, the key assumption is how many people would dual enroll in each benefit. That's proven to be a very elusory, challenging number to get minds to coalesce around what it would look like. But the magnitude of it, we hope we've tried to illustrate by describing who pays what. The extra information from the Collective Bargaining Agreement really starts to show you the potential order of magnitude and that the authorizing environment has been under a very core assumption that dual enrollment within the program is not within the financial picture.

Pete Cutler: I've dealt with coordination of benefits (COB) quite a bit while at the Insurance Commissioner's Office. It was a huge hurdle to administrative simplification for processing of claims. Most electronic claim systems, could not handle COB-type situations. I also have a bias against having COB situations in general in health care.

Secondly, I think the state's goal, and certainly with the PEBB Program originally, and I think now extended to SEBB, is to provide comprehensive medical coverage to employees and with a very strong commitment to affordability for family coverage. It's like a defined benefit type commitment of policy. It's not just treated as, "Okay, we give you so much salary and here's some dollars and you go spend those dollars however you want for health care." It's a, "We want to make sure employees can cover themselves and their families with good comprehensive coverage and at a reasonable cost."

In my mind, the cost involved with coordination of benefits, while it would be obviously much appreciated by those who would benefit from it, doesn't really contribute to that policy goal. If you haven't guessed by now, I'm a fan of the resolution. I'm not a big fan of coordination of benefits as a priority for spending money in a health plan.

Dave Iseminger: Proposed Policy Resolution SEBB 2018-15 – Dual Enrollment in SEBB Benefits is Prohibited. This is the same resolution that was originally presented in May, the same exact wording. It will go back out for stakeholder review and we'll provide their feedback part of the process.

Kim Wallace: Proposed Policy Resolution 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.

Lou McDermott: A clarifying question: if you had two people that are together, they have a child, then one of them could cover themselves and the child on one account and you could have the other one cover on the other account. And that's not dual enrollment?

Dave Iseminger: I believe what you said is if Kim and I are married and we have a child and the child is on my account, Kim could be on her own separate account. Kim and I can't have the child on both our accounts.

Kim Wallace: I don't have the child also on my account.

Lou McDermott: But that's not considered dual enrollment.

Dave Iseminger: It's not considered dual enrollment when I have the child on my account and my wife, Kim, has her own separate account. We get married a lot here in our examples. [laughter]

Kim Wallace: We do. We do.

Dave Iseminger: There's lots of examples.

Lou McDermott: Congratulations!

Kim Wallace: The theme there, the guiding principle is no human being, no one individual is enrolled in more than one account, child or adult, no matter how old.

Lou McDermott: Understood. I just wanted to make sure that was clear.

Fully Insured Medical Benefits

Lauren Johnston, SEBB Procurement and Account Manager. I am providing a brief overview of the outcome of the RFP proposals. There were six apparently successful bidders. The contract negotiations have begun with all six of them. We are going to request the Board take action at the November 8 Board Meeting to proceed with rate development on the proposed plan designs that you will see later in the month, then again on November 8. There are no rates at this time. The contract right now is focused around developing the plan designs, as well as operations, clinical programs, etc. However, we will go into not to exceed rates, which we hope to obtain sometime between December 2018 and January 2019. Out of the RFP proposals, there are two HMO plans and four PPO networks.

Dave Iseminger: I want to make sure when we talk about rates, the full picture is set out for folks. We would be asking the Board to say preliminarily go forth with rate development on the designs in November. We would then take that and go through the not to exceed rate-setting process with the carriers in December and January. That will give us the first real indication as to the high water mark for rates. That will then be used to guide legislative budget final assumptions as the Legislature finalizes its decisions. After the budget comes in, we go back to the carriers and say here's the real number. This is how it looks once you apply an EMC of 85% of the 88% AV plan. We'll come to the Board and say here's what the premiums are looking like. Are there benefit design changes that need to be tweaked before we settle in on final rates with the carriers?

When the Board votes next summer, at that point employees will be able to know exactly what they would put forward as their employee contribution for the entirety of plan year 2020. It’s come to my attention recently that sometimes school employees don't know exactly what they're paying until the month that they're paying. I wanted to make sure that it was very clear for everyone that once the Board makes its decisions in roughly July 2019, anyone who's looking at these materials will be able to see via the Board vote what the employee contribution is. All school employees will have information before them when making their elections that will definitively have what they will be paying in the new system. It just came to my attention that's not the way every school employee experiences the benefit system now. I did want to make sure that was very clear for the Board, as well as members of the public that are paying attention.

For example, I am about to get my PEBB newsletter that has the rates I will pay for 2019. I will get that information two to three weeks before open enrollment. I have that context. I make my selection in November and I know exactly what I'm going to pay for all of 2019. That is a similar model for this program.

Pete Cutler: Can we hope that the school employee communication next year might have a longer lead time than just a couple weeks before open enrollment just given how huge a change this is?

Dave Iseminger: I think the crunch time is going to be whenever the Legislature gets out of town and how quickly we can land the rates with the carriers. We're projecting open enrollment to begin on October 1. We're also planning to have a more extended open enrollment. In PEBB-land, we do a four-week open enrollment, the month of November. We're planning for a six-week open enrollment because of all the change that's happening in the system. We're working on ways to make sure the communication gets out. It really depends on when the final funding comes in and how fast we can get it for that open enrollment period.

Pete Cutler: That's understood. I just hope it's very robust.

Dave Iseminger: I would say information will be on the websites quickly and anybody who wants can go to that information. But the individual, tailored mailing we typically align that closer to open enrollment so that people get it and don't lose it in the month intervening. The information will be publicly available, just not in the hands of everybody individually. But it will be very robustly publicly available as soon as the Board takes actions on the rates.

Pete Cutler: Great. Thank you.

Lauren Johnston: Slide 3 – Initial Plan Development Process. In the RFP, we asked the carriers, in addition to submitting a proposal, to submit plan designs. Their original plan designs were not scored. We wanted to use that as a basis for starting the conversations around plan designs, but not have them scored.

At the end of August, we instructed all apparently successful bidders (ASBs) to submit updated plan designs based on some initial parameters, which include about two plans for Clark, King, Snohomish, and Spokane counties and around three plans for the other 35 counties. We reminded them of the self-insured SEBB plan actuarial values. We also foreshadowed to assume that the vision benefit would be carved out of the medical plans. In addition, we let them know that the premium tier ratio would be applied to employer contributions for medical benefits.

Sean Corry: Lauren, in my long-term memory, I believe that at least a vision exam is a required benefit under the old HMO rules. Is that no longer the case? At Kaiser Permanente, for example, with their HMO model, they used to have to have at least a vision exam baked into their HMO benefits. I don't know if that's the case.

Lauren Johnston: I remember looking this up because this was asked the last time and I believe the response is no.

Dave Iseminger: I did want to give more context to everyone as to why two plans in those four counties and why three plans in all the other counties. Part of it was based on the initial proposed service areas. The saturation point that could be reached with the number of plans in certain counties looked like it would be greater in the four counties that are listed here. We wanted to make sure we were signaling to other carriers that there was this concern, at least from the agency. We want to validate and get some insight from this Board regarding concerns about too much choice. We gave them that direction of about two plans in those four counties and about three plans in the others

Sean Corry: For clarity, would you help me understand what plan means in this case. Because for me, a plan is a plan choice. Maybe it could be four from a carrier. Are you talking about the plan being the insurance company, for example?

Lauren Johnston: No, I refer to that as a carrier.

Sean Corry: So, they could have multiple offerings?

Lauren Johnston: Yes. There could be a carrier who offers two plans in Clark, King, Snohomish, and Spokane. And that same carrier could offer three plans in the other 35 counties.

Sean Corry: Got it. So we just need the number of carriers and we can do the math.

Dave Iseminger: Correct. And the other way to think of it is although UMP is not a carrier, you could think of it as one, and the Board has authorized four UMP plans. That's the equivalent here. For example, Premera is one of the ASBs. They could offer about two plans in those four counties and about three plans in the others. Right now we're negotiating with six carriers. Multiply by two. Add four for UMP and you're at 16 potential for Clark, King, Snohomish, and Spokane Counties. The other counties, it's not quite six carriers and that's what we were trying to account for with about three plans because the service areas don't overlap in the same robustness as they do in those four counties.

Sean Corry: But we're in the teens.

Dave Iseminger: We're in the teens.

Lauren Johnston: Slide 4 – Accumulator Variability. The accumulator variability is based on plans requested from the information provided at the end of August. We've gone through three iterations: the unscored plan designs submitted with the RFP, the plans submitted in mid-September based on information given in August, and an update to the plans at the end of September.

This slide is based on the information provided in August with the updated plans in mid-September. The proposed plans included a wide range of accumulators. For the medical benefit, the deductibles for a single subscriber came in between $125 to $1,750. For a full family, the range is from $250 to $5,250, with a maximum out-of-

pocket between $2,000 and $5,000 for a single subscriber and $4,000 to $15,000 for a full family.

Pharmacy benefit deductibles were combined with the medical deductible, or between $0 to $500 for a single subscriber, or $0 to $1,250 for a full family. For the maximum out-of-pocket, all plans said their maximum out-of-pockets for their pharmacy benefit accumulated towards their maximum out-of-pocket of their medical benefit.

Slide 5 – Benefit Cost Share Ranges. The green row at the very top is the general coinsurance submitted. When you look at a list of benefits not included in the covered service types in blue on this page, you would apply either the in-network or the out-of-network coinsurance within the green row, depending on whether or not you see an in-network or out-of-network provider. The range for in-network is 10% to 25%, depending on selected plan. Out-of-network is 40% to 100%. When we take a look at some of the covered services, we wanted to provide coverage services that most people tend to look at when they think about their benefits. What am I going to pay when I go to the emergency room? What would I pay if I had to have surgery and I'm in-patient in the hospital? Those types of things. We carved out areas we felt were important. The copay for the emergency room was $0 to $250 and a coinsurance of 10% to 25%.

Dave Iseminger: Lauren, to be clear, there's not a plan that has both a copay and coinsurance. Some plans are copay, some are coinsurance?

Lauren Johnston: They all are. For the plans that you pay a $0 copay for the emergency room, you will pay a coinsurance. But there are some plans where you might pay $150 copay and pay a coinsurance of between 10% or 25% on top of that, depending on which plan you select. The same applies to hospital in-patient. You're going to pay $0 to $300 copay per admission, plus 10% to 25%. Again, for those where you pay $0 for the copay, you would only pay the 10% to 25% coinsurance. Out-patient, none of the plans had a copay for hospital out-patient services. They all have a coinsurance of 10% to 25%. For primary care office visits, there is a copay between $0 to $40 or 15% to 20%. When it comes to the office visits, it's unlikely that you would pay both. You're either going to pay a copay or the coinsurance, depending on what type of plan you select.

Sean Corry: This is a question out of confusion. I'm sure we'll see this in a minute, but just for the purposes of this, did we get proposals from, I'm presuming Kaiser Permanente for HMO only service. Is that where this doesn't really apply that there is no out-of-network except in an emergency?

Lauren Johnston: Yes, you are correct that the Kaiser Northwest and Kaiser Washington HMO plans do not have out-of-network coinsurance except for when, and that's what the asterisks are for, emergency care and for some carrier's urgent care where you would pay the in-network coinsurance.

Dave Iseminger: Did that answer your question, Sean?

Sean Corry: I think so.

Lauren Johnston: Office visits for specialty care, you'll pay either a copay of $30 to $50 or a coinsurance of 15% to 20%. For urgent care, $0 to $50 for copay or 15% to 25%.

Slide 6 – Proposed Treatment Limitations. We have listed a range of limitations. Acupuncture, depending on the plan is either 12, 16 or 20 visits. Chiropractic is 10, 12, 20, 52, or no limit. Those are your options depending on what plan you select. Massage therapy is limited to 45 or 80 visits, depending on the plan. There is no limit for occupational therapy/physical therapy/speech therapy/neurodevelopment therapy (NDT) for one carrier. For some carriers, their massage therapy benefit is separate from their other therapies. You're going to have 12, 16, or 20 visits. Some have a combined occupational therapy, physical therapy, speech therapy, and neurodevelopmental therapy benefit of 45 or 60 visits combined per calendar year, depending on the plan.

Sean Corry: Were there some proposals from carriers where there was a limit on neurodevelopmental therapies as the limits are for occupational physical therapy?

Lauren Johnston: Yes. The 45 to 60 combined applied to some carriers.

Sean Corry: Even if it's coded in the DSM 5? So it's not covered? You're saying that it's not covered under the mental health parity rules?

Dave Iseminger: We'll do some follow-up questions with the carriers about that piece. But from what we got in their proposals, it was a combined treatment limitation, at least on paper, the same way that it is in the Uniform Medical Plans. You'll recognize the structure is similar to the structure of the self-insured plans. We'll follow up.

Sean Corry: Well, just to make the point, I know that after the mental health parity laws were passed, there was a set of years during which the carriers were not, in my view, correctly interpreting the new law and were denying benefits. That’s the key therapy that drove lawsuits all the way up to the State Supreme Court, neurodevelopmental therapy. I think now, universally to be covered under the mental health parity act and on par with other medical conditions. I think that restriction might be problematic.

Dave Iseminger: We will further clarify with the carriers exactly that part of the box and make sure we address that piece, Sean. I will say one of the reasons we made sure that we put this information in is because of the questions this Board had about treatment limitations in the self-insured plans. We knew that you would be particularly interested in seeing these pieces. I did want to give you insight on the limitations. Chiropractic, for example, and the number 52. I did want to be clear that is one of the plans. If you say that we got somewhere between two to three plans, we have six carriers, you're looking around 18-ish plans. Out of those 18-ish plans, one had a 52 limit and one had no limit listed. The rest were either 10, 12, or 20.

You might be curious about what options school employees are going to have. If you want variability in the system, that comes from the fully insured side. I want to be very careful because we're still in negotiations about some of the service area aspects. But what I could say at this point with what we know, it looks like most school employees, most districts, and most counties would have some options in that 10, 12, 20 area for

chiropractic; 12, 16, and 20 for acupuncture; 12, 16, and 20 for massage. The self-insured plans you've authorized has 10 chiropractic, 16 acupuncture, and 16 massage. If you try to line those up, you see that it looks like, unless this Board directs otherwise, there could be variability in the system on these treatment limits. Some variability for most school employees in most areas. I know those are all very general statements.

Sean Corry: I guess I have a question about practice because in my firm, as an insurance broker, we would ask carriers for particular benefit designs or variations on what their standard designs would be. When you got these drafts, I don't know if they're proposals yet or what, did you specify the set of benefits they should try to emulate, imitate, copy?

Dave Iseminger: Sean, we made sure they knew what the benefit design was they would be competing against in the self-insured part of the portfolio. And they had a complete copy of the benefit treatment limitations, the benefit coverage levels of those so that they could try to position themselves in the market somewhat appropriately. And the next question for this Board, previewing a couple slides down, so the theme of the last couple of slides from Lauren has been, there's a lot of variability. And the question is, how much variability is too much variability. And so that's a question for the Board, are there areas you want us to be focusing on reducing variability? Do you want us to ask the carriers to match the self-insured design? Or do you want this variability? We started from a place of variability that we can collapse, versus the other way around. They were given the context of the plans for the Uniform Medical Plan self-insured plans that you authorized in June as a guidepost for what they would be competing against in this portfolio.

Lauren Johnston: Slide 7 – Actuarial Value (AV) Ranges. From the plans, we saw fairly even distribution from approximately 79% to 91% AV. There was a concentration of plans between 83% and 84% AV. We had one AV at the lowest at approximately 76% AV and two plans with the highest at approximately 91% AV. Just as a reminder, the Uniform Medical Plan AVs are UMP Achieve 1 at 82%, UMP Achieve 2 at 88%, and UMP Plus at approximately 89% to 90%.

Dave Iseminger: This is where I say, at least slide deck number one that Megan and I did this morning was internally consistent. And this slide deck is internally consistent. But the decks aren't consistent with each other about which AV is UMP Achieve 1 and which one is UMP Achieve 2. We will make sure that in the November packet, there is a follow-up in my presentation at the beginning that has a crosswalk from the resolution, to the plan, to the AV, and to the deductible so everybody has one piece of paper they can always go to forever and ever. I will acknowledge they are not internally consistent in this briefing book. I know which one I think is right. [laughter]

Lauren Johnston: Slide 8 – IRS Qualified High Deductible Health Plan (HDHP). For the IRS qualified high deductible health plan, we received one HDHP, which would not be available statewide. However, the UMP high deductible health plan is available statewide.

Dave Iseminger: If this Board is interested in sending a direction that you want more high deductible health plans, we would appreciate knowing that here. But in general,

with the constraints and portfolio that we described to the carriers, they didn't bid many high deductible health plan levels or offer them statewide.

Sean Corry: Could you ballpark the percentage of PEBB employees who have chosen that plan?
Lauren Johnston: I want to say on UMP, it's around 12,000 to 13,000.

Dave Iseminger: I think it's somewhere in the 10% to 15% in a high deductible health plan. We'll also follow up with that context.

Patty Estes: How not statewide?

Dave Iseminger: I would say a few select counties, but they tend to be more populous counties. Small when you talk number of 39 counties, larger when you go percentage of employees. Again, all of the service area pieces are still in flux. But that's pretty much where it looks like it'll probably land.

Lauren Johnston: Slide 9 – Variability Impacts. On one hand, standardizing some cost-share aspects of the plan design could help make comparing plans easier, as well as improve the member plan selection experience and provide parity among the health plans. On the other hand, standardizing all cost-share aspects of plan designs could potentially limit the range of AVs, as well as shifting the primary focus of member selection away from the plan design into the provider networks. Things to consider when we're looking at the variability of the different plans and whether or not there are different things you would like to standardize.

Pete Cutler: From your discussions with the carriers, do you have an impression about whether having more or less variability might have an impact on premium bids? Do they think they have some secret sauce with whatever particular mix of plan provisions they want to propose, that they think allows them to provide the overall plan at a lower cost than would be the case if they were required to adjust to a common set of plan provisions?

Lauren Johnston: We set up the meeting in August for them to put their best foot forward. We possibly already have those.

Pete Cutler: Did any of them, during discussions say, “I can give you a good deal if you allow me to do exactly what I want. But I don't know if I can give you such a good deal if I have to make my plan follow your template." Any kind of conversations like that?

Dave Iseminger: Pete, to this point, because we aren't into the rate-setting aspect of it, there hasn't been significant chatter of that nature. Discussions from some carriers are based on their experience with the market, school employees might be more accustomed to this type of plan design versus that type of plan design. We want to make sure that we're as attractive as possible with plan designs. If a school employee is already familiar with the carrier name, the carrier wants them to be as familiar with the plan design they're proposing as well.

But that's part of the challenge. Is there so much variability in the system right now that you could end up with just as much variability in the SEBB portfolio? When the

deductibles come in, I was counting in my head, and between the 18-ish plans, there were somewhere between nine and ten different deductible levels. That's an area we could standardize to make it easier for members when comparing benefits. We've selected a couple of different deductible levels based on the Board's prior actions and what we were seeing in the carrier responses. We asked them to resubmit, collapsing to these four different numbers. We got some push back from some of the carriers because their experience with deductibles was different than our request. They indicated they had X number of school districts that offer this level of deductible and Y number of school employees. We said we understood but there is value in having coalescence around a few deductible numbers.

Are there other areas you think are important to collapse?

Lauren Johnston: Slide 11 – Questions for the Board. To piggyback off what Dave said, are there other components of plan design where you are interested in seeing more standardization? Areas that might apply to this are the maximum out-of-pocket costs and office visit copays. Is there a point where you become concerned about too much plan choice for a member?

Sean Corry: Yes. Well, I find it confusing now. I wonder, because the question for the Board about plan designs is if we're interested in seeing more standardization, I think that's going to take conversation here. So my vote is yes. When school districts have an opportunity to choose among several plans, usually there's common language across the columns. It's relatively understandable changes in number of visits or what the copayments are going to be, etc. Then it changes the premium down below. What I saw here was something I could not track. It was just jumble. I vote for simplicity and I haven't seen it yet. I don't know what else to say.

Lauren Johnston: Remember what you saw earlier were ranges based on the 18 different plans we received. When we do put out communications for open enrollment for members to be able to select a plan, it will look like that. There will be coinsurance for different types of services. It will look the same and it's not going to be a range. It'll be one number for each of the different plans that they could select from. So we just wanted to show you that one of the reasons why we are going through the standardization process is because there's so much variability right now to select from.

Sean Corry: How are we to answer your question here about what we would like to do? What's that process where we can give you input?

Dave Iseminger: To some extent, Sean, our Executive Session tried to show you more about where we are in the contract negotiations. After previewing for the public, we're going to go back into an Executive Session at the end of this meeting to continue the conversation with very specific variability we're seeing. We want to at least have, in the public meeting, the ability for you based on what you see even just at the range level, to see if you think office copays in the $40 range feels like too far. Can you collapse that to two or three numbers instead of a full range of options? There's some direction from the Board about trying to coalesce just like we did for deductibles to three or four numbers for some of these other areas. Or, on Slide 4 you might think the maximum out-of-pocket, ranging from $2,000 to $5,000 in a medical deductible, seems like too much. Are there more numbers to focus on or more buckets that we can collapse like

we did for deductibles? We tried to use deductible to show an exact illustration. If you're concerned about too much variability on a specific accumulator or a specific coinsurance cost share, then we would take that direction and go back to the carriers and ask them to look for more standardization in areas.

Sean, you've expressed a view of wanting more simplicity. I don't know how far to take simplicity. We could go all the way to match the benefit design of the 82%, 88%, and 90% AV plans for UMP so you're down to comparing those three buckets of plan benefit coverage and then focusing on provider network. That could be one way to go. But that would then collapse the range of AV and affordability and you wouldn't end up with any AV plans lower than 82%. We weren't thinking that the Board wanted us to go so far to collapse to a couple of AVs with a couple prescriptive buckets on some of the accumulators, which are the drivers of AV. We think the Board is interested in more variability. The question is how much variability? What are the areas you want to focus on?

You can save your comments for Executive Session when we have specific pieces before you. But if there's anything that you're aware of at this point that you want to say publically, we would welcome that as well.

Pete Cutler: I, like Sean, would say yes and yes in terms of wanting to see more standardization and being concerned about too much plan choice. Also, probably just concerned about fragmentation of the enrollment and the instability that could lead to for the overall program. If you have 20 different plans offered by six different carriers, I'd want to have a hard look at does it look like these can all be successfully moved forward on a financial basis for more than just one year. Or would we end up with something where we had a lot of complexity and a lot of different plan options that don't really have much obvious difference from each other that we then have to engage in different communication efforts the following year because various plans have been dropped or changed or carriers have dropped out?

Having some kind of balance where there's a range of choices, certainly more than maybe what state employees get, given the number of six apparently successful bidders we have. But something short of The Exchange. We had one carrier on The Exchange who must have loaded 30 or 40 different plans. If you're a health care professional being paid to look at it, you couldn't figure out exactly what the differences were and you didn't see what value that added to the people who went to The Exchange to try and figure out what plan they wanted. I think some movement towards having a modest selection, but one where it's clear, without too much effort and you can distinguish this plan has this strong point. And the tradeoff is this rather than just a plethora of options that are hard to sort out. That's all very general but that's what I have so far.

Dave Iseminger: A couple of other things to keep in mind is when Lauren gets to the resolutions, we're teeing them up and asking you to endorse some plan designs for the purposes of going forward with rate development. That would not lock you in to final offerings and multiple plans from all of those carriers. If as you go through the rate development process and learn there are 18 plans with six carriers in King County, and that’s too much, you could not offer a carrier’s plans or work with us to talk to the carriers about offering fewer plans. I want to be clear that you're still at the high water

mark and you could do pruning along the way as you get more information about the total service area and total premiums as we get the not-to-exceed rates.

The Board wouldn't be locked into offering plans under all six carriers by passing the resolutions next month. We do have ways of appropriately unwinding a contract if the Board ultimately does not include a carrier's offerings in the final portfolio.

Sean Corry: If we were to go through that process the way I think you just described it and asked the carrier to drop a couple plans, for example, would that create some sensitivity with respect to the pricings of the other plans? Is it going to impact what the carriers think they need for the remaining plans if some other plans are dropped, because they would get a different risk mix.

Dave Iseminger: As we get further into the not-to-exceed rate-setting process. I'm sure more questions will come up from the carriers. What we typically do in the rate-setting process is take the complex funding model and the agreed amount under the Collective Bargaining Agreement to identify what is the likely employee premiums. We talk with the carriers about what the self-insured plans are going to look like. That tends to guide the discussion quite a bit as to refinements on their bids and their plan designs. That's typically part of how that process proceeds.

Patty Estes: I know that you are in negotiations. Are some of the providers still trying to broaden their networks to cover more service areas within bargaining or are they pretty set on where they're providing their services?

Dave Iseminger: I would say that it's still a somewhat fluid process right now. You have to realize that some of the carriers we're negotiating with have long-standing relationships with the Health Care Authority and understand how different pieces of the puzzle work. Other carriers are completely new to the Health Care Authority, at least on the commercial side. I'm helping them understand how different pieces work and their comfort with different contract language allows them to be more risk tolerant with regards to their service areas. There's still a lot in flux at this point.

Patty Estes: I know from my experience, the biggest question that I've gotten as this transition is going to happen is, "Can I see my doctor?" That is definitely a factor in my decisions, who we go with on the broader provider network. I mean, we're going to have some variability. But that's actually a pretty big factor.

Dave Iseminger: Patty, I know that we struggled a little bit with the vernacular earlier, let's just for purposes of all of our conversations say "carrier." Carriers have plans. What you're talking about, I think, is the provider network offered by different carriers. And you may be interested in more carriers across the portfolio with fewer plans than more plans and fewer carriers.

Patty Estes: Yes.

Dave Iseminger: I saw at least two smiles and a head nod. I wanted to see if that resonates and get that on the record for Connie. Okay, some interest in more variability, provider networks, less plan offerings per carrier but more carriers. At least preliminarily. Okay. Lots of head nods. Lots of smiles. Go Patty! [laughter]

Lauren Johnston: Slide 12 – Next Steps. HCA will incorporate Board insight into ongoing negotiations. At the November Board Meeting, specific plan design components will be shared, which you will see on Slide 13. The information will be provided to the Board as early as possible prior to the November meeting. Action will be requested on Policy Resolutions SEBB 2018-45 through SEBB 2018-50 at the November Board Meeting to proceed with rate development.

Slide 13 – Proposed Medical Plan. This is the proposed medical plan design. Basically, carriers will come back with their plan designs using this template.

Dave Iseminger: Our question for you, is there anything else that you think at a high level would be areas you want to see in this type of chart? We focused on those key accumulators, as well as the copay and coinsurance of different pieces.

Patty Estes: Some treatment limitations would be great to see on chiropractic, acupuncture, etc. because I think that is, for some of us, deciding factors on some of the plan designs because we want to have that variability.

Lauren Johnston: I likely won't include it in this format but it will be on another slide. It'll be like what you saw before, but broken out by plan.

Dave Iseminger: We'll have a supplemental slide that goes through all carriers and their plans.

Lauren Johnston: Slide 14 – Proposed Policy Resolution SEBB 2018-45 – Fully Insured Medical Plans (Aetna). The SEB Board endorses Aetna's proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Dave Iseminger: Lauren, I don't think you need to read all the resolutions. They are the same syntax, different carrier name. This will give you the opportunity at the end of the day if you do want to prune a carrier, so to speak, or prune plans. That would be the mechanism. That's why we tee them up as carrier by carrier votes.
Slide 16 – Proposed Policy Resolution SEBB 2018-45 – Fully Insured Medical Plans (Aetna). The SEB Board endorses Aetna's proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Slide 15 – Proposed Policy Resolution SEBB 2018-46 – Fully Insured Medical Plans (Kaiser Foundation Health Plan of the Northwest). The SEB Board endorses Kaiser Foundation Health Plan of the Northwest's (KPNW) proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Slide 16 – Proposed Policy Resolution SEBB 2018-47 – Fully Insured Medical Plans (Kaiser Foundation Health Plan of Washington). The SEB Board endorses Kaiser Foundation Health Plan of Washington 's (KPWA) proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Slide 17 – Proposed Policy Resolution SEBB 2018-48 – Fully Insured Medical Plans (Kaiser Foundation Health Plan of Washington Options, Inc.). The SEB Board endorses Kaiser Foundation Health Plan of Washington Options, Inc. (KPWAO) proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Slide 18 – Proposed Policy Resolution SEBB 2018-49 – Fully Insured Medical Plans (Premera). The SEB Board endorses Premera Blue Cross' proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Slide 19 – Proposed Policy Resolution SEBB 2018-50 – Fully Insured Medical Plans (Providence Health Plan). The SEB Board endorses Providence Health Plan's proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

[break]

Centers of Excellence Program

Marty Thies, Program Manager. Last month I was here to tell you about the Centers of Excellence Program. Today is to provide some highlights. In the PEBB Program, The Centers of Excellence Program is an overlay for the UMP Classic Plan and the CDHP. We offered our first bundle in January 2017, total joint replacement. The Program has proven both cost effective and clinically effective. The SEB Board can choose to adopt this as a program overlay on UMP Achieve 1, UMP Achieve 2, and UMP High Deductible.

First of all, we have two bundles. One is underway, one is going to be inaugurated on January 1, 2019. Total joint replacement is finishing up its second year and the second bundle is for spine care.

We anticipate future bundles for years to come. We try and select procedures and conditions that have high utilization; and therefore, there's a greater effect and/or high variability in cost and outcomes. We issue RFPs for a certain procedure, soliciting responses from facilities that are interested in becoming a Center of Excellence. They have adopted, or will adopt, the Bree criteria and have a proven record of great services for these procedures.

Examples of the Bree criteria: appropriateness, conservative therapy; surgeons must begin before 5 p.m. and do a minimum of fifty procedures per year; and member fitness.

Slide 4 – Benefit Design. For both current bundles, we incentivize toward quality. The participation in the Program is voluntary; low to no out-of-pocket cost, except for the CDHP programs due to IRS regulations; in-patient services; implant and durable medical equipment; case management for members from beginning to end; and transportation for those who don't live in the proximity of a Center of Excellence, and accommodations. This is a prospective payment. That is, we have agreed to a case rate for these procedures in the contract, which stabilizes our costs at the Center of

Excellence. There is a 90-day warranty. This is between the Center of Excellence and the Health Care Authority for specified complications over a 90-day period.

Dave Iseminger: The transportation accommodations is for a member who lives outside of 60 miles of a Centers of Excellence. For total joint replacement, the single Center of Excellence in the state is Virginia Mason Medical Center in Seattle. Anyone who lives 60 miles outside of Virginia Mason would have a travel benefit. For the spine care bundle that we're launching, there are two Centers of Excellence. Virginia Mason Medical Center in Seattle and Capital Medical Center in Olympia. Anybody who lives outside 60 miles of either of those Centers of Excellence would have a travel benefit.

Lou McDermott: I know the answer to the question, but I'm asking it so we can understand it. Why is there only one Center? Why aren't there multiple Centers throughout the state? Why didn't we pick one on the East side and the West side to get better state coverage?

Marty Thies: And that was the idea. We do have two for spine care. For the first Center of Excellence, we put out an RFP. We asked for information about their outcomes. And for total joint, the outcomes at Virginia Mason were far and above what anyone else in the state was able to report to us.

Lou McDermott: We did want to spread it throughout the state because we understood that was going to be an issue for some folks. But when the results came in and we looked at complication rates and readmission rates, one of the middle of the road entities had a 15% readmission rate. So 15 out of every 100 people are going back in the hospital to spend more time. And Virginia Mason's rate was .2. So 2 in a thousand. The difference was so stark between Virginia Mason and the other entities in the state that we just could not call another entity a Center of Excellence in good faith and tell our members to go there. The difference was that amazing.

Katy Henry: Can I ask a follow up to what Lou said? Is there a criteria, then that you're basing that on or is it just that Virginia Mason was so much more successful than the other centers that submitted information?

Lou McDermott: The basis for their clinical program is the Bree Collaborative. So the Bree Collaborative has done hip and knee bundles and said if you're going to do this right, you're going to have low readmissions and high outcomes, and you have to do these certain things. That is what's helping to make sure that the right people are getting the right service at the right time and they're prepped and ready for surgery and there's proper follow-up care and all those things are done. To be honest, some people aren't doing a very good job of that. And that's why they're having poor outcomes, which makes sense.

There are areas where the surgeon's done three of these in a year. I don't want to be the first and I don't want to be the third. I want to be the 85th! It's just one of those things where Virginia Mason, in partnership with Bree, has followed those criteria very closely and they're just getting their results. The only unfortunate part is that if someone were to go and be denied by Virginia Mason saying you're really not a candidate because you didn't do x, y, or z, or we don't really think you need a knee replacement, in our program today, they can still go somewhere else and have that done. We're still

evaluating to see if people who aren't qualifying for Virginia Mason are going elsewhere and trying to have the procedure done.

Marty Thies: There were only about eight or ten who were referred by Premera, our third party administrator of this Program, who did not go ahead and have the surgery. Family issues or perhaps they couldn't stop smoking or couldn't get their BMI down to the appropriate level. We haven't checked yet to see if they went and got a surgery elsewhere. That's something we can do.

Slide 5 – TJR Quality and Costs. Outcomes have been exceptional. To date, we have zero readmissions for members who have received their joint replacement at the Center of Excellence and zero complications when we checked the Regence data if they went elsewhere. Member experience surveys are issued 30 days post-discharge. There are a number of questions, one of which is, "How would you rate the overall program?" The average with a 70% response rate was 9.5 out of 10.

Lou McDermott: Marty, what's the total number of people?

Marty Thies: The total was 95 surgeries. We had a 70% response. With regard to cost, members have saved the average out-of-pocket, or ballpark out-of-pocket, year over year somewhere between $800 and $1,000. It depends on where someone goes for their surgery. Each surgery performed at the Center of Excellence was less expensive than those performed elsewhere in the Regence network.
Slide 6 – Recommendation. Our recommendation is that the SEB Board adopts the Centers of Excellence Program for these UMP Achieve 1, UMP Achieve 2, and the UMP High Deductible.

Slide 7 – Proposed Policy Resolution SEBB 2018-51 – Centers of Excellence. The SEBB Program will offer the Uniform Medical Plan Centers of Excellence Program (COE) starting in Plan year 2020.

Dave Iseminger: I want to make sure that I get something very clear on the record. On Slide 6 there are three plans specifically named. The Uniform Medical Plan Plus is not listed, but the recommendation and wording of the policy resolution covers the entire Uniform Medical Plan. The only reason we're recommending launching with just UMP Achieve 1, UMP Achieve 2, and UMP High Deductible in 2020 is we've not been able to reach terms with the networks in the UMP Plus to integrate that payment model and COE within that plan. But if we were, I wanted to be clear that the wording of Policy Resolution SEBB 2018-51 would be the Agency, if we are able to execute contracts with those networks, this resolution would give the authority to immediately imbed the COE Program upon execution of the contracts.

Just a slight clarification about the implementation within three plans, yet the resolution actually, would give authority for all four plans if the contract mechanisms ultimately exist. You're authorizing a program. So for example, now we've described to you the total joint replacement and the spinal bundle. As a result of Policy Resolution SEBB 2018-51, whatever bundle number three is, we would come back and talk with you about its implementation, but you would not have to vote bundle-by-bundle to incorporate it. You're authorizing a program that includes current and future bundles.

And as we describe things to you, if there was a particular concern about implementing, we would obviously address that with you at that time.

Uniform Medical Plan (UMP) Follow Up – Exclusions and Treatment Limits
Shawna Lang, Senior Account Manager; **Kim Wallace**, SEBB Finance Manager
Shawna Lang: We did a comparison of exclusions between the fully insured plans that came in for SEBB and the Uniform Medical Plan. In the comparisons, services that were not compared at all were Health Technology Clinical Committee's (HTCC) determinations because Uniform Medical Plan is mandated to exclude those types of services. If the majority of carriers aligned with UMP, we also didn't have those as anything we looked at either because the majority of carriers looked the same throughout. If we could not contractually change an exclusion then those were also not compared.

Pete Cutler: Shawna, can you explain what you mean by "contractually, the exclusion cannot be changed?"

Shawna Lang: You've heard about substantially similar language between the PEBB Program and the SEBB Program.

Pete Cutler: It's really to stay in alignment with that statutory provision that the benefits have to be substantially similar.

Shawna Lang: Our contractual provision, yes.

Pete Cutler: Oh, it's a contractual provision. Okay, great. Thank you.

Dave Iseminger: Shawna's going to go through some examples. There's only one thing that was knocked out because of that last contractual exclusion piece, just to be clear.

Shawna Lang: Slide 3 – Comparison Results. No services past all of those criteria. It means that the fully insured carriers and the UMP exclusions align. Examples of services that the criteria were applied to are skilled nursing facilities or confinement where the primary use is really a place of residence. Air ambulance if ground ambulance can serve the same purpose. Non-Affordable Care Act (ACA) immunizations and treatment caused after voluntary participation of riots, rebellion, or illegal acts.

Dave Iseminger: What we're saying is, these exclusions as they're described in the Uniform Medical Plan, a majority of carriers aligned with that. We didn't even look at anything that was HTCC related. That was the first cut. These first three are examples of things where there are exclusions in UMP but also the fully insured or majority of carriers had them as well. The last one is the example of something that doesn't completely align with the fully insured carrier proposals, but is contractually required to be maintained because of substantial similarity with the PEBB Program. It should come as no surprise that's a very humorous exclusion, but we are very participatory in our government here in this state.

Shawna Lang: We actually did look in claims and we haven't had any of these.

Lou McDermott: Excellent.

Sean Corry: I have a general question. There are lots of regulations in the insured world with respect to coverage and exclusions, permitted or not. Are there exclusions that come to mind that the insured companies would have in their plans that the self-insured plans do not? Any differences because of regulation or practice?

Shawna Lang: I will say for the most part, UMP tries to follow OIC regulations just to align as much as we can. I can't think of anything outside of HTCC that we don't cover and some of the fully insured's do. I can't think of any.

Kim Wallace: I am going to walk through chiropractic, acupuncture, and massage (CAM) therapy treatment limit data and information you have been considering over the past three to four months. The purpose is to give you an opportunity to think through the data and all the different numbers we presented to you and things that you've considered as you get very close now to determining what type of CAM therapy treatment limits you would like to have in the self-insured medical plan.

Slide 6 – SEBB June 13, 2018 – Fiscal Impact of Increasing Services. The first data we showed you was this chart. Essentially, it was comparing the PEBB UMP Classic treatment limits 10, 16, 16, and 60 with the limits that we named SEBB. That column is the high water mark, the high limits that existed in K-12 plans. We compared, moving left to right, if the limits were to be increased to this higher level that was existing in K-12, then what would we estimate the fiscal impact being for SEBB? We came up with that first $2 million a year figure.

Slide 7 – SEBB July 30, 2018 – Illustration – Changes in Visit Limits. Then you asked for us to consider, rather than just the big leap from current state to 52 and 52, for some gradation, some steps in between. On July 30, we came back and shared Option #21, Option #2, Option #3, and Option #4. Again, these numbers were based on the application of these different treatment limits to the PEBB population in UMP Classic, non-Medicare state active employees trying to get to the apples to apples comparison. What would the impact have been financially on that PEBB population of employees? We used that to predict an order of magnitude change for SEBB. We were careful not say this is what you'll see in SEBB. It's meant to be informative.

Dave Iseminger: We provided a copy of an email exchange between Sean and Kim in your Board briefing materials that are related to that exact page. It directly relates to Option #4. I bring it up because the resolution at the end relates to column four. There's another version of this slide that shows a different number for Option #4. The crux of the question between Sean and Kim was about the assumptions and the linearity of the costs as they went across the table. There was an uptick in the benefit utilization assumption that our actuaries recommended in Option #4 that was higher than in Option #1, Option #2, or Option #3. We produced an alternative version of that analysis without that uptick and that's the other version you see in the email exchange from Kim and Sean.

Pete Cutler: I'm a little slow but are you saying that the $2.30 PSPM, that calculation was done without the assumption that there would be that additional increase in utilization?

Dave Iseminger: Other way, Pete. It includes an uptick because of additional utilization when, for example, a provider feels more confident in saying do chiropractic care because you're going to have it on a more regular basis. The one that's in your email that's part of the exchange between Kim and Sean was if you take out that uptick, then the numbers are lower than $2.38 and $1.7 million.

Pete Cutler: You wouldn't happen to remember that number off the top of your head? I'll research it later.

Kim Wallace: It went down slightly.
Dave Iseminger: It's between $1.30 and $2.30. Sean might remember.

Sean Corry: I don't remember the specifics but with each incremental addition of coverage, the incremental cost went down until the last column, when it jumped way up. I questioned why there would be a reversal of cost for the incremental change.

Kim Wallace: Benefit-induced utilization assumptions.

Sean Corry: Right. So in any case, it didn't seem to make sense to me.

Pete Cutler: We can have this discussion later, but to me, that implies you believe that you don't have a medical necessity standard that would catch that. I do know that there were certain massage therapists who, back in the good old days, were pretty quick to sign off on weekly massages when even the person getting them admitted they didn't think they had a medical issue. I know that can be a problem. But it would seem to me that would be something that should be addressed.

Kim Wallace: Agreed. I think that one of the themes we've been carrying with us through all these discussions in all the different assumptions, is that we wanted to provide a reasonable scenario, reasonable set of assumptions, allowed you to challenge those assumptions. We changed some of them and tweaked them. And I hope that you feel we've been responsive in that way. What we've shown is that when you do change those assumptions and tweak them, such as the benefit-induced utilization rate, you see a change in the estimates. We've had extensive conversations with our consulting actuaries, challenging them, back and forth based on lots of your input and other thoughts we have.

Pete Cutler: Thank you, very much.

Kim Wallace: Slide 8 – Data and Methodology. This slide is also from July 30. It's a review of the caveats and cautions about the data we were using. We wanted to fully disclose and be careful about how we viewed and understood the data and the estimates that we were sharing with you.

Slide 9 – SEBB August 30, 2019 – Benefit Change Impact Analysis Follow Up. On August 30, Kayla Hammer shared our attempt to do the same type of analysis and estimating about changes in treatment limits and the fiscal impact based on the K-12 data instead of based on the PEBB UMP Classic state active data. She reported that we were unable to duplicate that July 30 Option 1, Option 2, Option 3, Option 4 analysis using the K-12 data. She pointed out a couple of interesting things that we saw

in the K-12 data that the amount spent per subscriber on these benefits appeared to be lower, actually, in the K-12 population than in the UMP Classic state active population. She also shared that the average number of visits per claimant, for every person who had a claim, didn't actually reach the 10, 16, 16 limits that exist in the current state scenario matching UMP Classic. Likewise, she reviewed the components that were reviewed to estimate the costs and noted on bullet two that the percentage of members who actually were claimants and the average visit per claimant were both lower in K-12 than in the PEBB state active population in UMP Classic. We saw a lot of variation in the average cost per service.

Slide 12 – Comparison of Treatment Limits – Proposed Fully Insured Medical Plans. You’ve already seen this slide. Just as a reminder, the fully insured plans are proposing to us these limits. It gives you a way at a glance seeing where the current state that HCA is recommending, how it compares.

Slide 13 – Recommendation – Align with Current State for 2020. You've seen this before as well that our recommendation is to align with the current state. And that's the 10, 16, 16, 60. We shared earlier that we felt, if there was a desire to increase the treatment limits, we felt that Option #1 Option #2 would be prudent, increasing to the 16 or the 24. And then increasing the combined therapies to 80.

Slide 14 – Proposed Policy Resolution SEBB 2018-52* - Self-Insured Plans Treatment Limitations. This slide is a proposed policy resolution that's responsive to a request, from Board Members.

Dave Iseminger: We’ve said all along that if there’s something the Board wants to consider, I would much rather work with you to find the best way to write it and have the Board consider an action. Dan and Katy had both requested a resolution and we’ve crafted a resolution. The structure of it changes, Resolutions SEBB 2018-20, SEBB 2018-21, and SEBB 2018-22, which is essentially UMP Achieve 1, UMP Achieve 2, and UMP High Deductible. I make no promises that's the correct order of those resolutions until I get you a crosswalk. But this relates to the three plans that are not UMP Plus. We have multiple contracts. There's three contracts related to UMP Plus. We don't believe that it would be prudent to try and change those when we haven't gotten a commitment from the networks.

The proposal that was requested was to put together something that could increase the treatment limits for chiropractic, acupuncture, and massage to 52. Ultimately, you'll see that there's no bullet related to the PT/ST/OT/NDT combined. The Proposal leaves that at 60, which is part of the original resolutions that were passed. By taking action on this resolution in November, the Board would be making changes to each of those three plans. We provided the structure to you. And again, we won't ask you to take action on this resolution today. This is teed up for you in November. In addition, per the prior presentation where Patty asked, and everyone nodded their heads, we'll show the fully insured medical CAM limits plan-by-plan in the November meeting. That may also further inform your decision as to whether you want to move forward with changes in the self-insured plan or not. We'll continue to tee all of that up so you have the flexibility at the next meeting.

Patty Estes: If we look back to Slide 13, with the PT/OT/ST/NDT being at 80, would that affect that hypothetical plan cost, with it being at 60 instead of 80?

Dave Iseminger: Would that change the numbers below?

Patty Estes: Yes. Because that one says 52, 52, 52, 80.

Kim Wallace: Right. The driver or drivers of the increase cost are in the chiropractic, acupuncture, massage treatment limits, not in the increase of the therapies from 60 to 80.

Patty Estes: Okay, it would probably be miniscule or nothing at all?

Kim Wallace: Call it nominal.

Pete Cutler: Diminimus.

Patty Estes: Okay.

Kim Wallace: I won't say miniscule.

Katy Hatfield: Patty, you can see that on Slide 6.

Kim Wallace: From June 13. We did indicate no change there.

Patty Estes: Oh, okay. Thank you.

Dan Gossett: I brought this forward. It's a placeholder, I guess, that can obviously be changed any time. When I look back to a chart that we received earlier about what school employees' options are right now, there's a wide range. I'll focus in on chiropractic for the record, with our comparables we did, which was Lynden, Seattle, Spokane, and the WEA select plans, when it came to chiropractic in Lynden, it was ranged from 10 to unlimited. In the Seattle School District, it was unlimited chiropractic. In the Spokane School District, it was 12 to unlimited. And in the WEA select plans, it was 12 to 52. The other one where there was a difference but it's hard to do because it's apples to oranges with massage because massage is pulled out in some plans. And in some other plans it is included with OT/PT/ST/NDT. With massage, there's a range because in Seattle, it includes PT/OT/ST/NDT and massage, it's 25 max. In Spokane, it was a 15 to 45 range. In the WEA select, it was 15 to 80. In Lynden, it says unavailable. I'm assuming the data was unavailable in Lynden. I wanted to point that out that people are used to this wide range.

Lou McDermott: When we say our limit is x, they can still exceed that if it's medically necessary? Is that correct? They can do a prior authorization request? An exemption? How does that work, Shawna?

Shawna Lang: Regence would ask for a group level exception and that comes to HCA to either approve or deny. We send it to our clinical team.

Lou McDermott: We use a clinical determination to see if additional visits are valid. So there still is that medically necessary as the backdrop behind the treatment limitation.

Public Comment

Fred Yancey, School Administrators and School Principals. I'd like to thank the committee for all their hard work and expertise. I'm sitting there learning as I go along and learning what I don't know as well. Two comments I'll make and then I'll be done.

The first concern is an example. Your issue of, let me think if I can get a resolution on it. This was the mid-year hires when you were talking about that. It was 2018-32 is the resolution. Your resolutions use the term "school year." And when I read that, I'm very confused. I don't know if you're talking a school year as defined as when kids are in session. Are you talking a fiscal year for a school year because that's why principals and superintendents start on July 1 because that's the start of their fiscal year. I mean, I'm just not sure what that term means. And you bandy it about in every resolution and I would just urge some sort of definition. Usually in RCWs, they have a definition of "school year." It seemed like some people were implying it was when students were present and then when they're gone then are you employed or not? And then I just am not sure what that term means when you use it.

So the other thing is from a consumer standpoint. And I don't know if this makes logical sense but if the baseline program that's been negotiated has an AV of 88%, AV as I understand what the Collective Bargaining Agreement said. Standardization across plans would be my and I think most consumer's preferred option because they're going to be given more choices I believe than we've ever had before. And in terms of comparing things like numbers of visits, annual deductible, copayments, annual out-of-pocket limits, wherever those could be standardized so that you're comparing apples to apples as much as possible, on that 88% AV because I know as the AVs change, then you're going to see the differences because that's how they change. I mean, so I would just urge standardization. And I know the committee was invited to make suggestions on what areas could be standardized if any. And I would urge you to look seriously at trying to standardize as much as possible so that the consumer can make a clear choice. That's all I have. Thank you, very much.

Lou McDermott: Thank you. Barb, do you want to say what we mean when we are saying "school year?" If we know, which I hope we do. Okay, what do we mean?

Barb Scott: “School year" is going to be September 1 through August 31 and that comes from Title 28A. I don't have the citation on the top of my head. And I couldn't find it fast enough. But it is a defined term. We've consistently applied it to mean September 1 through August 31 of each year.

Dave Iseminger: That's partly because in Senate Bill 6241, a definition was added to RCW 41.05.011 that says "school year" means what it means in Title 28A. It's already in statute in RCW 41.05 via the legislation passed last year.

Julie Salvi : Good afternoon. I'm Julie Salvi with the Washington Education Association. First, I wanted to thank Health Care Authority for all the work they've done on eligibility -- that keep coming back and keep getting reworded. I think the two that were re-presented today have come a long way and are addressing a lot of concerns. I

might have just a little bit more input as we go back and reflect on it. One example I can think of is the one that is looking back at the 17 and a half hours per week, the last six of the eight weeks. That averages to 3 and a half hours a day. And in the last eight weeks of school, there is probably by default, two weeks that are partial weeks where somebody who's working just three and a half hours a day will meet that standard if there are no other school weeks that are partial weeks, if there's no other early release day or day for professional development. And so I have a couple ideas popping around in my head about maybe we just make it six of the last eight full weeks or some other way to get to that issue just to make sure that everyone has an essentially equal opportunity to meet that standard.

In terms of treatment options, I just wanted to reiterate what Dan had talked about, that this is something where we are managing a very big change for K-12 employees who have been used to varied systems across the state. And this is one area where what's been out there and been accessible for educators is very different than what is being talked about in terms of limits here. When I look at the dollar impacts, I don't want to speak too lightly about those dollar impacts. But at the same time, they are relatively small in the scheme of the whole that is being offered. And when I see information, the presentation that talks about the per subscriber is less in K-12 than what was seen in UMP, it makes me wonder if we can accommodate within the same dollar amount that, say, UMP experiences. If we can accommodate a slightly higher treatment limit just because maybe the demographics are different.

There are a lot of moving parts as you consider everything that you can fit into your benefit amount. And while there was information that was provided that the average usage was within the limits that were being considered in terms of comparing to the UMP, what I would like to see is the numbers - if there is this information available - the numbers of people who are using above those limits. How many people are we talking about who might really be utilizing above what those limits are today and what might that impact be? So thank you for your time and consideration.

Next Meeting:
November 8, 2018
9:00 a.m. – 5:00 p.m.

Preview of November 8, 2018 Meeting
Dave Iseminger, provided a preview of the November 8 topics for discussion.

Lou McDermott: The SEB Board will return to Executive Session for the same reasons read earlier in this meeting.

Next Meeting

November 8, 2018
9 a.m. – 5:00 p.m.

Meeting adjourned at 4:07 p.m.

Washington State Health Care Authority

School Employees Benefits Board
Meeting Minutes

DRAFT

November 8, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 p.m. – 4:30 p.m.

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

Member Absent:
Sean Corry

SEB Board Counsel:
Katy Hatfield

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

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

October Board Meeting Follow Up
Dave Iseminger, Director, ERB Division: There are two pieces of follow-up information from the last Board Meeting and other questions will be answered during staff presentations. Slide 2 is the link to the collective bargaining overview you requested from Megan Atkinson's and my presentation.

Slide 3 addresses the inconsistencies we had in October when we were referencing UMP Achieve 1 and UMP Achieve 2. This is a handy chart that clearly indicates which plan is UMP Achieve 1 and which plan is UMP Achieve 2. Also listed are the AV values, the deductibles, and the crosswalk to the original resolutions the Board passed in June 2018. The CBA presentation in October had the plans backwards. The October afternoon presentation about the fully insured plans was correct.

Fully Insured Medical Benefits

Lauren Johnston, SEBB Procurement Manager. Today's objective is to present plan designs for action later today. Slide 3 – Follow Up From October 4 Meeting. A question was asked about whether or not vision exams are required to be provided in an HMO. The answer is no. There is no provision that requires vision exams to be covered.

Another question was about limits to the neurodevelopmental therapies benefit. It's combined with the rehabilitative benefit. The answer from all carriers is there are no limit to neurodevelopmental therapies when billed with a mental health diagnosis.

A question was asked about the percentage of Public Employees Benefits Board Program members enrolled in the PEBB Consumer Directed Health Plan (CDHP). As of October 2018, 9% of eligible PEBB Program members are enrolled in a CDHP (25,582 total members). Eligible members excludes Medicare enrollees.

Slide 4 – Plan Design Refinement Process. Previously, there was a lot of variability between the plans when it came to accumulators, which includes the deductibles and maximum out-of-pocket, and also the actuarial values. One concern we heard from the Board was that you wanted less confusion from members when it came to open enrollment. We worked with the carriers to refine their plans to provide a portfolio where members had enough options, but not so many that they would be overwhelmed and confused during open enrollment.

Slide 5 – Plan Actuarial Values (AV). This is a slide of data visualizations to give you a side-by-side look at plan actuarial values. The Providence High Deductible Health Plan is a qualifying HSA, but the AV is yet to be determined. If you go across the slide, you can see they have a similar trend. The plans considered the "1" plans have a lower AV around the 80% mark. The plans within the "2s" are around an 84% AV. The plans in the "3s" and Kaiser's KPWA's "4" plan is around the 88% to 90% AV range.

Dave Iseminger: We don't anticipate long-term that the plans will be carrier "insert number," but for now, we didn't want people to get too attached to a specific name. I wanted to assure you that the long-term plan isn't to have it be Premera 1, Premera 2, KPWA 1, KPWA 2, KPWA 3, KPWA 4. We made it simpler for purposes of where we are today.

Lauren Johnston: Slide 6 – Medical Deductible Levels: Single Subscriber and Family. The green bar is the single subscriber and the blue bar is the family deductible. We were looking around four deductibles. Either $125, $250, $750, and $1,250, with the outlier being the Providence HAS proposed. They have a higher deductible because they're the only HSA offered.

Slide 7 – Medical Maximum Out-of-Pocket Levels: Single Subscriber and Family. The single subscriber is the green bar and the family is the blue bar. We noticed a trend of a two-to-one ratio for single subscriber to family. We asked that they keep within that trend.

Slide 8 – Drug Deductible: Single Subscriber and Family. For the drug deductibles or the pharmacy deductibles for a single subscriber and family, the plans between Aetna 2 and KPWA Option 1, there is no pharmacy deductible for either the single subscriber or the family. That means there is first dollar coverage on prescription drugs. If I were to go to the pharmacy and get my prescription, I would not have to meet a deductible prior to paying the copays that you will see later in the presentation. The Premera plans have a deductible for both the single subscriber and the family at different levels for the two different plans.

The Providence 2 plan deductible for the single subscriber and the family is combined with medical. If a member has a $50 deductible left and their drug costs $50, they would pay the $50. But, the next time they go in, the member would pay the coinsurance or the copay on the drug.

Dave Iseminger: I want to highlight one of the variances because I know it was something the Board was interested in. When it comes to the drug deductible, the self-insured plans that the Board has so far given authorization to back in June had a $100/$300 drug deductible in one of the UMP Achieve plans. In the other UMP Achieve plan, it had a $250/$750 drug deductible. Depending on what the Board's thoughts are around alignment, there's more variance introduced here via Premera's proposa. Does the Board have any thoughts or concerns about that?

Terri House: I thought we had talked about, in the other plans looking out, having the drug deductibles aligned with the UMP plans? Didn't we discuss that?

Dave Iseminger: We have talked with all the carriers about what we believe is a preference from the Board to not have separate drug deductibles, or if there are separate drug deductibles, to align with being no higher than the highest in the Uniform Medical Plans that the Board has approved. I wanted to highlight for the Board that most of the plans meets that requirement and a couple do not. If that's something the Board wants to work on further with Premera, it would be helpful for us to get that guidance today.

Terri House: Could we ask for that?

Dave Iseminger: We could certainly ask for that. In fact, if that's something the Board wants, when we get to the resolutions in the afternoon, you could proceed and ask for the rate development with the plans that are proposed, and in addition, ask us to work with Premera and do a rate build for one that does not exceed the $250/$750 maximum that's in the UMP.

Pete Cutler: I definitely would like to see closer alignment with the UMP as in nothing above the UMP level. I think school employees are going to be swamped with far more choices than they've had before, and certainly than state employees have had to deal with. Anything we could simplify would be helpful. For example, on Slide 6, I think it would be more accurate to show an extension of the bar that labels the prescription drug deductible, because, if you have a mix of prescription drug costs and other services, this understates how much you're going to have as an out-of-pocket cost

before your coinsurance kicks in. I think something that graphically shows that you really are talking about an extended or double deductible situation. I would appreciate understanding what the policy motivation would be for having a separate prescription drug deductible rather than having the prescription drug costs dealt with, as in most plans, as just part of the overall deductible. I definitely would like to see it. If there is going to be a separate prescription drug deductible, it should be no higher than the UMP.

Dave Iseminger: Pete, to that question, I anticipated in the last day or two that there might be some questions about more policy reasons for separate drug deductibles and was working on being able to provide even more information today. But, again, it's just 90% of the homework. I think there's plenty of time to continue that journey. As we work on these refinements, we'll bring back to the Board some further discussion about the reasons and motivations for having separate drug deductibles. We are also anticipating a more robust pharmacy discussion with the Board over the next couple of months that will be a good opportunity to talk about that policy position.

Pete Cutler: Thank you.

Dave Iseminger: I want to reflect one piece in the conversations I've had with Premera that I think is important information for the Board to know. One of the reasons Premera wanted the proposal to be as it is, they felt it best aligned with their experience with K-12 members and it would be a very familiar plan design that school employees would experience. We are entering a new world where there's a lot of changes and shock going into this system for the amount of premiums people are going to be paying and affordability for dependents. I did want to convey their experience is one of the reasons they were so interested in this plan design. We will work with them to both assess these plan designs from a rate development standpoint, as well as something that more aligns with UMP. I'm seeing head nods in addition to the comments that were made.

Lauren Johnston: Slide 9 - Medical Coinsurance. This slide lists coinsurance for in-network coverage and the coinsurance for out-of-network coverage for all of plans. The majority of them are in the 20% range, with one being at 15% and another 25% for in-network coverage. The out-of-network coverage, you'll see more on the HMO side, the member would have 100% because you are completely outside of the plan's network. The others have a higher cost sharing compared to their in-network coverage.

Slide 10 – Plan Treatment Limitations. This chart lists plan treatment limitations for chiropractic, acupuncture, massage therapy, and a rehabilitative benefit, which is occupational therapy, physical therapy, speech therapy, and neurodevelopmental therapy (OT/PT/ST/NDT). We asked Aetna if they could separate their massage therapy benefit from their rehabilitative benefit combined number of visits. Unfortunately, their systems are unable to do so. However, they could increase limits if the Board wished.

Dave Iseminger: We'll keep that in mind for the refinement process. As it stands now, the current chiropractic, acupuncture, and massage (CAM) therapy limits within the

UMP designs the Board authorized is 10 for chiropractic, 16 for acupuncture, 16 for massage, and combined 60 for the OT/PT/SD/NDT.

Lauren Johnston: Slide 11 - Providence HSA Plan – AV TBD. The AV is yet to be determined. This is a preferred provider organization (PPO), so there's not necessarily a limited network that the member would have to go through. There are a number of providers available. The deductible single subscriber/family would be $1,750 for a single subscriber and $3,500 for a family. The coinsurance is 20% for in-network and 50% for out-of-network. The maximum out-of-pocket is $5,000 for a single subscriber and $10,000 for a family. For pharmacy, the deductible is combined with medical for a single subscriber and family, $1,750 and $3,500.

Pete Cutler: Quickly, on Slide 8 for Providence HSA, it shows a separate pharmacy deductible that doesn't show it as combined. Slide 11 shows it as combined.

Lauren Johnston: We left the numbers in there so you could see it's fairly higher than the rest of them. But it should be combined.

Pete Cutler: Combined. Okay, great. Thank you.

Lauren Johnston: The coinsurance for pharmacy for generic drugs is 20%, for preferred drugs is 20%, non-preferred is 50%, and specialty is $50. Any cost share a member would pay towards their drugs accumulates towards the maximum out-of-pocket listed under the medical. It would either be towards the $5,000 or the $10,000.

All services, emergency room, hospital inpatient, hospital outpatient, primary care, specialty, and urgent care, are all at 20% coinsurance. There's no copay on those services. There's the 20% coinsurance and they are all subject to the deductible. You have to meet the deductible prior to paying the 20% for each of those.

Dave Iseminger: We're not going to go through every plan slide like Lauren just did. We'll go to the comparator slide. The AVs at the top are always estimated, so we rounded. Don't get hung up on the precision of those pieces. As you flip through slides 11 to 26, you'll notice the change in color. All of Premera's are yellow, all of KP Northwest's are green, all of Providence's are purple. It was another way for you to have a snapshot to easily know which plan you were looking at. You could mix and match your slides to put all the yellows together and sort by carrier, etc.

Lauren Johnston: Slide 12 – Premera Plan 1 – 80.8% AV – PPO. For medical, single subscriber versus family, their single subscriber deductible is $1,250 and the family deductible is $3,125. The coinsurance for in-network coverage is 20% and 50% for out-of-network coverage. The maximum out-of-pocket for medical services is $5,000 for a single subscriber and $10,000 for a family.

There is a separate deductible under the pharmacy benefit the member would have to meet; $500 for a single subscriber and $1,250 for a family. The deductible is waived for generic pharmacy coverage, which means if you have a prescription for a generic drug, you would only pay the $7 copay instead of having to meet your deductible before

getting to that $7 limit. The generic for the copay is $7, preferred drugs are 30%, non-preferred is 50%, and specialty is 40%. That is what the member would pay. The maximum out-of-pocket for pharmacy is the same as the medical. It accumulates towards the medical maximum out-of-pocket. Whatever you spend on your drugs goes towards either the $5,000 or the $10,000, as well as your medical services.

Other benefits, like an emergency room visit, has a $150 copay plus a 20% coinsurance. For hospital inpatient and outpatient coverage, the subscriber pays 20% and primary care is a $20 copay. For specialty care, it's a $40 copay, and urgent care is a 20% coinsurance. Some services are subject to the deductible, so you need to meet the deductible prior to paying what your member cost share would be. The two exceptions for office visits for primary care and specialty care. You would pay either the $20 copay or the $40 copay and wouldn't need to meet your deductible first.

Dave Iseminger: Lauren is going to transition to the comparator slide and not go through the next 15 slides in the same manner. We wanted you to have a snapshot of the plan to be able to see how the inner workings of each plan works. Slides 11 through 26 are in order by escalating AVs, just like the very first visualization.

Lauren Johnston: The new SEBB Program medical benefits comparison chart includes the fully insured plans as well as the self-insured UMP plans. These plans are subject to legislative funding and final decisions by the SEB Board.

There are several levels of deductibles. The levels are either $125 or $250, $750 and $1,250. Aetna decided to present two plans, one at the $750 deductible level and one at the $1,250 deductible level. Their maximum out-of-pockets are $3,000 for a single subscriber and $6,000 for a family, and then $5,000 for a single subscriber and $10,000 for a family. The coinsurance for both plans is 20%. In general, unless you see something different within the plan design below, a member is going to pay 20% for in-network coverage.

I already discussed deductibles. It's the same thing with the maximum out-of-pockets. The majority of them kept a two-to-one ratio. The same applies for the UMP plans. They have a two-to-one ratio. The coinsurance across the board for in-network coverage is 25%, 20%, and 15% for all plans.

Air ambulance is 20% across the board, regardless of the plan you select. There is a 20% coinsurance on your ambulance for either air or ground per trip, with the outlier being Premera 1 Plan at 25%. There are other outliers in primary care, which are not on the chart - all of the Kaiser plans have a $0 copay for children 18 and under.

Dave Iseminger: Also, you'll see that for the networks in the Uniform Medical Plan Plus, the farthest right column, there is also that emphasis on access to primary care that similarly has a $0 cost share. That's the yellow primary care row on the far right under UMP Plus. Plan 4 under Kaiser Washington on the PEBB side is called SoundChoice. It was introduced at the same time as the Uniform Medical Plan Plus was introduced on the PEBB side. That's why those benefit designs tend to align.

You might question the four plans within Kaiser Washington and why nobody else has four plans, other than UMP. When we get further into service area, Kaiser Washington's proposed service area will not have overlap between Plan 3 and Plan 4. It would be one or the other. It's similar to the limited service area concept that exists within UMP Plus, which is the only UMP plan that is not statewide.

As you look at this, do you have concerns? Should we focus on trying to standardize this more? If you think of anything today, let us know. We still have multiple months to go through the refinement process. If you identify anything in particular in the next month or two as we move towards a rate build, it would be important to understand if there's other things that you're concerned about trying to align better.

Patty Estes: On the mental health visits, I know some plans have limitations. Is there a way to find out those for the future? I forgot to ask at the last meeting if any of the plans have those limitations. I know that it has copays on here, coinsurance, all that. But do they have limitations on how many visits you can have?

Lauren Johnston: We can confirm that information and bring it back.

The second page is for the pharmacy comparison. The Aetna plans and the Kaiser plans have no pharmacy deductible, whereas Premera has a separate pharmacy deductible, and the Providence plan pharmacy deductible is combined with their medical deductible. The UMP deductibles are there as well, the $250/$750, $100/$300. The UMP High Deductible is applied to the medical deductible and then there is no drug deductible for UMP Plus.

Dave Iseminger: We provided an updated version of this slide and it is slightly different from the one that was in the original Briefing Book materials, as well as the one that's on the website. We'll get the website updated in the next couple of days. There were four particular cells updated to be consistent with the rest of the materials you were provided, and that is under Providence's plan under the prescription deductible. The version on the website and the one you previously received had the word "none" rather than reflecting it was combined with the medical deductible. That really is the difference. The other plans that don't have a deductible, there's first dollar coverage and Providence's is combined. That's one of the areas that was updated.

The second area that's updated is under retail Tier 3, the next to last row on the far right in UMP where it says "50%, 50%, 15%, 50%," that first 50% and second 50% on the original slides reflected “10% to 50%,” in fact, it’s actually just 50%. I wanted to draw attention to those and make sure it was very clear what the corrections and updates were that prompted us to give you a new version today. And we'll get that up on the website.

Pete Cutler: Patty's question about mental health services rang a bell with me that, in some areas, and prescription drugs comes to mind, it's not just the cost share that's an issue in terms of member access, but there's also questions about medical management practices of different carriers. For example, is a step therapy approach required for access to non-generic or non-formulary drugs? I think that's what Patty was

getting at with behavioral health or mental health. While there is both federal and state mental health parity legal requirements, there are different mechanisms that plans use to deal with or try to influence utilization. Some would say to try to discourage utilization. Are we going to get an overview of that kind of information down the road, specifically with mental health and with the prescription drug benefit?

Dave Iseminger: Pete, we can definitely work on providing that information to the Board. These are the types of questions that would be very worthwhile for us to have and bring to the Board in the next couple of months while we're waiting for the final funding. It could inform refinement without actually teeing up votes on trying to get too precise until the funding answer comes in. We can talk more about the utilization management practices across the plans of step therapies, any behavioral health limitations, and those sorts of things. If there are other topics you want information on, send them to me so we can put them into the pipeline for the January and March meetings. We can work on the description and how it would work in the fully insured plans and the UMP.

Pete Cutler: And that certainly meets my needs. Thanks.

Dave Iseminger: I know there's concern about the number of plans that might be in the portfolio and how information would be presented. This was our first attempt to show some of the out-of-pocket impacts that members would experience. What are your thoughts about the digestibility of this information? This obviously isn't the only thing that we'd be sending out to members, but we're trying to think of different tools. For purposes of bringing it here at this point for this Board, we came up with this, hopefully high enough level, chart to try to compare. It also represent the breadth of options that could be on the table at the end of the day. What are your thoughts as you visualize for the first time, essentially, what 16 plans in a portfolio looks like?

Katy Henry: I think it's easy to read this way. It's nice that you can get it all laid out in one place. I think the size of it might be cumbersome for people, but being able to see it all at once, I know that it's what our district is used to. We have it all laid out in the same fashion. It would be nice to be able to have it replicated.

Patty Estes: I second that. This is pretty much exactly what we got when we switched over to PEBB and it was very easy to understand. Obviously, people have more questions about premiums and more specific questions that we can't answer yet. But I think the way this is laid out is perfect.

Lauren Johnston: Side 27 – Recommendations. HCA recommends moving forward with the fully insured medical portfolio presented today for rate development to see where rates fall for different plans and AV levels. Once the funding is set by the Legislature, next summer the Board will vote on 2020 employee premium contributions for the SEBB Program's offerings, and refinements to plan designs can continue until the Board votes on 2020 employee premium contributions. It falls in line with asking Premera to refine their drug deductibles.

Dave Iseminger: For clarity, even though I'm the one who wrote that last sentence, I realize it could be even more precise. Obviously, you won't be able to change the benefit design and vote on premiums on the same day. There will be a stair step from that because we will have to push things through the system. It'll be pretty close. You'll be able to do refinements after the legislative budget comes in. If that's in April, you'll be able to do that in the May/June area and maybe even early July. We then run things through all the models and bring that information to you towards the end of July. I don't want to give false precision that on the day that you vote on employee premiums, you would also be able to change benefit design. There will be a finite stopping point, but there will be meetings in the spring where you can do some refinements.

Lauren Johnston: The policy resolutions all say the same thing. The only thing inserted differently is the policy resolution number and the carrier name.

Dave Iseminger: These will come before you this afternoon for action. We talked about this at the last meeting that we weren't ready to show you where all the benefit designs were. We talked about the journey of where they were in Executive Session. We got your insight for further refinement. We brought them to you this morning hoping there would be time later this morning for you to reflect and ask questions, and ask you to take action in the afternoon. We purposely put action in the afternoon to give you as much time as possible reflect on these pieces today.

Pete Cutler: On the very first one, that's the particular plan that involved prescription drug deductibles larger than the UMP. It seemed we had several Board Members who supported the idea of not offering a plan with a higher prescription drug deductible than the UMP. Would you anticipate to convey that this would be a mandate as it's shown on page 28 to show that, or is that something that could be dealt with just as being in the minutes and then have your discussions with that?

Dave Iseminger: For clarity, Pete, I believe you mean Policy Resolution SEBB 2018-49 with Premera.

Pete Cutler: Premera, you're right.

Dave Iseminger: You could do it either way. I think it's sufficient if the Board is interested in seeing what the rates would look like, but at the same time, want a third plan design for Premera that better aligns the separate drug deductible, the $250/$750. You could either amend the resolution and we could work on some of that language to bring that to the Board this afternoon if you want it in the actual resolution. Or, I'm also comfortable if you want to just put it on the record as you're taking action on that resolution. I feel that's sufficient as well. It's either way. If there's consensus among the Board that you want it in writing, I could have people work on that now. If you want to put it on the record verbally, then they don't have to do that work in the next couple of hours.

Terri House: I would feel better if it was in writing.

Katy Henry: I agree.

Dave Iseminger: Lots of head nods. We will get to work on a refined version of Policy Resolution 2018-49 to allow them to go forward with the rate development of the two as presented, and an alternative that does not have a drug deductible higher than $250/$750. Thank you for that insight.

Wayne Leonard: If you go back to Slide 27, it talks about the second bullet point, once the Legislature sets the funding. Could you refresh me on the timeline on that? I'm particularly interested in when you think we will know what the legislative funding level is going to be? In terms of the K-12 individual school districts doing their budget, they start in the spring, and most adopt their budgets in summer. I don't think they need to know, necessarily, the premiums, but they would certainly need to know the funding level.

Dave Iseminger: I'll answer for now, we're also planning a more robust discussion about what the next six months looks like from a funding perspective at the December meeting. You've heard me talk about the chapters of the Board's work. We're coming up on the conclusion of Chapter 3. Chapter 4 includes legislative funding and the full rate development process. We have a much more robust presentation about that. But, in general, first the Governor's budget will come out in mid-December that will have a proposed funding rate that will be a starting point for the conversation as legislators come to town. HCA will be working on a rate development with the fully insured plans and the build of the rate development for the self-insured medical plan. Our goal is to have that completed by the end of February so we can provide that to the Legislature at the beginning of March. The chambers typically release their budgets in the later part of March, after the March revenue forecast for the state. Those proposals will be the biggest indicator of the funding rates, as to what the final solution is.

The regular session ends the end of April. History has shown that we sometimes get our budgets in April, sometimes in May, and sometimes in June. I think we're all very hopeful that we'll have that on the earlier range of that timeline. After the funding rate comes in, we'd be able to take the bid rates from the plans and shape out the employee premium contributions that we would bring to you. But that funding rate would also be the final indicator for local districts.

[break]

Vision Benefits

Lauren Johnston, SEBB Procurement Manager. The objective for today is to take action on the plan designs presented at the October 4, 2018 Board Meeting. Slide 3 – Follow Up from October 4 Meeting. A question was asked if there was a premium tax. On the fully insured plans, the answer is yes and it's 2%.

Slides 4 through 6 answer the question of the number of providers in each county by carrier. Providers are not unique to the carriers. This is the number of providers each carrier has in a county. At a previous meeting, you did see unique provider counts by county.

And lastly, there was a question of how much member disruption regarding providers will there be? HCA encountered some data limitations for this question. However, we feel that if all three of the apparently successful bidders are selected to move forward, the disruption is likely to be minimal.

Dave Iseminger: On the provider point, the carriers are all in the midst of seeing what they can do about expanding their provider networks and we've asked them for updates from the vision providers at the beginning of February. Some of these things could change a little bit, but this represents where they are today. If they're successful in further expanding their networks, that would minimize disruption even further.

Lauren Johnston: Slide 4 – Davis Vision Provider Coverage – By County. King County, which is the darkest blue, has the most providers, and it goes to through to the lightest blue, which I believe is Stevens County with one provider.

Dave Iseminger: There are providers everywhere but Columbia and Garfield Counties. We've asked the carriers to make it a priority to try get providers in their networks so there are providers in each county for each carrier. We've also provided them with what looks like the population distribution of K-12 and asked them to work on having similar provider member ratios for the populations in each county as well.

Lauren Johnston: Slide 5 – EyeMed Provider Coverage – By County. This map has the same set up as Davis. King County has the most providers, and Klickitat and Skamania Counties are the lightest with one. Slide 6 – MetLife Provider Coverage – By County. MetLife has providers in every county except for Columbia and Garfield Counties, which are the two counties with no vision providers for anyone.

Some things to consider as you take action on the resolutions is regarding the members purchasing experience and what their out-of-pocket costs will be, the premium tax paid on the fully insured plans, and then the additional reserves that would be needed if providing a self-insured plan.

Dave Iseminger: These were the same considerations mentioned in September. Obviously, the premium taxes paid on fully insured premiums wouldn't be a line item members would see. There was a question from the Board about having a self-insured plan. We brought forward fully insured plans only because of the need to build up reserves on a self-insured plan.

Lauren Johnston: Slide 8 – Recommendation. The recommendation today is to offer fully insured group vision plans for eligible school employees through Davis Vision, EyeMed, and MetLife.

The stakeholder feedback we received on the resolutions was positive. They agree with having a separate group vision plan for these carriers.

Lou McDermott: We will vote on the resolutions individually.

Katy Hatfield: I wanted to point out there is an appendix that shows what was presented on October 4 if people need to see that.

Lou McDermott: **Policy Resolution SEBB 2018-40 – Fully Insured Vision Plan (Davis Vision)**

Resolved that, beginning January 1, 2020, the SEBB Program will offer a fully insured vision plan by Davis Vision as presented at the October 4, 2018 Board Meeting.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-40 passes.

Policy Resolution SEBB 2018-41 - **Fully Insured Vision Plan (EyeMed)**

Resolved that, beginning of January 1, 2020, the SEBB Program will offer a fully insured vision plan by EyeMed as presented at the October 4, 2018 Board Meeting.

Dan Gossett moved and Patty Estes seconded a motion to adopt.
Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-41 passes.

Policy Resolution SEBB 2018-42 - Fully Insured Vision Plan (MetLife)

Resolved that, beginning January 1, 2020, the SEBB Program will offer a fully insured vision plan by MetLife as presented at the October 4, 2018 Board Meeting.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-42 passes.

Fully Insured Dental Benefits

Beth Heston, PEBB Procurement Manager. Today's objective is to take action on the fully insured dental plan designs presented at the October 4 Board Meeting. There is an appendix to show you what was presented on October 4.

There were a few questions from the Board that I'll address first. There was a request to evaluate capping both the fully insured dental plans' orthodontia coverage at $1,750

lifetime to match the Uniform Dental Plan. Our actuaries and finance staff found that the change would not generate sufficient annual premium dollars to increase the long-term disability basic benefit because the enrollment in the fully insured plans is not projected to be that high.

Dave Iseminger: We had discussions with both Willamette and Delta, everyone's actuaries, and everybody's finance people. The experience when looking at K-12 enrollment in dental is that there is a predominant movement towards a PPO plan. Since the Uniform Dental Plan would be the only PPO plan in the mix, the lion's share of the enrollment is projected to be in the Uniform Dental Plan, which already has a cap of $1,750 per lifetime. In the PEBB Program, the experience is also that the lion's share of enrollment is in the Uniform Dental Plan. Everyone agreed with the enrollment assumptions, and because of the enrollment assumption projections that were mutually agreed to by everyone, it didn't pan out as an option for a horse trade.

Beth Heston: The current enrollment in PEBB is 80% in the PPO. The second request was to evaluate removing orthodontia from all dental plans, self-insured and fully insured. We found that this change could generate sufficient annual premium dollars to support a basic long-term disability benefit increased to about $1,000 a month.

Dave Iseminger: But we continue to recommend, as we did before, the inclusion of orthodontia within the dental plans. The resolutions that the agency has brought forward for action today don't make this horse trade. If this is something the Board is interested in doing, that would be something you could move as part of the resolution process.

Beth Heston: The next question was how many dentists are accepting new patients in all of the plans. On Slide 5, the overwhelming majority of dentists in all three plans are accepting new patients. We shouldn’t have an issue with SEBB Program members being able to find coverage.

There were a couple of supportive comments from stakeholder, no comments that disagreed or needed to be addressed. Our recommendation is to offer the fully insured dental plans as presented at the October 4 Board Meeting.

Lou McDermott: **Policy Resolution SEBB 2018-43 - Fully Insured Dental Plan - DeltaCare**

Resolved that, beginning January 1, 2020, the SEBB Program will offer a fully insured dental plan by Delta Dental, with the same coverage services and exclusions, same provider networks, same clinical policies, and same copays as the DeltaCare under the PEBB Program.

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

Pete Cutler: I just want to thank staff for pulling together the information in response to the questions from last meeting.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-43 passes.

Policy Resolution SEBB 2018-44 - Fully Insured Dental Plan – Willamette

Resolved that, beginning January 1, 2020, the SEBB Program will offer a fully insured dental plan by Willamette Dental Group, with the same coverage services and exclusions, same provider networks, same clinical policies, and same copays as the Willamette plan under the PEBB Program.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-44 passes.

Policy Resolutions

Barb Scott, Manager, Policy, Rules, and Compliance Section. There are two policy resolutions before you for action today. SEBB 2018-32, midyear hires anticipated to work 630 hours in the next school year and SEBB 2018-36, eligibility presumed based on hours worked the previous two school years, were both reintroduced at the October Board Meeting. The title was changed slightly in order to include the two-year requirement, which was a portion of the policy proposal itself when it was reintroduced to you. We've included versions of both of these policies as they were presented at the October meeting in the appendix.

Policy Resolution SEBB 2018-32 – Mid-year Hires Anticipated to Work 630 Hours in the Next School Year. This resolution will allow employees who are hired midyear to be eligible for the employer contribution toward SEBB benefits if they are anticipated to work at least 630 hours in the next school year and they are a nine- to ten-month employee anticipated to be compensated for at least 17.5 hours a week in six of the last eight weeks counting backwards from the week that contains the last day of school, or a 12-month employee who is anticipated to be compensated for at least 17.5 hours a week in six of the last eight weeks counting backwards from the week that contains August 31, the statutory last day of school.

I know this sounds really complicated, and so what you're going to find as we move through this, I'm going to talk to you about stakeholder feedback we've received. I've also had staff add some calendar charts to the examples for you so that we can see

how this plays out. This was shaped based on the feedback received from stakeholders in order to ensure we're clear. And we also covered what we'd been asked to consider.

Dave Iseminger: I want to level set. There are some changes on the page for clarity purposes, but substantively, this is the same resolution presented in October. There's been refinement on the substance prior to October. From October to today, there's more technical clarification, but substantively similar policies. Barb will go through feedback that requested substantive changes as well as clarification changes. We've only made the clarification changes and Barb will go through why.

Barb Scott: A lot of it had to do with clarity and trying to make sure we had a shared understanding of how this would function as far as, are we the 17.5 hours, versus a 3.5-hour, versus the 52-point-something that we came to you with originally. Really, what we've got it down to is this last set of revisions that had to do with adding some clarity on how we expect this to be administered based on the questions we received as we worked with stakeholders.

This policy was originally introduced to address stakeholder concerns that 12-month employees hired to work full time, beginning on July 1, would not become eligible for the employer contribution toward SEBB benefits until the beginning of the next school year. We believe this version of the policy addresses those concerns that we received from stakeholders. The feedback included one stakeholder requesting greater clarity regarding partial or full weeks and another stakeholder recommending we use full weeks and remove the word "partial." In this version, we removed both full weeks and partial and are now counting weeks. We also had a request to define the word "week." Although we're not going to bring a definition of the word "week" to the Board for action, we will make certain it is understood that "week" is Sunday through Saturday.

Dave Iseminger: We'll codify that in our rule making exercise in the definition section, but the Board doesn't need to take action to define the word "week."

Barb Scott: Correct. Another stakeholder supported the resolution as written, but requested that we have tools to assist staff in determining eligibility as it is becoming more complex. We agree. We're now into the eligibility that will be more complicated to administer. We did assure them that we plan to have worksheets and other tools to assist them in their eligibility decisions.

Dave Iseminger: We also have staff available here at HCA for questions, especially in complex eligibility situations. We do the “train the trainer” model where our centralized staff help local benefits officers understand the rules. But, if they come across something where they are uncertain how it fits, they have access to an in-person resource here to help them through those complex areas. This is in addition to tools that we create that are more self-service.

Barb Scott: Another suggestion was to replace this policy with one that would allow any employee hired as of April 1 that is anticipated to work 630 hours in the next school year to be eligible. A stakeholder requested that school employees, hired late in the school year and work 3.5 hours per day, receive benefits at the start of the next month.

We did not bring forward a resolution to the Board to consider allowing any employee hired as of April 1 to receive benefits because that was substantially much more generous than the policy we have been developing as far as eligibility is concerned. The 3.5 hours per day, as we worked through this with stakeholders, would be very difficult based on some of the employees that were trying to be addressed in this because not every employee might work 3.5 hours every day. They might work the full 17.5 hours within that work week, and so that's why we stayed with the 17.5 hours per week, which is before you today.

Dave Iseminger: Some people thought the standard should be about days, some thought about months, and weeks hits the average.

Barb Scott: Example #1. The only change was to remove the concept of full impartial weeks from the example itself. In addition, after the word "example" in that first sentence, staff inserted that these employees are coming from out of state. You'll see that pattern within all of the examples related to this particular policy resolution today. As we start to apply all of the Board's eligibility decisions made to date, and as we determine eligibility going forward into the future, whoever's doing that determination will walk through an exercise to evaluate each eligibility standard and decide whether or not the employee gains eligibility through any one of them. We wanted to make sure in these examples that we aren't trying to apply the eligibility that was already decided by this Board, which was if I am an employee who works in SEBB Organization A and I move to SEBB Organization B in the middle of the year, I get benefits under certain conditions. To take that complexity out of these examples, staff inserted states in the examples. For this example, this is a new employee coming from Oregon. They're hired as a principal. This person is not moving from one SEBB Organization to another. They're brand new.

In this case, the employee is not anticipated to work 630 hours during the current school year because of the time of year they're hired. Her first working day is July 1, 2020, and the current school year ends August 31, 2020. She is anticipated to work at least 17.5 hours per week for at least six weeks in the last eight weeks of July and August 2020. She becomes eligible for benefits July 1 and her coverage would actually begin August 1, 2020 based on Policy Resolution SEBB 2018-12, first of the month following the date of hire.

Slide 6 is a calendar to see how to apply eligibility. In Example #1, you start counting back from the end of the school year. Looking at the week that contains August 30 and 31, you count eight weeks back, which has been shaded back to the week of July 12 through July 18, and that's your eight weeks counted back. In this case, as long as the employee has six out of the eight of those weeks with 17.5 hours, the employee is eligible. If they were less than that, they would not be eligible. You'll see that pattern throughout these examples. This happened to be a 12-month employee example.

Example #2 is a bus driver coming from Idaho. Again, full and partial weeks is taken out and the language changed a bit based on that. Slide 8 is the chart on how this would play out for a nine- to ten-month employee. You count back from the week just before summer break. In this example, the last day of school was June 18, so you

count back from the week of June 14 through June 20. Eight weeks takes you all the way back to the last week of April. As long as the employee works six out of the eight weeks and has 17.5 hours in each of those weeks, and as long as the employee is anticipated to be at least 630 hours in the upcoming school year, they would meet the eligibility criteria.

Katy Hatfield: Barb, could you explain the difference between the resolution language "anticipated to be compensated" versus the example's use of "anticipated to work?"

Barb Scott: Yes. The last time I brought this proposed policy resolution to you, we talked about this being the one eligibility proposal I brought before you where it introduces the idea of compensated hours. Generally, the Board cannot be more restrictive in their eligibility, so you can't be more restrictive in the eligibility that you adopt, than to allow an employee who is anticipated to work 630 hours in a school year to be eligible. You couldn't say that those 630 hours have to be compensated because the RCW doesn't say they have to be compensated. It says, "anticipated to work." In this particular instance, though, with this policy you're being more generous than what is required by RCW. Because you are being more generous, you can apply the requirement that those be compensated hours. The difference that makes is that I cannot be someone hired on July 1, automatically put on leave without pay, and then come back in August with only four weeks of the school year remaining and still gain eligibility if they only work 17.5 hours in four out of the eight weeks. The policy before you to consider includes the idea of compensated hours. We've worked through this with different stakeholders. We've been clear that in this particular case, the Board's well within its authority to apply the concept of compensated hours rather than allowing something like I described.

Dave Iseminger: This is a very complex resolution, but at the same time, it treats all employees the same, regardless of whether they're a nine-month, ten-month, or twelve-month employee. When you look at the original resolution on the Slide 4, although you count backwards differently based on the last day before summer break, or the last day of the school year, structurally, it's the same hours, the same number of weeks across the same number of weeks.

One of the things we were trying to do for stakeholder feedback was, although this is a complex topic, not have separate rules for 12-month versus nine- and ten- month employees. There are definitely some stakeholder requests for an even more generous policy than an eight-week look back. But, when you look at the calendar, some of the reasons why there's only eight weeks and you look at all the ways the calendar falls. For example, August 31 can be on a Saturday. That means when you count back, you would start to straddle into June if you had a look back greater than eight weeks. Our experience and understanding is that many 12-month employees are hired around the month of July. We were trying not to straddle back into time before the bulk of individuals' typical hire date for a 12-month employee.

The other advantage, when you look at nine- and ten-month employees, as we looked at the current school calendars for the current summer breaks, and not knowing how many snow days there will be, and there's a lot of fluctuating in each calendar, we didn't

hit any scenario where eight weeks started to straddle back over spring breaks. If you evaluate more than an eight-week look back, you start to get really far back into the calendar year and you can start to get a lot more generous with this eligibility piece. You also have the problem of, “do you have the same look back for a 12-month employee or not.” We felt this was the right balance between all of the feedback proposals.

Barb Scott: Staff looked at seven or eight calendar years in order to see how the schools breaks and different things that might be falling. All of that was considered.

Slide 9 - Example #3. This example works much like the last few. This person is coming from Alaska and hired as a teacher. The calendar on Slide 10 will walk you through the same type of example as what you've seen before. It walks you through the calendar and it shows how we did that count. Slide 11 uses the same calendar and the same type of green lines that you've seen before, same concept.

Dave Iseminger: In this example, by having the concept of compensated hours, the last day of school is June 16, 2020, but there may be school employees who have compensated hours after the last day that students are in the building. By counting any hours in that entire week, an employee would be able to get credit for the hours compensated after students exit. It's the last day of school being the last day of students is the benchmark for counting week one back to week eight. I did want to draw attention to that. That compensated hour is also generous for the week that has the last day of school in it because it can capture work that happens after students leave.

Barb Scott: Correct. On Slide 11, the reason it's in here is we brought back example two that was used in the August 30 meeting. It was used in describing the effect of Policy Resolution SEBB 2018-34, school employees' eligibility when moving between SEBB Organizations. I wanted to bring it back because we wanted to note that it is no longer a usable example because of the changes that have been made to the proposed policy resolution SEBB 2018-32, which is before you today.

Wayne Leonard: On Example 2, I'm confused. I don't know how to quite verbalize this correctly. The concept of a fiscal year, if someone were to not work 630 hours in a fiscal year, like this bus driver example, where they've been hired in April, and essentially work somewhere between 100 and 140 hours in that fiscal year, and then have a two-month break in service. They wouldn't be anticipated to work to meet the 630-hour eligibility criteria until the next fiscal year. I'm confused as to why they would become eligible on April 20 instead of the start of the next fiscal year, start of the next school year.

Dave Iseminger: Barb, I think there was an assumption that you didn’t say and I think that's where the disconnect is. On Slide 7, if you look at after “time of year they are hired” in bold, it says, "But are anticipated to work at least 630 hours the next school year." Wayne, your scenario, I believe, was that they *aren't* anticipated to work 630 hours in the next school year.

Wayne Leonard: No.

Dave Iseminger: Okay, I misunderstood.

Barb Scott: No, I believe what you said is that, in this particular example, the school bus driver is a nine- to ten-month employee. Based on when they're hired late in the current school year, they're going to become eligible for benefits on April 20 and their coverage will begin on May 1. The school year ends fairly quickly after that and then they're not going to be working for a number of months before the next school year begins. Your question was, “why are we allowing for that eligibility when they're not going to work the hours in the current school year even though they're anticipated to in the next school year?”
This is one place where what's being brought before the Board is more generous than the required eligibility. What you've described is generous eligibility being offered here. Does that answer your question? So, you're right. They're going to get coverage through the end of the school year, which is August 31 based on having worked for a short period of time during the actual nine- to ten-month employee work period that's associated with the current school year.

Dave Iseminger: Wayne, this resolution has had quite a journey. It started with a 12-month employee, a superintendent example hired and able to have benefits before September 1 under the eligibility framework of prior Board resolutions and statutory framework. As stakeholders asked more questions about treating all employees the same, we started addressing the two prongs of a nine- and ten-month employee versus a 12-month employee. To treat all employees the same, regardless of their classification or certification status, we got to a six- of eight-week look back for all employees. But you are correct that it is a generous eligibility requirement. Nothing like this exists in the PEBB world because there is no typical September 1 start cycle for state agencies.

Barb Scott: Probably the closest ones that you'll see would be maybe our academic year employees who are quarter to quarter, or maybe for PEBB, as far as other things we've looked at would be maybe seasonal employees. PEBB has an eligibility for seasonal employees that allows for coverage for a season that is as short as a season that spans three calendar months. PEBB has an interesting math used for determining coverage eligibility. This is complicated eligibility. We brought this forward because it is our understanding that in the current environment, folks hired July 1, like superintendents, principals, and others, are given benefits right away in today's environment. In order for districts to fulfill their business needs, they would want this eligibility within the SEBB Program. That's why it was brought forward originally. It's morphed in order to cover both 12-month and nine-to ten month employees as Dave described.

Dave Iseminger: I think it's important to remember that with the eight-week look back, the maximum amount of months an individual would get coverage is essentially May, June, and July. If there are questions about making that eight-week look back a 12-week look back, you start getting into April or possibly even March, depending on the scenario. This is generous, but it keeps it that you might get benefits May, June, July, and August when you otherwise would not get them in September.

Katy Hatfield: I'm not sure that's quite right.

Dave Iseminger: We don't have any examples that go further back with eligibility.

Katy Hatfield: But that's the look back period for eligibility. Someone might get benefits, I believe, as early as March.

Dave Iseminger: This one is just looking at the end of year hires that don't meet the other eligibility requirements of anticipated to work 630 hours. If I was hired early enough in the year and I got eligibility under that door, you wouldn't even look at this eligibility framework. This is just late-year hires.

Katy Hatfield: Right, but someone could be a late-year hire in March and not qualify for 630 hours and they could still qualify under this and they would get their benefits in March.

Barb Scott: As long as you could count back in doing the anticipation, you're correct, Katy. As long as you could count back from that last green line on the chart, into those eight weeks and say six out of the eight, they would've satisfied that anticipated eligibility, then you are correct. You could gain it earlier than that but this is the minimum standard under this eligibility.

Dave Iseminger: So, let's go through that one again because I didn't have an appreciation for that piece. I want to make sure everybody understands.

Katy Hatfield: In example 2, you could change the date to March 20 instead of April 20 in the example.

Barb Scott: If we change it to March 20, a month earlier, then their SEBB coverage would begin on April 1, 2020 based on Policy Resolution SEBB 2018-12. We would be counting back, still based on the resolution as it's presented to you today, from week one, which is the week of June 14 through the June 20. We would count back eight weeks and even though their SEBB coverage begins on April 1, you would really be counting back to the last week of April for the eight-week look back and they would definitely meet eligibility.

The example that Wayne's described is an employee who works more weeks at 17.5 hours probably, but still meets this eligibility standard. If I were determining eligibility, which is what SEBB Organizations will be doing in not too many months from now, they will have a worksheet that will cause them to look through multiple different eligibility decisions. If an employee fails to meet the condition of anticipated to be 630 hours within the current school year, I would move next to more generous eligibility that they might meet. Are they moving from one SEBB Oganization to the next? If they fail that one, then I need to move to the next eligibility they may meet, which might be this one. I would look at when the employee is hired and I would count back. If they met the eligibility under this, I would identify the date of eligibility. If they didn't meet the criteria, they would not be eligible. I would provide them with that information as well as appeal rights so that they would have the opportunity to appeal the eligibility decision I just

made. That is work that is downstream from all of these decisions you all are making today.

Pete Cutler: I guess more of a thought but it's related to Wayne's point. It's to acknowledge that much of what we've been asked to do is aligned with what is required by statute. In this case, we actually have a policy that says above and beyond what's required by statute. Let's provide medical coverage for the months of, let's just say somebody who starts in late April, for the months of May, June, July, and August for somebody who's going to work 17.5 hours a week for at least six of those last eight weeks of the school year. In this world, that's a very generous eligibility standard for what most working people would consider a very generous package of benefits. It is significant. But it does also promote the goal or the policy of promoting continuity of coverage, which is, in my opinion, much preferable to having people on coverage for a month or two, then off, then on, then off. It's better for everybody, both providers and the patients, if they have stability of coverage. But it is, admittedly, a very generous benefit, beyond what the statute actually requires.

Patty Estes: In the stakeholder feedback around these examples, did anything come through that this could possibly change some hiring practices?

Barb Scott: They may have talked about hiring practices. All the stakeholder feedback would be in your packets. But I think most of the feedback we received from the different groups is this is happening today and most of these positions the employers are recruiting at this late stage in the school year are employees that they're recruiting for positions they couldn't recruit for without being able to put benefits on the table.

Initially, that's where we started, but we worked through almost every example I could think of with stakeholders. We've looked at bus drivers who pick up different routes or they work during certain periods of time moving from one district to another because it happens that you have retirements a certain time of year. You're trying to recruit for those positions that you're securing for the next upcoming school year. We worked through a number of those examples with stakeholders. They don't all jump out in my mind, but for the most part, as we worked through them, they said they do this today.

Most often, we're not bringing them from Alaska, Idaho, or Oregon. They're going to come from the district next door. More than likely, they would meet the eligibility under the moving between SEBB Organizations. But stakeholders could see examples where they needed this one or they felt they had a need for this policy in order to recruit those people they might bring out of Oregon, California, or Idaho for specific positions. I don't know that some of them hit bus drivers so much as some of the other types of positions that are hired for, but I don't remember if they were bus drivers that they bring from out of state as well. Maybe if they're bordering districts.

Patty Estes: The only reason why I ask is because it creates a deadline, especially for nine- to ten-month employees on when they need to be hired and when they need to start working to be eligible for benefits.

Barb Scott: If they were brand new and not coming from another SEBB Organization within the state of Washington, yes. There were different conversations around drawing a line. One stakeholder said, "Let's just draw a line of April 1 and be done with it. Anybody hired April 1 or before you're in and anybody hired April 1 or after, you're out."

Wayne Leonard: I don't know if the practice of offering benefits like that is universal among school districts. Would there be a way to word this that would give some permissiveness, I guess, to districts if they wanted to interpret this less generously?

Barb Scott: My recommendation to the Board would be that this eligibility be standard across the SEBB Program so you don't have different treatment and don't set up anyone to cherry-pick who they give benefits to and who they don't because that would, I believe, create a legal risk for the Program.

Lou McDermott: I think that's Barb's nice way of saying no.

Wayne Leonard: In the other examples, you used in terms of a principal or a teacher, those are positions typically contracted out for a year and it was easy to anticipate they would work more than the additional hours in the future. But a lot of our bus drivers or classified groups are not necessarily contracted for a year. They're hourly employees and it's difficult to anticipate meeting that 630 hour criteria if they're hired late in the spring. And sometimes life changes happen and they don't show up in September. That's one of the big concerns I have with this. I don't have any concern at all if I have a bus driver or a classified employee that starts the school year on September 1 and they're anticipated to work 630 hours, offering them benefits the first day of school. I think that would be great. But I do have a lot of concern about offering benefits in the spring that are more generous than necessary to someone who works 100 or 150 hours and then may disappear in the summer and we may not have that employee to work in the fall.

Barb Scott: We worked very hard with WASBO on this and the bus driver. They were in on the thinking that they may be hiring bus drivers and it's a hard one for them to get sometimes. We did have those conversations with them and they did support this in this particular way. Rob meets with them significantly in order to get their feedback. We did walk through the bus driver scenario, the food service worker scenario, and a number of those. They felt they needed this in order to recruit positions they really needed to hire. Now if you have an employee who starts and then doesn't show up, if the employment relationship were terminated by the district, that would end benefits early based on an earlier resolution of when coverage ends that the Board has already passed. That would really be the only way to get out of paying for coverage through the end of the school year.

Dave Iseminger: The other piece I'm hearing is, if you hire a bus driver in May and you can't actually anticipate that they will meet the 630 hours the next year, that would be your basis for denying benefits under eligibility. If you've gone through the other pieces that Barb identified, you checked door A, no; door B, no. This is door C: you've hired them; you know they're going to work 17.5 hours in the timeframe, in the six out of eight weeks; but you can't actually anticipate 630 hours in the next school year. That is a

criteria to meet under this eligibility prong. If you say no to that, then you issue the benefits eligibility denial and the employee would have the opportunity to challenge that decision. On appeal, the employee could try to provide proof they met the 630 hours criteria. That's how that would work out. There are two requirements. It's the 17.5 hours in the six out of eight weeks counting backwards *and* anticipated to work 630 hours in the next school year. If you can't anticipate that, that could be a basis for denial of eligibility under this pathway.

Barb Scott: And then, they'll receive appeal rights and that can be reviewed if appealed. That helps to put checks and balances within the system. Did I get it wrong, Katy?

Katy Hatfield: No, I think that's right. I just wanted to give a slightly different response than Barb's response, which was right, but to answer Wayne's question. We have not talked about it very much yet, but there is language in the statute that allows individual SEBB Organizations to have the ability to locally negotiate eligibility criteria for a school employee who is anticipated to work less than 630 hours in the school year. There is a possibility that there could be a way to have discretion for that situation at the district levels. I wanted to point that out. The cart is before the horse a little bit, but I wanted to make sure you were aware of that statute. That could possibly be a different way to address this issue.

Barb Scott: That's true. And staff have been working on the below 630 hour pieces for you, so you'll see that here within the next couple of months. I would say there's been probably at least six months of work just with legal and others trying to work through that for you. That's why you haven't seen it yet, including Katy.

Patty Estes: That brings up the question for me of how are we evaluating the anticipated to work? I know that some districts do a letter of intent for the next year saying, “we are anticipating that you are going to be in this school district next year for X amount of hours at this position.” They do that every year. However, I know some school districts do not do that. So, how are we, I don't want to say regulating, but how are we regulating the “anticipated to work?”

Barb Scott: I answered a question very similar to this when Rob and I were in Pasco on Tuesday meeting with WASBO folks. We talked about resolutions the Board has made, where we're at on HCA decisions that have been made, and how some of those are being rolled out into rules that are well through the process today. One of the reactions we saw from them was they may have to make some changes in their business processes as they implement the SEBB Program. They're recognizing that. I don't know if they've come to solid ideas as to how they will adjust. I don't know that I could answer those questions for you today because I don't think that I could predict that even based on conversations with them.

Based on what I did hear, they're trying to think about their current practices and how those practices might need to shift slightly based on the SEBB Program implementation. We will probably see after year one of the implementation how they've adjusted, and then this Board could reevaluate based on what we see. We'll be watching that for you

because we will be helping those SEBB Organizations to understand the eligibility and how to implement it. I would be wrong to sit before you today and think that we know how that's going to play out because I don't think we do, but we'll watch it for you.

Dave Iseminger: Patty, when the information is in our system as the golden record for who has eligibility for benefits, we'll be able to see if there are outliers in districts that have a lower proportion of individuals getting eligibility. If district A is only offering benefits to 50% of its employees, but everybody else in the state is more around 75%, we may need to talk about that. Is the Program being administered incorrectly and we need to provide more training? There will be ways to monitor that.

Lou McDermott: We also have the opportunity with appeals. As we see appeals come in, sometimes a rule change will take place because, during the appeal, it may be that we rule in favor of the member over, and over again on the same rule because there's an issue with the way it's being implemented. That's how some things come to light.

Dave Iseminger: We had that with PEBB Program where we see a pattern with an agency and then we have a training opportunity with that agency. Or, we see a pattern with a rule and we work to refine the rule and bring it to the Board. It works both ways.

Patty Estes: That's exactly what I was talking about so thank you.

Pete Cutler: I can't help when my budget analyst background pops up. Following up on Wayne's observation. I did a little quick math and if you work 17.5 hours a week for six weeks, it's about 105 hours. If you're paid $14 an hour, that gets you to roughly $1,500 that you would receive as your cash compensation. We're going to keep pension contributions or other issues out of this. And then, your health contribution as an employer would be roughly $3,800 for those two weeks, but because it would really be for four months. It would really be for May, June, July, and August. We know for sure it's at least $950+ a month in the first year, assuming the Collective Bargaining Agreements are ratified by the Legislature, because that's on the printed material showing for state employees.

While we see no specific number for K-12, we know the K-12 funding rate cannot be lower than the state number. I can understand if I were a business administrator at a school and I had somebody who was a college student saying, "I can drive your bus for the next two months. And sure, I'll continue to do that next year." But in reality, they're thinking, "I'm going to go to school full time next fall." They could get their four months of insurance coverage for pretty darn cheap and I could understand why a business manager at a school district might think that's awfully generous. But, there again, we have the statutory framework we have and the continuity of benefits is also important policy. So, all I can say is I have sympathy for business managers.

Alison Poulsen: I think you answered my question. It was really in the oversight and compliance portion. Where that line is. It seems like it's not a super sharp line and that you would start in a more passive way to say, “We've noticed this from your data. This could be a training opportunity." And then, the next step would be a policy change if it was actually not meeting the intent, which is, in my mind, we're trying to be generous

with coverage because having health insurance is an important part to starting to improve population-level health. Is that a correct assessment?

Barb Scott: I would say so. I know when we met with WASBO earlier this week, they did ask questions about being able to apply it differently. We cautioned them that they would not want to apply it differently. They will want to consistently apply the standards throughout their organization, not employee by employee, and that protects them too. Once you're in a bigger system, more people are looking at you. It's going to be important for them to be consistent in their application and we're going to do everything we can to help them get there. Watching the enrollment is one piece of that, providing them with worksheets, telling them how this is applied. It doesn't matter if it's a nine- to ten-month employee or a 12-month employee; this is how it's applied.

Lou McDermott: **Policy Resolution SEBB 2018-32 – Mid-year Hires Anticipated to Work 630 Hours in the Next School Year**

Resolved that, a school employee who is not anticipated to work 630 hours in the current school year because of when they are hired, but is anticipated to work at least 630 hours the next school year, establishes eligibility for the employer contribution toward SEBB benefits as of their first working day, if they are:

- A 9- to 10-month school employee anticipated to be compensated for at least 17.5 hours a week in six of the last eight weeks counting backwards from the week that contains the last day of school; or
- A 12-month school employee anticipated to be compensated for at least 17.5 hours a week in six of the last eight weeks, counting backwards from the week that contains August 31, the last day of the school year.

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

Pete Cutler: Once again, I want to thank staff for putting a ton of time into working with the school employers because this, I know from past work experience, is an incredibly complex setting in which to try and deal with eligibility issues. And so, I applaud you for all the work that went into it.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-32 passes.

Barb Scott: Slide 12 – Policy Resolution SEBB 2018-36 – Eligibility Presumed Based on Hours Worked the Previous Two School Years. This policy resolution requires eligibility be presumed for a school employee who worked at least 630 hours in each of the previous two school years if they are returning to the same type of position. For

example, a food service worker 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. Again, our worksheets that we develop will include walking through the eligibility and notifying the employee of their appeal rights. The employee signs it so they'll now they got their appeal rights. We really have a path to help make this fairly easy on the administrative side of it.

Stakeholder feedback on this policy had one stakeholder who didn't support the resolution because it included substitutes being eligible. This proposal was originally introduced to address eligibility for substitutes, as well as others that hovered near the 630-hour threshold. The same stakeholder asked if we will be providing worksheets, or other documents, to satisfy the notice requirement. I assured them we would. There is an example that is included in your packet, but there was no change to it from the last time we showed it to you. There was also no change to the two examples.

Pete Cutler: I'm curious. Right now, if I understand correctly, people retired under teacher Plan 2 can work up to 800+ hours a year as a substitute and still collect their retirement benefits and still be covered as a retiree in the PEBB Program. And the question is, how would this impact somebody who was a retiree and came back, retired under Plan 2 who was enrolled in the PEBB retiree benefits coverage, but then hit the 630 hours, and suddenly triggered eligibility under SEBB as an employee rather than a retiree. How will this deal with that context?

Barb Scott: There's nothing in place today that would prevent an employee who met the eligibility under this policy resolution to have eligibility under both SEBB Program eligibility and eligibility as a retiree under the PEBB Program. There's nothing in place today that would prevent that. There is, on my list of things to look at, is a question as to whether or not the PEB Board, or SEB Board as well, should look at a policy that addresses dual eligibility between those programs. It also may be that, as we move forward in seeing what the Legislature decides around retiree eligibility, that problem resolves itself. It's within the programs and the Boards of those programs to decide how they deal with eligibility within their own program. At this point, there is nothing that would prevent that.

Lou McDermott: **Policy Resolution SEBB 2018-36 - Eligibility Presumed Based on Hours Worked in the Previous Two School Years**

Resolved that, a school employee is presumed eligible if they:
- worked at least 630 hours in each of the previous two school years; and
- are returning to the same type of position (teacher, paraeducator, food service worker, custodian, etc.) or combination of positions with the same SEBB Organization.

The SEBB Organization rebuts this presumptions 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.

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

Fred Yancey, Washington State School Retirees. Mr. Cutler's question is certainly germane. If I'm a substitute retiree, early retiree, or receiving a retirement and have insurance through the PEBB Program, the question is, if I qualified, does that mean the district will help pay the premiums on my existing plan or do I have to enroll in a second plan? It really is a question that needs answered. The easy thing would be the district would pay what they would pay for a regular employee that qualified would pay toward the premiums that I'm already paying. But it's an unresolved question that certainly needs resolved. You certainly can't expect me to have two insurances. One, my current Medicare insurance, plus another one because I qualify. So we're anxious to see that resolution.

Barb Scott: I can speak to that, Mr. Yancey. In answering Pete's question, there's nothing that prevents an individual today, without another policy passed, that would prevent a person from being eligible, as Pete described it, under both programs. In reality, if I were an employee eligible under both the SEBB and PEBB Programs, the PEB Board has put in place a number of policies that allow a retiree to defer their enrollment in the PEBB Program. They can defer during a period of time in which that person is eligible under K-12 school district coverage or under another employer program, whether I went to work for Boeing, Weyerhaeuser, or someone else. I could defer my enrollment, as long as during that time period, I am enrolled in qualified coverage, and that would include things like employer-based coverage, as well as Tricare and a number of other provisions the PEB Board has adopted over the years. But, I could defer my enrollment in that program while I'm covered under that other coverage.

If I were that person in that situation, I would defer my enrollment in my retiree coverage through the PEBB Program. I would take advantage of my coverage under my SEBB Organization employer. When I left SEBB Organization employment, I would re-enroll in my PEBB retiree coverage and take advantage of the subsidies available. Does that answer your question?

Fred Yancey: I think it does, assuming the transition between is seamless and allowed and I'm assuming they would be allowed. In other words, I could re-enroll in the PEBB plan upon the conclusion of the SEBB plan, regardless of when it happened during our calendar year.

Barb Scott: Absolutely. You would want to re-enroll in your PEBB retiree coverage immediately when your SEBB coverage ended. You wouldn't want to leave any gaps because you would lose your eligibility.

Fred Yancey: That does answer the question. And I do remember the discussion on the Tricare issue. But I just hadn't applied it to this. Thank you.

Barb Scott: Yes, and the PEB Board just passed an additional way to defer qualifying coverage this year.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-36 passes.

Eligibility & Enrolment Policy Devlopment

Barb Scott: I am introducing two policy resolutions today. They are Policy Resolution SEBB 2018-53 – School Employees May Waive Enrollment in Medical and Policy Resolution SEBB 2018-54 – Default Enrollment for a School Employee Who Fails to Make a Timely Election.

Dave Iseminger: There is the perennial question from employers, if someone is waiving benefits, why do I have to pass on that money? It's the way the funding rate is ultimately set in both the PEBB Program, and anticipated in the SEBB Program. The funding rate represents the average employee. The system already takes into account there will be waivers, but the average dollars needed for the program have to come to HCA whether the person enrolls in benefits or not.

Barb Scott: Proposed Policy Resolution SEBB 2018-53 would allow a school employee to waive enrollment in SEBB medical coverage if enrolled in medical through another employer-based group medical program. For example, a spouse's employer's coverage. The proposed policy would only allow employees enrolled in other medical to waive their enrollment in SEBB medical. It would not allow employees to waive enrollment in benefits that are 100% paid by the employer, which include SEBB dental, vision, basic life and accidental death and dismemberment, and basic long-term disability coverage.

Staff looked at the benefit booklets for a number of districts and it looks like school employees are generally not required to have other coverage in order to waive their enrollment or opt out. They are used to an environment where some benefits are mandatory and others are optional, with medical typically being an optional enrollment. Administratively, in order to have the eligibility system function well, we need to have at least one benefit required that will allow the HCA to track and invoice SEBB Organizations for school employee benefits, even when a waiver is in place. The funding rate model that HCA delivered to OFM for development of the Governor's budget includes a medical waive rate similar to what is used for the PEBB Program population.

We recommend requiring employees to attest to being enrolled in other employer-based group medical in order to prevent adverse selection, which could impact bid rates. That's why you're seeing this policy brought to you in this way.

Proposed Policy SEBB 2018-54 would address whether an employee who fails to elect coverage within the required time period is defaulted into coverage versus no coverage. Staff looked at benefit booklets again, and it looks like school employees are used to an environment where some benefits are mandatory and others are optional, typically medical being an optional choice. It also looks like some SEBB Organizations default employees to no coverage versus into coverage. The policy we're bringing to you would default them into coverage. Based on our experience, we know that employees do fail to make elections at times, and this would ensure employees are enrolled in coverage. If a school employee doesn't make the election in time, they would be defaulted into a coverage designated by the HCA, and that will be determined based on criteria used to make sure coverage is available to employees where they live.

Dave Iseminger: There is the question of which coverage. It's still too early to get into that granularity. There are 16 potential plans. We don't know exactly where they're going to land, what the employee premium contributions will be, and the overall service area to have a uniform default. There are too many variables, but we wanted to make sure the Board considered and took action on whether to default people into coverage or not, and have that be a foundational part of the rules codified in Barb's second rule making process.

Barb Scott: When you look at this policy proposal, you will see that the default would be enrollment in employee-only medical coverage and employee-only dental coverage, as well as vision. You're seeing this because we would not have information to enroll any dependents. We found this within the PEBB Program. You could only default them to the employee-only tier because you don't have any knowledge as to whether or not dependents exist. That's why you're seeing it presented in this way.

Pete Cutler: Would the plan then be to bring to the Board a proposed resolution regarding which specific medical coverage, dental coverage, or vision coverage once it's known what are the options, the coverage areas?

Dave Iseminger: We believe the setting of the default plan is within the agency's authority. We will bring this to the Board for their insight before making a final decision. It's an area the Board would have intense interest, but we don't believe it needs to come to the Board as a resolution.

Pete Cutler: Okay. My initial reaction is that it is a policy decision that the Board should have influence over, but we can save that for another day as long as it is going to be discussed with the Board.

Dave Iseminger: It absolutely will be discussed with the Board. We don't believe it's a resolution topic. But it is absolutely a discussion topic.

Pete Cutler: Thank you.

Patty Estes: Can we define "timely" again?

Barb Scott: Timely, 31 days. The election period for new enrollment is the 31 days, and that's a policy that the Board has already adopted. For special open enrollment, the employee will already be enrolled in order to exercise their right under a special open enrollment unless it was to return from waiver, and they would have options based on that special open enrollment event specifically.

Katy Hatfield: Barb, could you give a little more context for SEBB 2018-53 in terms of whether or not as written, employer-based group medical would include retiree coverage, and talk about Medicare and Tricare?

Barb Scott: On the retiree coverage, it's not jumping into my head, Katy, so I'll start with the others. When we brief you on these rules being implemented, you'll see the rules will allow employees to waive medical based on the Board's policy, if you adopt it, that says they can as long as they're attesting to being enrolled in another employer-based group medical, for example, through a spouse. The rules will also allow them to defer coverage if they chose to enroll in Tricare coverage, based on the way the Department of Defense has implemented Tricare. Employers cannot put in place a barrier to a member who's eligible under Tricare being able to use Tricare as their coverage instead.

We also, based on Medicare rules, will allow employees to choose Medicare as their primary insurance. The rules will include that as well. The policies I'm bringing forward to you are those within your authority. I'm not bringing you those policies that are required under federal regulation or federal guidance from those agencies that govern those programs. And the retiree one, Katy, just doesn't jump into my head.

Katy Hatfield: I think maybe if we've had some scenarios where someone was perhaps enrolled, or they had the option to enroll, in their spouse's retiree Boeing coverage, for instance, or spouse's retiree Weyerhaeuser coverage. If someone had the ability to be enrolled in their spouse's retiree-based coverage, would that fall under this policy or not?

Barb Scott: I'm still not clicking on anything there. It may be that is related to work with the PEB Board on their deferral policy. The PEB Board's deferral policy doesn't allow a person to defer their enrollment in PEBB retiree coverage for enrollment in another employer's retiree coverage. That may be where that's coming from. As far as employees, other employer-based group medical, that could include, for example, if my husband worked for Weyerhaeuser, terminated employment with Weyerhaeuser, chose to enroll in COBRA coverage through Weyerhaeuser, and he wanted to keep the family on that coverage, we could pay to do that. It wouldn't be something we would do because, for us, we would do the math. The retiree one, though, Katy, it's just not getting there for me.

Dave Iseminger: That's an area we'll follow-up on at the next meeting. Katy and Barb know how to find each other.

Patty Estes: On that same one with the employer-based group medical, and this may be just some lack of knowledge for myself, if someone was on state assistance medical, would they be able to waive this in place of that?

Barb Scott: No. If someone were eligible for Medicaid (Apple Health), the Board would need a different policy that would allow them to waive their medical through the SEBB Program if they were enrolled in coverage under a state Medicaid plan. That's not a proposal I'm bringing before you today. That would be a very complicated proposal to navigate, because the Medicaid programs re-determine their eligibility at different times. Those folks who are eligible under those programs have a responsibility to report income. Trying to put in place a policy like that would be quite complex. It also would need to be evaluated regarding the funds that are being used and which state dollars to use.

We've had this same question under the PEBB Program and the PEB Board has not allowed for waiving of coverage in order to be enrolled under Medicaid.

Patty Estes: It makes for a very complicated situation because I know several school employees on state assistance, or their children are. I don't know that they waived their coverage.

Barb Scott: Children are different than the employee themselves. This is allowing the employee to waive their enrollment in a medical plan if they're enrolled in other employer-based group medical. There's nothing in the eligibility that exists that the Board's put in place as of today that would require an employee to enroll their dependent children even if they're eligible. Now, if there was a national medical support notice in place, court ordered, every employer would have to act on that.

Patty Estes: Right. I'm just trying to think of all the scenarios. Thank you.

Alison Poulsen: I'm curious, in that situation, wouldn't this be a more generous set of benefits than what someone would be eligible for in Medicaid?

Barb Scott: I don't know that it would be a more generous set of benefits. When I receive this question, it’s not necessarily because the employee has evaluated the benefits under each program, but they're evaluating the cost out of their monthly paycheck.

Wayne Leonard: A follow-up question to Patty's about time limits. You mentioned 31 days is the definition of that. Since our plan begins January 1, is that 31 days December 1 through December 31? Because there's a lot of holidays in there. There's non-business days, there's non-workdays. What would the 31 days be?

Barb Scott: When Patty asked that question, she was asking for the definition of timely. This applies to an employee who is making their initial election and new employees, based on Board policy, have 31 days in order to elect coverage when they first become eligible. That would count from, for example, if I was hired by a district effective July 1, then I would have 31 days from July 1 where my election form needs to

be with my SEBB Organization employer by the 31st day. That policy was driven by cafeteria plan rules that allow an election window of 30 days, the 31st day being the date that the employer has it in hand in order to act on it.

If we were talking about annual open enrollment with the plan year that goes January through December, employees would make elections to change plans, enroll, or waive, during the open enrollment that precedes the beginning of the plan year. Year one, they'll have a little bit longer than the month of October. Years going forward, I don't know that it will be a month and a half, but for year one it will.

Wayne Leonard: Does it include Saturdays, Sundays, holidays? It's calendar days, it's not business days.

Barb Scott: Calendar days, not business days, yes.

Dave Iseminger: Wayne, that 31-day election period was part of Policy Resolution SEBB 2018-13 that passed in May. Katy Hatfield has a copy of all the resolutions if anybody needs to reference them.

Barb Scott: Slide 8 – Next Steps. If you have feedback for these policy proposals, we'll incorporate those. Otherwise, post today's meeting, staff will be sending these out to our stakeholders and then we'll bring recommended policy resolutions to the Board for action at the December meeting.

Lou McDermott: The Board will be 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.

[Lunch]

Centers of Excellence

Marty Thies, Account Manager. Today I'm presenting a policy resolution for action to adopt the Centers of Excellence Program. Slide 2 – Overview. This benefit option overlays the UMP Classic and CDHP plans in the PEBB Program. This is a voluntary program. It's about quality and incentivizing members toward facilities that have adopted best standards and have demonstrated optimal outcomes with regard to serious procedures. To date, we have a total joint replacement bundle. We are finishing our second year and have completed over 150 surgeries with great success and great member experience.

We are now implementing a spine care bundle, which will go live January 1, 2019. The contracts are signed for that bundle. This resolution today is to adopt this program for the SEBB Program. All future bundles that are a part of this program will follow.

Lou McDermott: Marty, I know the answer to this, but I love to ask it. How many readmissions have we had on those 150 surgeries?

Marty Thies: We've had no readmissions.

Lou McDermott: That's a great number.

Marty Thies: Full disclosure, we had a minor infection for one day.

Lou McDermott: Come on, man.

[laughter]

Marty Thies: It makes it more real.

Lou McDermott: Okay, one minor infection.

Marty Thies: And they went back to work. The recommendation is that the SEB Board adopt the Centers of Excellence Program in UMP on January 1, 2020, with implementation beginning in UMP Achieve 1, UMP Achieve 2, and the UMP High Deductible Plan.

Lou McDermott: **Policy Resolution SEBB 2018-51 - Centers of Excellence**

Resolved that, the SEBB Program will offer the Uniform Medical Plan Centers of Excellence Program (COE) starting in Plan Year 2020.

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

Dave Iseminger: This was one of the slides on the table in the hallway as an updated slide. We had copied the version that said it was proposed and didn't have the resolved language. It's actually the exact same thing, it's just the voting version of it.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-51 passes.

Fully Insured Medical Plan Resolutions

Lauren Johnston, SEBB Procurement Manager. Today's objective is to take action on the plans presented earlier today. Slide 3 – Recommendations. HCA recommends moving forward with the fully insured medical portfolio presented today for rate development to see where rates fall for different plans and AV levels. Once funding is set by the Legislature, next summer the Board will vote on 2020 employee premium

contributions for the SEBB Program's offerings. Keep in mind that refinements to plan designs can continue until the Board votes on 2020 employee premium contributions.

Before taking action, I want to make some updates based on what you heard earlier. We did find a couple of inconsistencies in the information. On the SEBB benefits comparison chart, if you look at Premera's Plan 2 under emergency room says $150 plus 20%. That should be $150 plus 25% because it would be subject to the same coinsurance the rest of the plan is subject to.

TAB 4, Slide 8 of my fully insured presentation from earlier today, at the very bottom of the slide, for Providence HSA Plan, the drug deductible should say, "combined with the medical deductible". Right now it says $1,750 and $5,250. It should be combined with the medical.

Dave Iseminger: For clarity, because this is one I noticed when Pete asked a question earlier, right now it says $5,250, but on your benefit comparison chart, that number says $3,500. It's really $3,500. And the shorter way is to say it's combined with the medical deductible. I wanted people to know that that $5,250 should have been $3,500, and even more streamlined, it should've just said, "combined with medical."

On Slide 9, the Premera Plan 1 and Premera Plan 2 has out-of-network coverage as 100%. It should be 50%.

Dave Iseminger: We'll get all of these updated and provide an updated version of the briefing book online so only the correct version is posted.

Patty Estes: When you say refinements we can make later on, I want to make sure I'm understanding, and the public understands, how we're moving forward with these. Just because these are on here does not mean that these are what we are going to launch. These are just what we're proposing to go forward for rates. We don't necessarily have to offer all the carriers. Is that correct?

Lauren Johnston: Correct.

Dave Iseminger: Patty, right now there are 16 fully insured plans and the four UMP plans. This represents the maximum high water mark that the Board's looking at. As time goes by, either a carrier might find a reason that they no longer want to offer something in the SEBB Program, or the Board could identify that they want even fewer plans or fewer carriers. The rate development process will just give another layer of information and the Board will have its final decision about what exactly will be offered when setting the employee premium contribution in the summer. But, I do think what we're asking the Board to buy into is these are potentially reasonable type of plan designs and the right direction, but you still have those refinements and those final decisions. And you're not 100% endorsing any one plan or carrier at this point.

Lou McDermott: **Policy Resolution SEBB 2018-45 - Fully Insured Medical Plans (Aetna)**

Resolved that, the SEB Board endorses Aetna's proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-45 passes.

Policy Resolution SEBB 2018-46 - Fully Insured Medical Plans (Kaiser Foundation Health Plan of the Northwest)

Resolved that, the SEB Board endorses Kaiser Foundation Health Plan of the Northwest's (KPNW) proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.PO

Alison Poulsen moved and Dan Gossett seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-46 passes.

Policy Resolution SEBB 2018-47 - Fully Insured Medical Plans (Kaiser Foundation Health Plan of Washington)

Resolved that, the SEB Board endorses Kaiser Foundation Health Plan of Washington's (KPWA) proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-47 passes.

Policy Resolution SEBB 2018-48 - Fully Insured Medical Plans (Kaiser Foundation Health Plan of Washington Options, Inc.)

Resolved that, the SEB Board endorses Kaiser Foundation Health Plan of Washington Options, Inc. (KPWAO) proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Dan Gossett moved and Terri House seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-48 passes.

Policy Resolution SEBB 2018-49 – Fully Insured Medical Plans (Premera)

Resolved that, the SEB Board endorses Premera Blue Cross' proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting and an additional plan design with a separate drug deductible that does not exceed that of UMP Achieve 1 for the purposes of rate development.

Patty Estes moved and Alison Poulsen seconded a motion to adopt.

Jim Grazko, Chief Underwriting Officer for Premera Blue Cross. I'd like to introduce a recommendation that, for pricing, the Board consider not just the two options you've seen so far, and I guess we've added a third with the drug deductible, but another option to what you've seen already, which would basically place us with an actuarial value range of 0.78% to 0.81%. So the additional one we're proposing that we introduce for pricing purposes is a 0.78% AV benefit design that basically is a $1,250 deductible major medical PPO. And the reason we are proposing this is because we have a long history with the school districts in Washington, going back over 60 years, either under the WEA Program, and most recently now with school districts on their own. But we have about 85,000 members and I think at the peak we had 104,000.

So, we essentially understand the benefits very, very well and we know that in the past that two of the three plan designs that we're proposing to price have become the most popular. And over time, to keep the plans affordable, we've been asked by the districts to come up with actuarial values that are slightly lower than those that are proposed. So those that are proposed are 80% to 91%. We're proposing 81% and 84%, which are the two plans you've seen so far and then introducing the 78% as a way to reach a price point that we feel is going to be competitive.

What this would do is it would allow us, just again, for pricing purposes, to create a little bit of runway. I think folks know that just in general, when you set an actuarial value, if those benefits stay static, that actuarial value starts to go down over time. The percentage of member cost share drops and the percent that the plan pays goes up over time just naturally the way the math works. This would do is it would create a little

bit of runway so that you could leave the benefit design roughly static and keep that AV within a tolerance range because you're pricing it slightly below the 80%. We think that, if that were to be offered, we could probably, in the market, attract up to 30,000 school district members on a plan based on how people have enrolled in the past through WEA and through the regular district plans.

Also, I think it's important that teachers be given a choice. I think that this would allow us for about a $15 per member per month premium drop just to go from 80% down to 78%, so that roughly three percentage point AV difference would be worth about $30 per employee per month on the premium rates, again, making it more affordable.

And the last consideration is just that, when you're looking at how the overall business is priced, this is really a private exchange. We have experience with a couple private exchanges. They can be very volatile and you want to make sure that you have enough choice and a range that allows people to select within that tight range. And adding this option we believe would help create that range. Also, there's a little bit of a difference now between the fully insured versus the self-funded plans. So, there's premium taxes, insurer tax that go with the fully insured options that add about another 5% to the overall cost, as well as the UMP underlying reimbursement design that goes with the self-funded. So, we're talking really a 5% to 10% differential between the fully insured plans and the self-funded plans just out of the gate, apples to apples on benefits.

What this does is, again, allows the price point to come down somewhat for purposes of setting price tags in the initial round. That's really what we're asking for. So, we're proposing that Premera basically provide pricing for the two benefits that you've seen today. And I guess the third with the drug deductibles that have been normalized to the UMP plans and then adding in this 78% major medical plan that's also a $1,250 deductible.

Pete Cutler: Mr. Grazko, two questions. One is my understanding is, if you have a health plan design that has a lower actuarial value; and therefore lower cost, the general dynamic would be that you'd get your healthiest population, people who don't think they're going to use health services, would be attracted to that plan design compared to one with greater coverage. And so, I'd just like to hear your thoughts on that. And the other topic is does this include a separate prescription drug deductible like the other two Premera proposed plans?

Jim Grazko: It does not. No, this is just drugs subject to major medical -- the medical deductible.

Pete Cutler: Okay and on that question, if you have any comments, explain why Premera believes a separate prescription drug deductible is a good plan design in terms of the interests of individuals. I'd be interested in hearing about that, too.

Jim Grazko: Absolutely. So, the first question relative to the risk selection, I guess is what you're referring to on that. That is absolutely true. Within a private exchange setting where everyone's making a decision based on their own economic circumstances, people that have health conditions are going to want to probably stick

with what they have now, and generally speaking, choose much richer plan designs relative to lower deductible, lower out-of-pockets. If you introduce a range of product designs that have a very wide range of actuarial values, you will absolutely see what you just described, Pete, in terms of adverse selection.

I think if you're looking at 78% and we're looking at right now 78% to 81%, that's tight enough that really what you're doing is just basically addressing affordability. You shouldn't see in such a tight range adverse selection going into plans other than this lower 78% because that's really what that would be implying is that you're going to be pushing some of the higher risk off of that plan. But I think they're close enough with the highest and the lowest being 78% and 81% that they're pretty much within range. I don't think you really see that adverse selection.

In terms of the drug deductible, the reason we did that was because that is the plan that we currently have in the market that's the most popular. People are very used to that now. And, really, within a private exchange-type selection setting, every penny counts. I think that it's really a price point issue. It's a way to keep continuity of benefits because that's what they have today. That's what they know. They're buying it, they're choosing that plan design, and if we were to go with a lower deductible or eliminate the pharmacy deductible, it's really a pure price point issue so the price would need to go up by that amount. So, it's a way to keep the costs down in short.

Pete Cutler: My question, thank you for your responses, is why, because you could get a lower cost point, a lower actuarial value by just having a larger overall medical expense deductible and just say it's all lumped together. I don't really quite understand what are considered the policy advantages or the benefit designed advantages of having a separate deductible for prescription drugs versus other medical expenses.

Jim Grazko: You're absolutely right on that, too. There is a way to do that. I mean, there's a lot of ways to get the price point down or the actuarial value down. Again, it had more to do with this is what we have in place today. We have about 85,000 members under coverage with the districts around the state, and just continuing with what they know and what they are currently selecting is a way to hit that price point. But you're right. If we theoretically eliminated that altogether, there'd be a way to get back to that same set of price points on the actuarial values, a number of other ways.

Pete Cutler: Thank you very much.

Wayne Leonard: When you said your most popular plan, are you referring to one of your Easy Choice options?

Jim Grazko: Yes, they're within the range of those Easy Choice. So, when we first had the WEA, going back over a year, we priced out a range of, and I brought that, about 73% to 90%. Over time, we were asked to price in the 73% to 84% so really to sort of shift the range down a little bit. And that became, by far, the most popular set of plans in the program, the Easy Choice plans. That's where the bulk of the enrollment sat until the time when the WEA went to that other structure about a year ago. And now, it's the plans that we're offering today that we have about 85,000 members under coverage are

very similar to those Easy Choice plans. And two of the three AVs that we're proposing are largely like those plans.

Dave Iseminger: So, before Jim leaves, in case there's something to follow up on, I do want to assure the Board that as we go through the rate development process, if the rates come in and it looks like there's affordability concerns, I'm not going to wait until the next Board Meeting to ask if you want other options. We'll go back to all the carriers and treat all potential players equally, and ask them to bring us an AV plan that is less than 80%. There are a couple of reasons that the agency has explained to you that we believe all roads lead towards 80% being the lower point before there's a negative employee contribution. And a couple of those, just to remind you of some of the terms of the Collective Bargaining Agreement that Megan and I described last month, is the employer medical contribution under the tentative agreement is 85% of the premium of an 88% AV plan. That's fixed so if you're buying a plan that's below 88%, then more than 85% of that total premium or bid rate would be paid by the employer. The way that employer medical contribution is set up for the launch of the SEBB Program under the tentative agreement is a fixed 85% of an 88% plan. And so, that will provide some upward pressure because of that contribution.

The second piece is under the Collective Bargaining Agreement. Don't forget that there is an agreed upon minimum employee contribution that represents at least 2% of the employer medical contribution. So for example, if the employer medical contribution ends up being $600, and I'm just using that as an example, then the minimum employee premium per month would be $12 per month. Those two factors have led the projections within the agency to believe that 80% AV is going to be the lower end tolerance whenever you look at those financial factors. But if that turns out wrong, as we go through the rate bill process, we would certainly open up to all the carriers an opportunity to bring additional plans. And then, we will bring you that information in addition to all of the information that would be requested under all the resolutions today.

Patty Estes: Dave, that was actually my question.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-49 passes.

Policy Resolution SEBB 2018-50, Fully Insured Medical Plans (Providence Health Plan)

Resolved that, the SEB Board endorses Providence Health Plan's proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-50 passes.

Self-Insured Plans Treatment Limits

Kim Wallace, SEBB Finance Manager. This presentation is focused on giving you an opportunity to vote on a change to certain treatment limits in the self-insured medical plans.

Slide 2 – Recommendation – Align with Current State for 2020. The Health Care Authorities recommendation was to align the chiropractic, acupuncture, massage, (CAM) and therapy visit limits to the current state that matches the PEBB UMP plan treatment limits. We've walked through this data before on Option #1, Option #2, Option #3, and Option #4. The dollar values and figures in this table, at the lower rows, show an increase in plan paid PSPM and increase in plan paid per year. Those dollar values were based on analysis done on the PEBB population, essentially saying, "what would be the increase in plan paid on a total paid basis if the PEBB Program population in 2017 had the increased limits?" It was a way for us to see the order of magnitude change that could be reasonably expected on a statewide population of this size under the SEBB Programthat would be likely similar as seen under the PEBB Program. The resolution before you, if passed, would change from the current state to a different level of treatment limitations.

Lou McDermott: **Policy Resolution SEBB 2018-52 - Self-insured Plans Treatment Limitations**

Amending Policy Resolutions SEBB 2018-20, SEBB 2018-21, and SEBB 2018-22 to change the treatment limitations as follows:

- Chiropractic visits are limited to 52 per calendar year
- Acupuncture visits are limited to 52 per calendar year
- Massage visits are limited to 52 per calendar year

Dan Gossett moved and Katy Henry seconded a motion to adopt.

Pete Cutler: I have to admit, this is a huge increase, a huge disparity compared to what state employees have as coverage and not an insignificant cost increase. I guess I'd be interested in hearing from the sponsors a little bit more in the rationale, but at this point, my inclination is to think this is a reach too far given that the state is about to spend a ton more money on extending health benefits and increasing funding for health benefits for school employees.

Wayne Leonard: The last time we went through this, it seemed like not a lot of people got to even the state limits, or a smaller limit like maybe Option #1 would have covered the vast majority of all visits, or of all claims. Is that correct?

Kim Wallace: Yes, you are remembering correctly.

Dave Iseminger: Just to reiterate that. I think the point was the claims data that the agency and Milliman received back in April, shows that most people wouldn't hit the treatment limits that are the 10, 16, 16, 60 that is the current starting point based on the Board's June decisions.

Kim Wallace: That statement actually holds true for both PEBB Program state employees, active employees in UMP, and current K-12 employees enrolled in plans with various treatment limits. When we reviewed the utilization to help predict what raising the limitations would mean, and how much benefit-induced utilization there would be, we believe that there does not appear to be a significant number of people who would automatically reach or utilize the limit, or anywhere close to it, actually.

Dave Iseminger: At the same time, Kim, the numbers that are on the prior chart with the options represents an estimate of the total liability the plan could incur. That is a factor. It doesn't seem like there's a rush and you might ask why this number matters. It's the potential plan liability that would exist.

Wayne Leonard: Right. I was just wondering about that because, especially with the chiropractic, I wouldn't mind increasing that a little bit. I would agree with Pete. 52 seems like quite a large jump and quite a big additional cost potential and not even covering many people.

Alison Poulsen: I had a question, which I think is what you just said about the plan liability. Is that what this increase in plan paid per year line is or is that something different?

Kim Wallace: It is different. The total plan liability, essentially, how much money could the plan actually pay out, would mean you would take every single eligible covered member and give 52 visits to every single person. That would be the total possible liability. That is not what’s reported here. These numbers are specifically an assessment of how much more would it cost if PEBB Program members that were enrolled in UMP Classic had higher treatment limits for these services. That's what this is reporting. It is taking into account an assessment of how many people would use the full number because it was offered to them, close to the full number but not the full number, likely to use zero. As you can imagine, there are lots of different factors and assumptions to be made. We did this in consultation with our actuarial consultants.

Katy Henry: Part of the thinking around this was based on feedback both Dan and I received from members who were concerned that it was a significant decrease in plans they already had access to. I think we are definitely open at looking at another option on here. The current one just seems very low to us. And that was the feedback we got

from members. To Pete's point, it might be a way to distinguish us a little bit from PEBB that we don't have to look exactly the same. This might be a way to do that.

Terri House: The $1.7 million. If we voted for this, where would that come from? What would we sacrifice to have this benefit?

Kim Wallace: I don't know that I would say something will be sacrificed, but what I would say is that the self-insured plan designs that are endorsed will, over the next few months, will undergo rate development. All of the factors and features in the plan design, the treatment limits, the coinsurance, the copays, all of those factors will be taken into account in predicting what the costs are likely to be in 2020 for people who enroll in the UMP plans. If that sounds like a big guess, it is.

Lou McDermott: As we talk about modifying previous resolutions, this can be modified as well. As rate development, as we just had the conversation about Premera and the 78% actuarial value, that can be changed as well. This is informing rate development. It's not a final decision, it's just a piece. The question is whether the Board wants to continue on with a vote. We can just see where the chips fall.

Dave Iseminger: We brought information to the Board. This has been June, July, August, October, November, I think it would be good at some point for the Board to give direction. Is this a topic for continued discussion on future agendas? We're presenting the same information over and over again, quite honestly at this point.

Kim Wallace: I'd like to add that I used a casual term and I'd like to caveat that a bit. I talked about it being a guess.

Lou McDermott: Educated guess.

Kim Wallace: Yes, as the Finance Manager, rest assured, we will take great care in making as clear and as reasonable assumptions as possible, using all the data we have available. But, to your question, Terri, the rate development will be informed by many, many factors. One of which are these treatment limits listed here. These treatment limits will not be a major driver of the rate development, but they will be factored in.

Lou McDermott: Dave and I have a meeting to attend from 2:00 p.m. to 2:10 p.m. We will hold the vote after the meeting. It will give everyone a chance to reflect on what they want to do. If they have questions, we'll continue the comment phase from the Board. We will take a ten minute break.

Dave Iseminger: Board Members are also welcome to ask Katy Hatfield for advice if you have amendments you want to consider and the process. It'll be another opportunity for that. I just want to assure the public that the meeting Lou and I have has absolutely nothing to do with this resolution or the SEBB Program. It's absolutely unrelated.

[Break]

Lou McDermott: Thank you for your patience.

Patty Estes: Is it possible for us to only do the 52 limitations in just one of the UMP Plans and not all three? I know we've had some discussion behind that before.

Kim Wallace: We also talked about the necessary alignment. We use the phrase "substantially similar." How substantially similar the SEBB UMP plans are to the PEBB UMP plans is you could increase the treatment limits on one of the UMP Achieve plans, like UMP Achieve 2 but not UMP Achieve 1, or HDHP, or Plus. The question would be, does that still meet the criteria of standard of substantially similar in terms of how we would set up the administration and work with our current TPA contract, etc. That's essentially the heart of the question. I don't know if we have that answer.

Dave Iseminger: We've talked with Regence and there is that level of flexibility. I think our recommendation would be if you're looking for variability across plans, you have a fully insured book of business and we've provided the information about the variability they're proposing. There's 12, 16, 20, 50, and 52. When we talk about uniformity, consistency, and member experience in the complexity of the benefit designs to be able to say UMP looks like this or the UMP benefits that are statewide have these same benefit pieces that helps reduce some of the complexity and that the members would still have other opportunities for other levels and other benefits. Our recommendation would be to go with all three plans versus fragmenting the plans themselves. We've just gone through an exercise with the fully insured carriers to try to get them more aligned. And moving everything would be consistent with that approach.

Patty Estes: I think the point behind this resolution was to be able to offer something for those members who want something more. I think as long as we have something within the breadth of what we're offering that offers choice, I think that'll be attractive to those members. I just have a really big problem with $1.7 million. It's a lot.

Terri House: I'd like to make a motion to amend 2018-52 to reflect Option 1.

Dave Iseminger: Terri, just for confirmation, all of Option 1? So 16, 16, 16, 80?

Terri House: Correct.

Dave Iseminger: Okay. Let's see if there's a second.

Pete Cutler: I would second that motion.

Dave Iseminger: I anticipated this was going to be an interesting event. I have an alternate slide.

Lou McDermott: Katy, a technical question. We had a motion on the first one, we had a second on the first one. Then we had a motion to amend the first one and we had a second for the second one. Does that mean the first one's gone?

Katy Hatfield: No. What that means is we will discuss the motion to amend and vote on it. If the motion to amend fails, we go back to the original. And, if the motion to amend passes, we amend it and go back and vote on the original with the amendment. You could vote that you want to amend and then still vote no on the original after it's been amended.

Lou McDermott: Okay, we're at the point of public comment.

Katy Hatfield: Yes, we can have public comment and/or Board discussion on the amendment only.

Dave Iseminger: For clarity, we have on the screen the version I just handed out, which basically had all options with blanks. Because acupuncture and massage is currently set at 16 based on the June Board decision, technically, Terri's motion is amending Policy Resolution 2018-52, the opening clause, first bullet, chiropractic visits are limited to 16 per calendar year and then the fourth bullet that's on the screen, which is combined PT/OT/ST/NDT are limited to 80. There's no acupuncture or massage bullet because there's no change that's moved by that option. The amendment is changing chiropractic from 10 visits to 16 visits and combine PT/OT/ST/NDT visits to 80.

Lou McDermott: So, leave the first bullet and the last bullet.

Dave Iseminger: Yes.

Pete Cutler: I think a slightly more generous set of visit limitations would be appropriate and I think the cost involved is, I'm not supposed to say de minimis, but it is still a reasonable balance and I think a fiscally prudent one, so thank you.

Wayne Leonard: I would second Pete's comments. I think that offering slightly more generous chiropractic benefit would be good without going too far up the scale in terms of cost.

Lou McDermott: I will re-read the resolution and then we'll take a vote.

Katy Hatfield: You're going to read the amendment. You are voting on the amendment. Do you want me to say it?

Dave Iseminger: Let me try it. **Amending Policy Resolution SEBB 2018-52 – Self-Insured Plans Treatment Limitations to read:**

Amending Policy Resolutions SEBB 2018-20, SEBB 2018-21, and SEBB 2018-22 to change the treatment limitations as follows:

- Chiropractic visits are limited to 16 per calendar year
- The combined physical therapy, occupational therapy, speech therapy, and neurodevelopmental therapy visits are limited to 80 per calendar year

Katy Hatfield: That's not accurate. Sorry, but it's not correct.

Dave Iseminger: I opened it by saying you're amending it and it reads as follows so that I didn't have to say deleting, deleting, adding, deleting.

Katy Hatfield: Okay. The most important thing is that everyone understands rather than we get it technically right. Does everyone have clear understanding on what we're doing?

Patty Estes: Yes. [And others nodding yes.]

Voting to Approve: 8
Voting No: 0

Lou McDermott: The amendment to Policy Resolution SEBB 2018-52 passes.

Katy Hatfield: Yes. Now we need to vote on the resolution as amended.

Dave Iseminger: Let me make a suggestion, Chair McDermott. You are asking the Board to now vote on Policy Resolution SEBB 2018-52 as amended, which now reads:

Policy Resolution SEBB 2018-52 – Self-insured Plans Treatment Limitations

Amending Policy Resolutions SEBB 2018-20, SEBB 2018-21, and SEBB 2018-22 to change the treatment limitations as follows:

- Chiropractic visits are limited to 16 per calendar year
- The combined physical therapy, occupational therapy, speech therapy, and neurodevelopmental therapy visits are limited to 80 per calendar year

Lou McDermott: What Dave said. Let's go ahead and take a roll call vote. Does everybody understand?

All: Yes.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-52 passes as amended.

We've got to figure that out better for the future.

Katy Hatfield: That was really good, actually. It was great. Everybody knew what they were voting on! That's the most important thing.

Disability Benefits

Betsy Cottle, Contract Manager. Today's objective is to take action on the disability plan designs presented at the September 17 Board Meeting.

Slide 3 – September 17, 2018 Board Follow Up. The Board had a couple questions about clarifying the disability insurance taxation issue, the Washington Paid Family and Medical Leave qualifying period, and the utilization of disability insurance in general.

Slide 4 – Taxability of Disability Benefits. Taxability is relatively simple. Disability benefits are either taxed as you pay for it or as you receive it. I've provided two different examples and it can show either you pay your tax when you purchase it or you pay your tax when you receive your benefit. The PEB Board's employer-paid long-term disability benefits are taxed at the time of claim.

Pete Cutler: I have to admit, I'm confused. Under example one, the first sentence says, "The employer-paid basic disability insurance as a taxable benefit for the employee." And that is my understanding of the rule. But then under example two, the last bullet says, "Employer-paid basic disability insurance is not a taxable benefit for the employee." And I'm not seeing why they're saying different things.

Betsy Cottle: I made the example to show either/or. You can design a plan to do it one way the other.

Pete Cutler: But if the employer pays it, are you saying there's a way for the employer to pay on an after-tax basis so that then it would not be taxable when received by the employee?

Dave Iseminger: Pete, there are ways in which you can structure it so that an employer pays in a way that makes the claim paid tax-free. The more common way is the way the state does it, but there are scenarios and structures in which you could craft it so that you impute the dollars that are paid so they're paid on a pre-tax basis even though they're coming out of the employer's pocket. There are structures that can result in example two where the claim is paid tax-free, but it is not as prominent in the market. It's possible it's not well utilized.

Pete Cutler: Okay, thank you.

Dave Iseminger: We can follow up. At one point, there was a very complex slide that went through the taxing structure. We thought it was too detailed for here. But it sounds like you may personally be more interested and we may follow up with that slide. It doesn't show how you get there. It just shows that it exists.

Pete Cutler: Okay. And, actually, I was involved with IRS taxation of benefits quite a bit before, so I probably would be interested in the details. Thank you.

Dave Iseminger: We'll go through the weeds with Pete and anybody else who wants. I'm not seeing any other head nods on that one so you might be on that journey alone, Pete, but we will certainly follow up with you.

Betsy Cottle: There was a question about how the qualifying period works for the Washington Paid Family and Medical Leave. We confirmed that Katy was absolutely correct. An individual must work a continuous four quarters in the past five quarters. So, you cannot work the first two quarters, skip a quarter, and work two quarters. It's the first four or the last four of the last five quarters. So that does mean that the SEBB Program employees who work more than 630 hours per school year but less than 820 will not will not qualify for the Washington Paid Family and Medical Leave Program unless they accrue additional hours with another employer.

Dave Iseminger: The Employment Security Department (ESD) is presenting at our December Board Meeting. Our recommendation is to not go forward with a short-term supplemental employee paid disability benefit as Betsy will describe in a minute. But, after further conversation with ESD, if there's continued questions about that from the Board, we can continue the discussion,

Wayne Leonard: Would that potentially change our decision about not offering a short-term disability plan if we felt like a lot of our employees wouldn't be covered by this state family paid medical leave?

Dave Iseminger: I think the Board is asking how large of a population is it that could be between 630 hours and 820 hours. In the context of getting you more information about the paid family and medical leave piece, we'll also work to describe the part of the population that could fall in that area. But whether there is a short-term disability benefit that is established by this Board as an employee paid benefit that supplements the portfolio really shouldn't change the bulk of the recommendation, which is that the paid family and medical leave new state program should dovetail with the long-term disability benefit for the vast majority of school employees. I think your question is how big of a gap is it for 630 hours to 820 hours and is there a benefit offering that should this portion authorize for employees to be able to opt into?

Wayne Leonard: Yes. That's the essential idea. But also, since the last discussion, I've gotten a lot of feedback in terms of the dollar amount that's paid for under the state family and medical leave act being a pretty small amount relative.

Dave Iseminger: If you would hold that question for ESD to answer. Small and large is in the eye of the beholder, but they will be able to describe, and we'll make sure to have them prepared to talk about examples of different income sizes, and what a payout would be. And everyone here can individually, subjectively decide what's small and large.

Betsy Cottle: The last question was whether we could find a way to compare the K-12 school population's utilization of disability compared to the PEBB Program. Our vendor, The Standard, was able to do so. This is a representation of Washington PEBB, K-12 school districts of their book of business, and their national group. You can see how the PEBB Program, the existing K-12 school districts that purchase disability insurance from The Standard, and then The Standard's national book of business. In general, school district employees do not appear to access disability benefits at the same frequency as

PEBB Program members. Other than that, I'm not sure that we can extrapolate a lot of specific meaning from here.

Dave Iseminger: We were trying to give you general utilization information, differences that we have. I want to be clear that the blue bar is Washington PEBB Program, which includes 71 school districts, and the green bar does not include those 71 districts. That's Standard's separate book of business, but it doesn't have the K-12 districts that are included in the PEBB Program.

Betsy Cottle: For disability insurance, there is much less specific detail. We do end up having to do some interpretations.

Slides 7 and 8 are Stakeholder Feedback that we received after our September meeting. We presented at a couple of meetings and these are the reactions. Two responses were that the basic long-term disability amount is too low to be useful to most school employees and is lower than what most school employees currently receive. Another comment was to recommend offering a supplemental long-term disability benefit only and putting the funds for the basic LTD toward increasing life insurance or another benefit. We made the clarifying statement here, and responded to the stakeholders when they called out this question that, if this Board does not offer an employer-paid long-term disability benefit, the school districts do not have the authority to offer one.

Dave Iseminger: Just a general reminder about the inner play of the authority, remember, you have the exclusive authority for the benefits that are in your jurisdiction. If you don't offer something, there is no alternative authority.

Pete Cutler: To be clear, school districts do not have the authority to offer one, period. It doesn't matter whether the SEB Board decides to offer one or not. Because it's within the SEB Board's purview of authority, school districts do not have the authority to pay for one. Okay.

Betsy Cottle: Exactly.

There was also concern expressed about sick leave being used prior to the waiting period beginning, forcing members to experience a period of no income. This comment was made for both the employer-paid and the employee-paid disability products. We reminded stakeholders the benefit waiting period begins the day of the incident that requires a disability claim, not after a member has used all their sick leave. A member who has accrued more sick leave than their waiting period will be required to exhaust their sick leave balance. But they will, in general, not end up with $0 income by using sick leave. If you have less sick leave than your waiting period, you obviously have a gap for income.

Participants do support choice for pension because it allows a member the best option to manage their income during a disability. We told them the reason we recommend choice for pension is that, if you are disabled at a very young age, your pension could be negatively impacted.

Slide 9 – Short-Term Disability Insurance Recommendation. The Health Care Authority continues to recommend that the SEBB Program not offer a short-term disability benefit. Offering a short-term disability benefit would likely lead to confusion and redundancy. The Washington Paid Family and Medical Leave is a required program that employees will already be paying for. Offering a short-term disability insurance would be duplicative. We believe there will be minimal gaps in coverage for employees who are either just starting employment in the state or exceed the maximum weekly salary. As a result of the Washington Paid Family and Medical Leave, it is assumed the commercial short-term disability market is going to constrict. Enrollment in short-term disability insurance has also historically been very low.

Dave Iseminger: We will continue to scope what we believe is the size of the population that falls in the 630 hours and 820 hours. But, with what we know today, this is the recommendation. If there are more questions that come up after learning more about paid family and medical leave from the Employment Security Department next month, we will continue to have this discussion. You don't have to take an affirmative vote to not offer the benefit. If you have continued questions on this topic, we can continue working on this area.

Betsy Cottle: Policy Resolution SEBB 2018-38 – Employer-Paid Basic Long-Term Disability is before you for action.

Dave Iseminger: As we are about to move into the voting cadence, I want to discuss this because I know the Board is probably not particularly excited about a benefit starting level of $400. So far the agency has provided about four or five different examples of potential horse trades that could be made to reduce a benefit somewhere else and raise this benefit. There haven't been amendments to the other benefit resolutions, and this is the last one of the suite of benefits that's presented to the Board and I designed it that way in case there was a horse trade made in other meetings or at this meeting. There would have been that opportunity to make that trade and then, consequently, immediately amend this resolution to reflect the changes of the horse trade.

I'll go back to my 90% of your homework today, 10% of your homework after the funding comes in. If you're not happy with this piece, I think it is important to be able to describe that there is an intent to have an employer-paid long-term disability benefit and that is something that you want in the portfolio. As the final numbers come in, there could be some refinement and maybe more amenable horse trades. The agency is more than willing to work with Board Members about other alternatives that you're interested in seeing as potential horse trades.

We've shown one on life insurance. You either take some of that money or you don't. There's not as many variables as there are in vision, dental, or in the medical area.

If there are ideas and specific pieces you want costed out as a potential horse trade, we can bring that information to you. We brought orthodontia information because of a Board request. I'm not sure there was a majority of the Board that was particularly

interested in that horse trade, but you wanted to know what the numbers looked like. We'll go through any and all exercises to describe potential horse trades. For today, you could view this as showing that there is an intent to have an employer long-term disability benefit in the suite and that this is a starting point.

Lou McDermott: **Policy Resolution SEBB 2018-38 – Employer-Paid Basic Long-Term Disability**

Resolved that, the SEBB Program will offer the following Employer-Paid LTD Plan to subscribers beginning January 1, 2020:

- Later of 90 days or the End of the State Paid Family and Medical Leave Benefit
- No Choice Sick Leave
- Choice Pension
- Maximum Monthly Benefit $400 (60% of $667)

Wayne Leonard moved and Alison Poulsen seconded a motion to adopt.

Pete Cutler: I'll just start out by saying this is an issue that I feel very strongly about, whereas I tend to feel pretty flexible about most of the other issues we've been dealing with. In my opinion, this $400 maximum benefit is worse than no benefit at all, because frankly, I know in the state employee context, it leads many employees into a false sense that the employer provides something, they don't pay close attention, and when they have a disability, they realize they can't begin to cover their costs. In my opinion, it would be better to put the money into marketing, and really stress very strongly with employees, this is a much more likely occurrence to impact your life while you're working than a life insurance benefit.

I think a $2,000 minimum benefit or maximum benefit would be much more appropriate. I also, under the Collective Bargaining Agreement, for whatever reason, it did not actually lock in a dollar amount for the SEB Board to work with. We really don't have an idea of what the proposed funding for SEBB benefits is on a per member rate. But it clearly states that whatever this Board adopts as an employer-paid benefit, which would include this benefit, would be funded by the employer. It will not involve some kind of trade-off or cost sharing. So, I'm going to vote no on this resolution. Thank you.

Alison Poulsen: Can you remind me how this compares to a PEBB benefit?

Dave Iseminger: Alison, the PEBB benefit, is a maximum monthly benefit of $240 or 60% of $400. It's a $240 benefit. The difference you see here is reflective of the risk corridor and the risk differences associated with the job classifications that predominate within the SEBB Program population compared with the PEBB Program population.

Betsy Cottle: The utilization slide actually does exactly that.

Terri House: You had mentioned horse trading. Could you trade on life insurance somewhat to, like Pete suggested, make this a little more robust?

Dave Iseminger: The answer to that is yes. When we brought up the life insurance resolutions for consideration by the Board at the October meeting, one of the benefit horse trades we described was decreasing the basic life insurance benefit from $35,000 to $25,000. That would allow you to generate annual premium dollars to support increasing the basic LTD benefit from $400 to $600. That is one of the horse trade ideas. To make sure the Board has an appreciation for why that could be one of the more tolerable types of trades you might lean towards, when you go into the employee-paid supplemental life insurance benefits, the employee can elect more coverage in $10,000 increments.

There's a lot of flexibility in what the employee can get on the life insurance side that tailors to their personal financial situations that they want to insure. On the LTD side, it's more of a pass/fail test. There's the basic benefit that goes to a certain level and then, when you want to elect a supplemental benefit, you have to make the complete jump up to 60%. There's no gradation. So, by raising the basic LTD benefit, you're leveraging that people have flexibility on life insurance. If they need that extra $10,000, they can elect that in a $10,000 increment, but you're enhancing and lowering the big jump they have to make to get up to 60% in LTD.

If this Board wants today to convey that they want a resolution brought in December to do the horse trade in life insurance, we can certainly tee it up that way. If that is the consensus with the Board, and I'd want more people to chime in that is a trade you want to acknowledge, you could amend this resolution to be $600 and then we would bring the second resolution to amend life insurance down to $25,000 for you in December.

Alternatively, you can know that's on the table, and do that during the refinement process and see what other ideas your fellow Board Members have about other potential horse trades while waiting until the funding dollar comes in. I would recommend the Board not engage in trying to do false precision over January, February, March, April, but if you want to convey a horse trade before going into the legislative session and then wait until after the legislative session to do the rest, that would be one way you could proceed.

Terri House: If others are interested, I'm interested in doing that today.

Lou McDermott: Dave, wouldn't we want to vote this in and then in December bring one that switches both of them at the same time?

Dave Iseminger: We can do it that way, too. That may be clearer because it shows the horse trade.

Lou McDermott: Yes, because if we get to the second one and they vote no, it's problematic.

Dave Iseminger: I agree with your suggestive strategy, Chair McDermott.

Lou McDermott: Okay. I would say we vote on this one now and then in December, we'll bring that trade if other members of the Board are also interested in that trade. So, other members are interested? I see heads nodding. Okay.

Pete Cutler: I'm sorry. I'm not interested in the trade because I don't think going to a $600 a month maximum benefit is going to fundamentally change the dynamic that people are going to have the accident and are disabled before they realize they don't begin to have enough money to cover even rent, much less other expenses. So, no thank you.

Alison Poulsen: Yes, I think the trade would be a good option.

Patty Estes: I have to agree with Pete.

Katy Henry: I agree with Pete.

Wayne Leonard: I agree with Pete. Our district's current LTD is 60% of base salary up to maximum $2,000.

Dave Iseminger: That was a nice straw poll for whether to tee something up at the next meeting or not.

Lou McDermott: More deliberation.

Dave Iseminger: Yes, more deliberation. To me, that's signaling that there's a fundamental question about LTD that I think it will be best to engage with the Board about other opportunities for horse trades. We identify other areas that you want the agency to cost out. You're focused on waiting until after legislative session to see if there's any relief that comes in the legislative process.

Wayne Leonard: Just for clarification, though, you indicated that we had to offer a plan. If we don't offer a plan, then school districts aren't able to offer a plan. I will support this resolution today just in that context that we want to offer a plan, not necessarily at this level.

Dave Iseminger: And you do have a correct understanding, Wayne.

Patty Estes: Could we possibly amend the resolution to take out the maximum monthly benefit until a further subsequent meeting to show our intent of offering something but not setting that dollar amount yet?

Lou McDermott: So, my two cents. For rate-setting purposes, you have to have something. You have to put something in and then the horse trading is more real because you'd have to put in a placeholder. You've got to stick a number in anyway. At the end of the day, back to Pete's comment of it's better to offer nothing and let them know that they need to go and get their supplemental, we can also do a resolution to end it.

Dave Iseminger: You could ultimately come back and repeal Policy Resolution SEBB-38 and say there is no basic long-term disability benefit, and use those funds to do something else.

Lou McDermott: But this would give us a starting point.

Pete Cutler: With all due respect, it seems to me that the Board could make a motion to strike the last bullet about the maximum monthly benefit, go on record in favor of having a long-term disability benefit, and then in terms of rate setting, you'd be dealing with the carriers or the insurance company. You'd come back with dollar amounts and essentially punt the decision of that level of benefit until further down the road. In my view, it is quite feasible, unlike health care, the negotiations with the health plans, you're going to a set market with a set company. The cost is what it is. Making the decision five months from now is not going to materially impact the cost or the opportunities, whereas it would have a huge impact if you tried to make the same kind of delay in decision making for the health benefit, or probably even the dental benefit, or vision benefits. I would definitely support a motion to amend the resolution to delete the final bullet. Thank you.

Lou McDermott: I guess my perspective, I'm not sure if I see the point of the resolution then. I don't know what it would do.

Betsy Cottle: It would give everything except the value.

Dave Iseminger: It conveys an intent.

Lou McDermott: But we already have that intent.

Dave Iseminger: Not in a formal action by the Board.

Lou McDermott: No, not in a formal action by the Board. I guess I'm not seeing. If we don't have a number then I don't know what it does.

Pete Cutler: From my view, as Wayne said, it would get us on record that we definitely believe this is an important benefit and there is intent by the Board to offer it. Going on record for those parts and leaving undefined what the level of benefit will be until later in the process.

Lou McDermott: I guess I'm thinking everything that we say during the meeting is on record. So, we have expressed our intent. That's what we want. It's up to you, Dave.

Dave Iseminger: I'll just say, typically, OFM and legislative staffers, if they're not in the audience, they're on the phone, and they're hearing the Board's struggle with this piece. It been a longstanding struggle, both on the PEBB side, and with the level of this benefit for you. I do think it's important to be able to describe to the Legislature, here is the preliminary suite of benefits in its totality. I think there is value to showing people that there is the full suite of benefits, even though it's preliminary. It will have the same asterisk that was at the top of the comparison chart subject to legislative funding and

final Board determinations. Showing everyone that there is this preliminary consensus, although not complete consensus, on all aspects of the benefit design. There is a way to thread this needle and show that this program can launch with a full suite of benefits. I think there is an inherent value being able to go into the legislative session that way.

Alison Poulsen: I would support keeping the dollar amount in there so that we have some good parameters to work and then allow the process to play out over the next period of time.

Terri House: I just have one more question. Can we take out the word "maximum" and put "minimum?" That's the bottom where we're starting. We horse trade up. Can we do that?

Dave Iseminger: Interestingly, Terri, in my mind I was wondering about the value of the word "maximum" or "minimum" because the reality is that would be the benefit. Upon reflection, as soon as you asked that question, I thought there's no value to that adjective either way.

Katy Hatfield: If somebody's salary is less than $667.

Dave Iseminger: So, there is value to the maximum side.

Lou McDermott: Yes, depending on how many people would fall underneath that threshold and receive less than $400. If they receive other money, too, that's counted against that. There is a chance that they would receive less than $400.

Betsy Cottle: Same problem with the word "minimum."

Lou McDermott: It would cost more to say $400 period. We would have to recalculate.

Dave Iseminger: I think we're in the middle of Board discussion but I don't know if there's more Board discussion or public comment about it that may have come up.

You do have a motion and a second on the table right now.

Katy Hatfield: Patty made a motion to amend so I don’t know if that is resolved.

Patty Estes: I didn’t make a motion, I just asked.

Katy Hatfield: Okay.

Dave Iseminger: I was listening very carefully. Nobody made any motions to amend the main motion at this point. There was just lots of hypotheticals.

Voting to Approve: 7
Voting No: 1

Voting to Approve:
Wayne Leonard
Terri House
Alison Poulsen
Katy Henry
Patty Estes
Dan Gosset
Lou McDermott

Voting No:
Pete Cutler

Lou McDermott: Policy Resolution SEBB 2018-38 passes.

Dave Iseminger: I know this is a very difficult resolution for folks. It is not the end of the journey on that benefit. I want to reassure you of that. I appreciate being able to have a full suite of benefits at the end of the day to go into legislative session. That is not the end of the journey.

Lou McDermott: **Policy Resolution SEBB 2018-39 – Employee-Paid Supplemental Long-Term disability**

Resolved that, the SEBB Program will offer the following Employee-Paid Supplemental LTD Plan Design:

- Waiting Period - Later of 90 days or End of the State Paid Family and Medical Leave Benefit
- No Choice Sick Leave,
- Choice Pension
- Maximum Monthly Benefit $10,000 (60% of $16,667)

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-39 passes.

[Break]

Dual Enrolment
Kim Wallace, SEBB Finance Manager. The objective of this agenda item is to take action on Policy Resolution SEBB 2018-15 regarding dual enrollment in SEBB benefits.

We do have a little bit of information regarding stakeholder feedback before we ask for your vote.

Slide 3 – Stakeholder Feedback. One stakeholder did not support the policy of prohibiting dual enrollment because it is significantly different from what employees in some districts have currently. They went on to describe the two sub-bullets on this slide and asked the Board to consider a separate policy for medical versus dental and vision benefits.

Slide 4 - We received a comment from one stakeholder who supported prohibiting dual enrollment for medical benefits, but not for dental or vision.

Slide 5 – Recommendation. The Heath Care Authority's recommendation is to prohibit dual enrollment in SEBB benefits, to limit enrollment in SEBB medical, dental, and vision coverage to a single enrollment per individual.

Lou McDermott: **Policy Resolution SEBB 2018-15 - Dual Enrollment in SEBB Benefits is Prohibited**

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

Alison Poulsen moved and Wayne Leonard seconded a motion to adopt.

Fred Yancey: Thank you, Mr. Chair. My name is Fred Yancey and now I'm wearing the Washington Association School Administrator hat. And they are very much in support of this policy. It is very expensive for districts to double cover employees, and as much as there's an advantage to it and I've been a beneficiary of such a practice in the past, there's a financial cost that is just, you know, we're already looking at a substantial financial cost. So, they're very much in favor of passage of this resolution. Thank you.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-15 passes.

<u>Next Meeting</u>

December 13, 2018
8:30 a.m. to 2:00 p.m.

Preview of December 13, 2018 SEB Board Meeting

Dave Iseminger: First I just want to thank the Board for your 18 votes today.

We've just ended Chapter Three of our journey. Chapter One was orientation and procurement resolution, Chapter Two was self-insured medical, and Chapter Three was a preliminary suite of benefits. We'll talk about the next coming chapters and the work to come for the Board between January and July.

In December, we'll do some myth busting. There are numbers out there that people are asking about. "What exactly is that $1,174 number?" "How is this going to work?"

We'll start a multi-month journey talking about pharmacy, pharmacy trends, and ways you might want to think about modifying a pharmacy benefit going forward. The Employee Security Department will present on Paid Family and Medical Leave. We'll bring back Policy Resolutions for action.

We'll discuss wellness and tee up resolutions related to decisions you have to make related to the wellness program authorized under the Collective Bargaining Agreement.

Lou McDermott: Dave, I want to thank you and your staff for doing a great job. Katy, thanks for helping us through the amendment process. I appreciate the Board for devoting their whole day to this endeavor. It is important and I appreciate your candor and speaking your mind and allowing each other the space to do that. These are hard topics. Nothing is straightforward. There's a hundred ways of looking at it and I appreciate you. So, thank you.

Meeting adjourned at 3:21 p.m

Washington State Health Care Authority

School Employees Benefits Board
Meeting Minutes

DRAFT

December 13, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
8:30 p.m. – 12:45 p.m.

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

Member on Phone:
Alison Poulsen (In Transit)

SEB Board Counsel:
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 8:30 a.m. Sufficient members were present to allow a quorum. Board self-introductions followed.

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

Approval of May 30, 2018 Meeting Minutes
Lou McDermott: Pete Cutler moved and Katy Henry seconded a motion to approve the May 30, 2018 minutes. Minutes approved as written by unanimous vote.

November 8 Board Meeting Follow Up
Dave Iseminger, Director, ERB Division. I'm going to turn it over to Lauren because these are much more technical than I usually handle at this part.

Lauren Johnston, SEBB contract manager. Slide 1 – Fully Insured Medical Follow Up. A question asked was whether there are limits on mental or behavioral health visits for all of the vendors. There are no limits to behavioral and mental health visits within the proposed plans.

Slide 2 - Fully Insured Medical Follow Up. The Board wanted us to ask the plans to provide information on utilization management for mental health that included pharmacy. I'll go through the carriers one at a time and address mental health utilization management (UM) and pharmacy. For Aetna, they responded that they have an integrated approach that uses evidence-based medicine and is a holistic model. Around their pharmacy UM, they review misuse, waste, and abuse. They review every claim before a drug is dispensed to ensure there are no issues prior to them receiving that drug.

For Kaiser Permanente Northwest (KPNW), Kaiser Permanente Washington (KPWA), and KPWA Options, they basically have the same policies. For mental health UM, providers do not need prior authorization to prescribe, only to determine coverage for a patient. A provider could prescribe a service, but in order to determine if the service is going to be covered, there might be utilization management once they get to the coverage point. For pharmacy UM, they use a Pharmacy in Therapeutics Committee to regularly review new and existing medications.

Slide 4. For Premera mental health utilization management, they do a concurrent review that focuses on member acuity and facility utilization patterns using nationally recognized criteria. Their pharmacy UM does a concurrent drug utilization review and a prior authorization review.

Providence uses an integrated utilization management program that is contracted with Optum. Optum is a vendor that does utilization management like prior authorizations, etc. For pharmacy UM, they have UM edits that require approval from the Pharmacy and Therapeutics Committee.

Pete Cutler: Thank you very much, Lauren. This is a good, very high-level summary. But I have to admit, if I were an employee, I would not be satisfied with such a generic overview. The question would be is it possible to get detailed information for what these plans do because as the saying goes, "the devil is in the details." And that would be in this area. It would be very helpful if we had, at least, access to that.

Lauren Johnston: We do have that. It was not my understanding that you would want that kind of detail. How would you like it provided?

Pete Cutler: Well, if it could be either available sent as a PDF document in response to email, or posted where we could get it on the web. Either would be fine.

Dave Iseminger: Pete, we did get a fair amount of detail. It started to become unwieldy as we tried to put it in presentation format, so we presented at a high level. We can make sure more detail is available.

Pete Cutler: That's great. I would agree that I don't think going through the detail would've been helpful in this context. Thank you.

Lauren Johnston: Slide 5. The next question we asked carriers is if their pharmacy policies included step therapy for certain classifications of drugs and specific diagnosis codes. Aetna, for the step therapy for drugs question, their formulary does include step therapy as a standard component of pharmacy benefits. However, it does not apply to specific diagnosis codes. All of the Kaisers had the same response, which is that some drugs on the formulary are subject to step therapy, and step therapy is based on prerequisite drug therapy only, not diagnosis code.

Dave Iseminger: Just to level set, can you describe, generally, what step therapy is? I want to make sure everybody knows what we're talking about.

Lauren Johnston: I will try. I'm not a clinician.

Lou McDermott: Let's have Ryan come up.

Ryan Pistoresi, Assistant Chief Pharmacy Officer, Health Care Authority. Step therapy is a preferred medication used as the frontline medication. Once someone uses that medication, they may step into another medication if the medication doesn't work, or if there's an adverse event.

Lauren Johnston: Slide 4 – For Premera, they also use step therapy for drugs, and their policy does include step therapy for certain classifications for drugs. They use the drug utilization review to ensure cost effectiveness and safety of the member's prescription therapy. Their policy does include step therapy for specific diagnosis codes. And lastly, Providence said they have step therapy edits placed on select antidepressants and antipsychotics. They do not utilize diagnosis code step therapy edits at this time.

2019 Open Enrollment: The Vision for School Employees

Dave Iseminger, Director, ERB Division. I want to talk about where you've been and where we're going. I often describe the Board's work as a multi-chapter book. Chapter One was the orientation phase, and ultimately culminated in procurement resolutions. From October 2017 through March 2018, we were setting a foundation. The agency explained what we learned about the new school employee population that was going to be in the SEBB Program and level setting insurance concepts in the employer benefit world. Then the Board took action on procurement resolutions. That ultimately triggered three procurements by this agency that were performed over the summer.

While the agency was working on the procurements, the Board was in Chapter Two of its journey, which was developing the self-insured medical plan. That was a multi-month conversation about the values of having a self-insured plan within the portfolio. We talked in Executive Session about the financial advantages of the state's Uniform Medical Plan. That culminated in the Board passing four resolutions that set the stage for the Uniform Medical Plan offerings within the SEBB portfolio.

In Chapter Three, you refined benefits within the self-insured plans, specifically related to treatment limitations last month. This chapter really began in July and culminated last month with the multiple benefit design resolutions for medical, dental, vision, disability, life insurance, and AD&D.

Now that the Board has turned the corner of the November Meeting and has a preliminary benefit suite that we will give context to the upcoming legislative debate, we are into Chapter Four. The Board's work in this chapter will be focused on refining the final core eligibility requirements. Barb Scott talked about the detail that needs to be fleshed out on the eligibility framework.

The Board has already passed 8 resolutions related to eligibility in enrollment policies. You passed 36 resolutions between the procurement and benefit design world. But there are still ongoing topics that need to happen with eligibility. As Barb and I have described over and over, it is an iterative process when it comes to eligibility. The PEB Board is still working with esoteric aspects of the eligibility framework within its 30- to 40-page rule set. This Board, future members of this Board, and future directors of this program will continue talking about eligibility until the end of time. We're building off of the statutory framework the Legislature passed in 2017. We'll continue refining that with some key topics that really need to be in place as a foundational setting for the program launch.

The other piece that's in eligibility in this next chapter is the authority that the Board has to put some terms and conditions around the below 630 hours or the requirements for individuals who don't meet SEBB eligibility. In Senate Bill 6241 last session, the Legislature gave districts the authority to offer optional benefits that don't overlap with this Board's jurisdiction and are below the eligibility framework this Board sets up. There are foundational terms and conditions that Barb will be bring to the Board next month for action to give terms, conditions, and framework to that setting. This Board will be working on more eligibility pieces in the next couple of months while the Legislature does its work. We've described many times in the SEBB Program launch that there's a lot of chicken and the egg issues that have happened in the last year and a half. Fortunately, this Board has been able to take action in the last year to give more context for the next stages of the program launch.

For implementation, the decisions you have made are driving IT decisions and IT work that is being done at HCA in order to prepare for open enrollment. We are hoping that open enrollment will have a significant IT online experience, but not exclusively that. We know not everyone has robust access to a computer for all jobs. There will be paper options, as well. But, we are making sure there will be a robust online opportunity.

The Legislature will be in town next month and they will answer the funding question. Later today, the Governor's budget will come out, and I'm hoping by the end of the meeting I can give you a little insight. We'll have a broader discussion next month about what that proposal is. The Legislature will make its decisions during the regular session, which ends April 28. Once we know the Legislature funding, whether that's April, May, or June, the Board will enter the final chapter of refining the benefits. Once we know the final fiscal target, the agency will bring you recommendations and resolutions about refining the benefits. Then, it will be the final push on communications for open enrollment.

We wanted to talk about when school employees walk into open enrollment, next October, what it will look like and how that differs from the world they're in today. Slide 3 – Simple, Transparent, and Equitable. These are the three core concepts the agency

is using to describe the SEBB Program. We know the current system has a lot of complexities, a lot of variance. School employees can't necessarily turn to their brother and sister school employees who are in other districts and compare notes. Everybody's allocation could be different. The funding coming in from local districts that's supplementing what's coming from the state can vary. Benefit packages vary. This consolidation includes that consolidation of purchasing so there will be the similar access to plans for all school employee. Now there is an overlay of service areas, so not every plan will be available to every employee. But, there will be more consistency across the state about what plans are available to school employees.

The transparency in benefit cost is another key part. The Legislature has funded school employee benefits at $2 billion a biennium. That was disseminated to school districts for use on benefits. By consolidating purchasing, the agency will be the one-stop for the Legislature to have accountability for how those funds are used.

The other piece that's important for transparency is what school employees will actually experience. Many of you know that there are allocation worksheets that school districts have throughout the state. You basically have to go through a form writing down the multiplier of your FTE, shopping off a list of a la cart, and eventually find out at the end if you are going to pay the district or is the district going to pay you. There'll be a lot more transparency for school employees about what exactly their costs are and the consistency of those costs over the year. Because, in the current system, a lot of changes to premiums happen either on a monthly or quarterly basis, depending on which district you're in. Through this new system, once premiums are set for January, they will stay the same for the entire calendar year.

The equity piece is in the eye of the beholder. What’s equitable to one person may not be equitable to another person. When we say "equity” from the state's standpoint, it's about once individuals meet the eligibility threshold for benefits that they should have access to high quality, full benefits. Because of the way the eligibility framework is set by the Legislature, once an individual reaches 630 hours, they will not have prorated benefits. They will have full access to the benefits the state believes they should have. Those are the pieces we're focusing on to ensure there is a healthy workforce. If you have a healthy workforce, all of that's off of the table, and educators and school employees can focus on producing a quality education for children.

We are anticipating a six-week open enrollment from October 1, 2019 through November 15, 2019. For anyone who's been an administrator, November 15 is a Friday. It's much easier to end things on a weekday than a weekend, because inevitably there will be something that happens with an IT server on the last day. It's easier to have things end in the middle of the week. You also have customer service centers open for people to get their questions answered.

The agency is building an online open enrollment system. We plan to do a demonstration at the January Board Meeting. It's still in the development phase. Our IT team has been working on it for about ten weeks. What has already been built is quite impressive. Individuals will be able to enroll directly through this platform on the Health Care Authority's website with their own credentials and be able to make their plan selections and their attestations for tobacco and spousal surcharges.

The primary portal people will use is the online platform hosted at the Health Care Authority. Between now and then, we will send out communications about the benefits. We will send newsletters, mailers, and emails. We will share the communication plan at the next Board Meeting. Your Briefing Books have copies of some of the core materials produced in the last few weeks. A one-page sheet is included that shows the preliminary suite of benefits. We are going to collaborate with business officials and unions that were part of the super coalition bargaining sessions this summer. We had a meeting yesterday to talk about a communication strategy that would involve them and communicating directly with school employees. We're collaborating with WSIPC to have direct member contact information so that the agency can communicate directly with the new members. There'll be a very robust rollout of communications over the next couple of months, especially once we get past the legislative session, once funding questions are answered and employee premiums are set by the Board in approximately July.

We are also working on tools to provide a self-service option for this portal and we will be doing a lot of training. We are collaborating with the ESDs to be able to host bigger training events for business officials, and we will collaborate with the unions because they have a strong history of working with their members and helping explain benefits. They're also going to be part of these trainings so that they can help the school employees who typically turn to them. We are trying to take a holistic approach about providing support because HCA is based in Olympia and there are 295 school districts across the state. We won't have the staff to do 295 separate presentations in each of the school districts.

Slide 5 – Choices: Medical Benefits. When they are in this platform, they'll have a lot of choices. I know that's something this Board has highlighted as an important goal and strategy for the portfolio of benefits. We're anticipating there'll be anywhere from two to six carriers in counties. That includes the Uniform Medical Plan, which technically isn't a carrier. That means there'll be a range of five to 16 plan choices. If the service areas the carriers were proposing held true through next July, we would anticipate that most counties and most school employees would have access to somewhere between four and seven plan choices. On the high end, there would be 16 if the Board authorizes all of the proposed plans.

Because of the wide range of carriers in the mix, we're anticipating that approximately 90% of all physicians will be in at least one of the networks. At open enrollment, individuals can do a provider search to ensure their provider is part of the benefit they select.

Another key piece is that there will be a range of plan choices and monthly premiums. We've talked about, and the Board has coalesced around, four separate deductibles. Those separate deductibles and other out-of-pocket maximums will be part of the decision making process as subscribers select their plans.

Pete Cutler: Regarding the network coverage, do you have a sense of how soon employees will be able to check the availability of their own physician? Do you think it's not going to happen until open enrollment, which would strike me as being very late in the process given how many employees there are and how many people may be making inquiries. I'm not sure what the process or timeline is for getting that data in.

Dave Iseminger: I don't have that with me today, Pete. I agree with you that waiting until open enrollment would be too late. I know we are having conversations with the carriers and they're interested in being able to start communicating to school employees. We've said it's a little premature until the Board authorizes your plans and you have some sense of the premiums. They are asking what can they do. I told them a provider search is going to be key for people to be able to make their selections. And, whatever you can do to make your provider search engine as robust as possible, as intuitive as possible, as accurate as possible, that's going to be something that's key. But I'll bring back to the Board at the next meeting what we think is the actual timeline for when provider information will be out. I agree it should be before October.

With medical plans, I'd appreciate any feedback you have about the things that we anticipate school employees will be focusing on. They're obviously going to focus on provider network and how much their monthly premium will be. That won't be set until June or July after we go through the final carrier negotiations and bring that information to the Board. And then, what their out-of-pocket costs could be.

The last one, is the 11x17 chart from the last meeting. I've received a lot of feedback and it's been a good tool for people to describe what the benefits could look like. I think some people were hesitant to distribute it because it is not a final product. You endorsed those for purposes of rate setting. It does give a snapshot into what the general accumulators could be for the plans.

Through the Uniform Medical Plan and the Board's actions last month, there is the Centers of Excellence Program. Anybody who needs a total joint replacement will have access to essentially a free knee or hip if they choose to go to the vendor contracted with the agency. We'll be working more on this, but the financial incentives with wellness that were agreed to during the collective bargaining process and then this Board has some additional eligibility requirements.

Pete Cutler: You might anticipate this, but for the record, I continue to believe the collective bargaining statutes do not permit the agreement to go into requirements regarding reducing cost sharing or anything in terms of design of a Wellness Program, and that is actually a matter under the jurisdiction of this Board. I personally have nothing against it, assuming the Board wants to go forward with that. But, from my point of view, when I read this, there are two things you can absolutely say are going to be there, and there's a third thing that is queued up to be there. But, from my point of view, it's not a done deal until this Board votes. So, just for the record.

Dave Iseminger: So noted for the record, Pete.

Slide 7 – Affordable Medical Benefits for Dependents. During open enrollment, school employees will experience changes in the system related to the three-to-one ratio. There's been this mythical three-to-one ratio unicorn that many people have been chasing for decades. It is clear in the statute the SEBB Program cannot exceed the three-to-one ratio. This Board passed a resolution that set up the three-to-one ratio and the tiered ratio between four tiers and did not further compress and shock the system. But, from the school employees' perspective, they're going to see an overly simplified chart with four tiers that does the multiplication for them and simply says, "if you want a plan, this is what it costs for that plan. If you want to add a dependent, this is what it will

cost." They're going to see the variance between the single subscriber tier and the full dependent tier as much more compressed than a lot of school employees have experienced in the past.

I do recognize that some school districts made strides and achieved that three-to-one ratio, but many other school districts had not. There'll be a significant number of school employees, when they see these premium charts for their monthly out-of-pocket premiums, that will have a very different experience around the affordability for those dependents. Two or three years ago when I sat in the Legislature audience on one of the bills, there were several individuals who were pouring their hearts out because of their inability to cover their family members. There was one testimony that sticks out in my mind about a woman who was pleading with the Legislature to do something about dependent affordability for school employees, because her daughter couldn't get married to her long-term partner because of their financial situation. They would have lost eligibility for other programs. They couldn't get married because they couldn't afford adding him to her school-based benefits. I'm hoping that we start to hear less and less of those stories as this program is launched and that three-to-one ratio really makes dependent affordability real.

Lou McDermott: Dave, to your point of the shock in the system, there also will be employees who have an experience of no premiums who will now be experiencing premiums. There is that side of the tale.

Dave Iseminger: Yes. I have not been in rooms where that conversation has come up from the new members. But I do understand that a lot of times, in school employee meetings when an individual paying nothing now learns they will pay something in the future, other people in the room will speak up and talk about how much they're paying out of their paychecks. I know we've heard a lot of stories from Patty and Terri about people who write checks to their school district or that benefits are 90% of their paycheck, and that has tempered some people's concerns when they realize how much some of their colleagues are paying. It is shock in the system for sure on both ends.

Slide 8 – Choices: Dental Benefits. There will be three plan choices based on actions by the Board. We're not anticipating any significant provider disruption. We're anticipating 94% to 96% percent of all dentists will be in one of the plans. We'll make sure we're clear about what the provider search engines will look like and their availability when I bring that back to the Board.

Sean Corry: Dave, I should've asked this before when you used that type of percentage. 94% to 96% of all dentists are in one of the plans. But, for a particular plan, it's quite possible that the percentage is actually much smaller than that.

Dave Iseminger: That's correct. Especially in the medical setting. On the dental setting, the Uniform Dental Plan, Delta Dental is the third party administrator. There's a fairly significant overlap between existing plans and the Uniform Dental Plan, which has statewide coverage. Would you like me to bring that breakdown back?

Sean Corry: Do we want to see that?

Pete Cutler: I think maybe we should. I have to admit, I'm somebody who's under Uniform Dental Plan now and I decided to give a hard look to the Delta Dental Care Plan and Willamette. I would, with all due respect, my choices were much more limited. As I would portray it, it's like, yes, Uniform Dental Plan gives you an extremely broad network. The other two are managed care plans. You trade off that you have a much more limited panel of providers you can go to, and in the case of Willamette, a much, much smaller number in exchange for more generous coverage. I have to admit, as a consumer, I was frustrated by the difficulty in determining -- because of course, every dental practice believes they all do wonderful work and only wonderful work and all their patients are happy. I ran out of time in terms of trying to track down some objective source of information about quality of care, patient satisfaction. And I'm not sure whether that's something that the Health Care Authority tracks, in terms of contract compliance, or whether it's something that no one's really been able to fill that gap. But anyway, it would be helpful to get a sense, because in Seattle, you'd want to have a sense of how broad is the network for Delta Care, especially in that area versus the access in the Uniform Dental Plan.

Sean Corry: And finally, Dave, even within the Uniform Dental Plan, the percentage of available dentists varies significantly by county.

Dave Iseminger: Correct.

Sean Corry: So, that 94% to 96% is one way to tell the truth, but it doesn't give me a good picture of real access.

Dave Iseminger: For vision, we brought provider maps every possible way. We'll go back and see if there's a way to bring similar things for dental like we separated it apart for vision to give more insight.

Lou McDermott: I think that speaks to making sure we have the tools available for the member to find which plan is right for them, which one covers their provider, so they can make that choice. That's really going to be a key element to success.

Dave Iseminger: All very good points. We'll work on being able to describe that for the Board, but more importantly, in anticipation for describing it to the members.

Another feature of the dental plans is that there is no employee premium that will be paid. In the allocation worksheets that school employees experience now, it's a mandatory benefit. But they actually go through the math of subtracting out the premium from their allocation. All of that will be behind the scenes now. Instead, they'll just see, I'm going to pay zero per month. These are my three plans. Pick a plan after researching the plans.

Slide 9 – Choices: Vision Benefits. Because of the Board's actions at the last meeting, we're on the road for three different plans for school employees. We have provided some very robust provider maps up to this point, but we've also challenged each of the three vendors to work on expanding their provider networks. They have an obligation to us to report back their efforts on that by the beginning of February. We'll be bringing some updated information to the Board then, We'll have a better sense as to what the fuller network looks like. They have been given the rallying cry to expand their networks

as much as possible between October through February. There are going to be a variety of retail options, online option for purchasing hardware, in addition to brick and mortar stores people can visit. Similar to dental, the member experience will be a zero dollar premium and instead focus on plan features. They won't have to do a subtraction on their allocation worksheet. That allocation worksheet will no longer exist.

The other benefits, life and long-term disability (LTD) - they won't have to take specific action on unless they want supplemental coverage. I know the Board may be revisiting the level of the LTD benefit is as we go further into 2019 after the Legislature gives us the final financial target. But, essentially, they will be described what their benefit is and they won't have to take a particular action to enroll in a basic LTD benefit. Same for the basic life and basic AD&D benefits. They will have opportunities for electing supplemental insurance without medical underwriting during the open enrollment period.

They will also have the opportunity to enroll in an FSA or DCAP, as long as they don't enroll in a high deductible plan. Inevitably, we take care of all the administration on the back end. It's one of the reasons open enrollment will end in the middle of November and the plan doesn't begin until January. We go through a reconciliation to make sure employers are not facilitating violations of IRS codes. There are certain enrollment limitations. During open enrollment, they'll make their elections and we'll do clean up on the back end during the six weeks after open enrollment.

Slide 11 – School Employee Decision Making Pre-SEBB. This slide embodies what my team understands is an experience that's happening to school employees today. There is a lot of information flowing around them that stems from the local Collective Bargaining Agreement. Their eligibility may be different. They can't compare it with another bargaining unit within the same school district, let alone across school districts. The pooling arrangement can be extremely different. Their plan options are different based on bargaining and and by school district. There's variability. From that flows out this allocation, there's funding from a couple of different sources. From the employee's perspective, they're basically told what this number is they can spend on a shopping menu. They go through and try to figure out what applies to them. Which things to elect? What things not to elect? What can they afford?

Premiums will even be different after their selections are made. In some instances, either the month or two months after they make their election, the variance in the pooling arrangement will result in some sort of shift in their premiums. They don't know exactly what they're going to pay. They have an estimate as to what they're going to pay when they're making their elections. On top of that, they have to take into account if their allocation is prorated or not.

Lou McDermott: Could somebody familiar with this explain to me how the premium changes during the year?

Sean Corry: I'll do it. With some of our firm's clients, there's a reallocation once or twice over a year's time. Generally, that's the limit for our clients at least. The intent, generally, in my firm's experience, is to help the districts use all of the money intended for benefits without overspending. We target for the end of the fiscal year, or with respect to the payment to the health plans, an endpoint. So we target that and make adjustments once or twice to get close enough to be able to spend all of the money

allocated for benefits without dipping into funds from the school district that weren't intended for that purpose.

Lou McDermott: So, there's no mechanism for a premium stabilization fund where you have a certain percent that's held back so you can continue to keep premiums level? You try and get to zero each year?

Sean Corry: I was trying to explain what I thought was your question, which is what the mechanism is or what the purpose of that is. I think there are some school districts that do have stabilization funds that carry over. But, it’s not universal for sure.

Lou McDermott: I see. And is it small adjustments or is it significant adjustments?

Sean Corry: With our clients, they're small adjustments because the first prediction is generally good. But sometimes it's off because the exigent forces where we can't predict the elimination of a health plan, for example, and what those people will be choosing when they're leaving a health plan and choosing among others. That prediction's a little hard to do, for example.

Lou McDermott: I see. Thank you.

Dave Iseminger: There's all this complex information and decision making and this web of determining whether an employee has the adequate funding and their ability to afford different parts of the benefits package. Employees all have unique questions that the employer and the employee have to track. They have to know who is in what bargaining unit and what’s their FTE. There are so many different questions that employees legitimately have because of the complexity of the system, as well as the business officials. They have to navigate all of these different financial mechanisms to understand what it is that they can afford and buy.

As we go forward, a lot of the collective bargaining pieces are out of the way. The Collective Bargaining Agreement is the same for all. It's the same financial measure. All of the pooling is done behind the scenes at the state.

Slide 12 – School Employee Decision Making Post SEBB Program Go-Live. From the employee perspective, they'll see the monthly premium they will owe. There won't be this premium stabilization or variance that exists that changes the premiums after their election. Once the Board sets the employee contribution in July, everyone will know exactly what they're going to pay starting in January for the entirety of that next calendar year. As employees go into open enrollment, they'll know exactly what their defined employee premium contribution will be. They'll be focused on those core questions without the clutter and complexity of what they can afford or how much money they have to spend on benefits. It really comes down to, “what does my paycheck look like and what can I afford for different plan options?”

They're going to be much more focused on those provider questions on what the cost shares will be. And, hopefully, getting a little bit more into those accumulators and focusing a little bit more on some of the high level aspects of design rather than having to get over the hurdle of understanding their allocation before they can even get into the benefit design. That simplification, hopefully, will make this a better experience.

Patty Estes: I can tell you, as someone that has gone through the chaos of not having anything before moving into the PEBB Program, which I'm guessing that transition's going to be a little similar for a lot of people. It was so simple that it was confusing [laughter] because we were so used to having to figure all of these other aspects out before we could actually look at just simply, what plan do we need?

Because we were, “wait, don't I have to worry about pooling?” No, you don't have to worry about that anymore. We were expecting to have to worry about things that were not even remotely on the table anymore. I know I went back and forth with the PEBB Program people quite often, trying to figure out what I was going to do.

Dave Iseminger: You were looking for where the other shoe was going to drop because you thought you were missing something.

Patty Estes: Yeah. That's from a member standpoint, it's going to be a big shock to not have to worry about any of that.

Dave Iseminger: But hopefully a welcome shock.

Patty Estes: Yes. And now that I've been through it, it's way easier to explain and help other people with picking plans and figuring out, “well, this is how we're going to do this.” Even comparing plans from the options we have now to the options we had before, that transition was easy but eerily easy.

Lou McDermott: What I'm hearing though is that, in our communication plan, we have to be ready for people who are going from a very complex system to a very simplistic system. We need to make sure to articulate in such a way they don't look for the hidden machinery that doesn’t exist.

Patty Estes: "Where's the fine print?"

Lou McDermott: Okay.

Pete Cutler: When some pension changes were put through, I know there was a strong undercurrent of, I don't know if paranoia's the right word, but just concern of, “what are you not telling us? What are you hiding from us?” “What's your real motive?” And so, trying to keep communications as transparent as possible would be helpful.

Katy Henry: I also think that most districts have a streamlined process that most employees are used to having gone through for years and years. We will be butting up against that known entity. I think ensuring districts have all the tools they need, and their employees, who are typically running them, are well informed, will help it go much smoother.

Dave Iseminger: On the dental and vision side, there isn't even that question about affordability. They won't even have to subtract from the allocation worksheet. It'll just be, “what benefit do I want?” because it's fully paid for by the employer.

Slide 13 – Allocation vs. Contribution. On the left-hand side, it’s an illustrative example of an allocation worksheet that staff found from this past open enrollment. It takes you

through this math formula: what's your FTE status times a specific allocation? That's what your contribution is. Put that in line A, subtract line B, leave line C. Go over to this page, put this in here, subtract C to get to D. And, at the end, you go down to the bottom and is it a positive or a negative number? "Do I write a check or does something come out of my paycheck?" And then, at the end, there's that kind of asterisk for medical premiums. After open enrollment, local pooling funds could change and your monthly premiums might differ from what was used in your decision making tool.

In the future state, you'll have one 8 ½" by 11" page. I just showed Tier 1 and Tier 4. You'll have your medical plans and a chart that explains what your monthly premium will be based on who you're enrolling. You will dive into, just like in the current system, into other plan information to go, "what is the differences between A, B, and C?" And we'll have comparator charts like we brought to the Board last time for different benefits. From a financial framework, you're not going to have to do all that math. Instead, you're going to go to this chart and determine what you want and whether you can afford it. That's the number I'm going to pay. Can I add my kids? I can afford 1.75, that's the plan I'm picking.

It doesn't involve as much math, so to speak. What that leads to then is, in addition to folks on that premium chart, there's the original two questions that were on a prior slide. They're going to focus on the provider search engine and making sure their provider is in their network, and then some of those high-level accumulators, the deductible and the out-of-pocket expenses. I understand one of the challenges some school employees have at this point is, they have to do that allocation worksheet multiple times. They have to do it for themselves as an employee only, and then they do it for their dependents. And so, they're really going through that math multiple times.

Whereas in the future state, they'll see the monthly premium, see it multiplied out on the chart and go, "Okay, $25 or $37.50. Can I afford $37.50? That's the plan I want and they enroll themselves and their dependents. Looking only at the employee contribution really is a seismic shift for the member experience.

That's what we're anticipating for open enrollment, focused on an online experience but knowing that we have to have a paper-based backup system for employees who don't have as much access to computers in their day-to-day work or at home. And then, making sure we're describing differences in the financial aspects in making it simple to understand. Addressing those issues and really having employees focus on those provider searches and those key features of the benefit plan.

Slide 14 – Milestones. How do we get there in the next nine to twelve months. Today the Governor's budget comes out. We have kicked off the formal not-to-exceed rate negotiation process with the carriers. We've had some conversations with the six of them over the last month. Their access to data to be able to start working on rates begins today. We will be going back and forth with the carriers over the next two to three months. We're to deliver refreshed financial modeling to the Legislature at the beginning of March, along with some other information that the agency provides for budgetary purposes as they get the March revenue forecast, so that can be the most up-to-date information as the various chamber budgets come out, as they march towards the end of session and passing an operating budget.

The real key part was this Board in November endorsed moving forward different plan designs for rate development. We'll work on rate development and bring that to the Board and to the Legislature during the legislative session. Once the Legislature makes it's final decisions, we'll bring back information to the Board in May, June, or July for working on refining benefits and setting the final employee premiums. That work should end in late July and we should have about 60 days to finish the end of the communication push into open enrollment.

Open enrollment will begin on October 1. We'll do some cleanup and move into the administrative launch. We think of this program launch at the agency in two phases. There's the October 1 open enrollment member-facing phase, and the go live for the administrative services that begin January 1, 2020. Between now and then, we'll do the final execution of contracts with all of the carriers. We will be completing the IT build for that front-end enrollment system that we'll be offering for school employees. We're anticipating that that will be completed in the late-April, early-May, and that will be when we are able to kick off the formal training with ESDs, business officials, and unions so they are able to go out and support school employees once open enrollment happens. After the budget is enacted, but before premiums are set, we'll have the refinement discussion of benefits with the Board.

Sean Corry: I have a question that I think can't be answered now. I was in a meeting yesterday where the general budget was discussed. The context was that basically the ask among people around the state and organizations was well over a billion more than what the budget's going to be able to afford. So, the discussion yesterday was we're going to have to be careful about what we ask for and keep our expectations reasonable with respect to a limited sum of money. So, that in context, we'll see the Governor's budgets, which is not, of course, the final budget. I don't remember having a conversation here about the possibility, maybe not the likelihood, but the possibility that the funding to K-12 benefits as determined as hoped for by the bargaining numbers that occurred a couple months ago is actually going to be the number. What are we going to have to think about? And this could be a question for an answer on another day. But what are we going to have to think about if the funding is not what was originally proposed through the bargaining agreement?

Megan Atkinson, Chief Financial Officer. Sean, I was going to mention this at the beginning of my presentation, so, great lead-in. The process in collective bargaining is obviously this last summer the state had negotiations with the labor union coalition. That tentative agreement was submitted to the Office of Financial Management (OFM). The next step in the process is for the Director of OFM to certify the Collective Bargaining Agreements as financially feasible. That was done earlier this week. There is a letter from the OFM Director, actually for all the bargaining agreements, but including the SEBB bargaining agreement that they are deemed financially feasible.

Since that determination has been made, the Governor will include funding for the bargaining agreement in his budget, which we'll see later today. The Legislature has a binary question in front of them. They can approve funding the collection of bargaining agreements, or they cannot fund and turn the bargaining agreement down. They cannot tweak the bargaining agreement. If they turn it down, we end up going back to the table. In the past, there have been times when the Legislature has turned down an agreement and offered a certain amount of money and sent everyone back to the

bargaining table, or they've provided other direction. There are questions about the legality of that, but it has happened in the past.

There is a provision in the bargaining agreement to get the state and the unions through the first year, even if we're renegotiating the bargaining agreement. I don't have the agreement in front of me and I can't remember the exact language.

Dave Iseminger: Essentially, the part of the Collective Bargaining Agreement says that, if the bargaining agreement is funded but yet there are still some other things that are changed that could be potentially impacting the bargaining agreement, the launch of the program can go forward. And then, we would go back to the table to negotiate the impacts of those changes that the Legislature made, while simultaneously negotiating potent impacts to the second year of the bargaining agreement. There's this clause that allows the status quo that was agreed to for the launch. Then we're back at the bargaining table to talk about the impacts of any legislative changes next summer rather than waiting two full years until the next cycle of bargaining.

Pete Cutler: I just wanted to confirm that is specific to the K-12 health benefit contract.

Megan Atkinson: Yes.

SEBB Program Financial Terms

Megan Atkinson, Chief Financial Officer, Financial Services Division. Before getting into the sides, I want to make a couple of notes. With the bargaining agreements being financially feasible and the Governor's budget out today, if we're able to have any materials pulled and available, I'll disseminate stuff back to you. But again, with the OFM Director deeming the bargaining agreement financially feasible, we expect it to be funded in the Governor's budget.

Dave Iseminger: We will make a presentation on the Governor’s budget in January.

Megan Atkinson: I also wanted to do a some financial staff housekeeping. Unfortunately, Kayla Hammer, who you've met and worked with before, accepted a really great opportunity with the Senate Ways and Means Committee. I always hate to lose staff, but it is a great opportunity for her and we wish Kayla well in her work with the Legislature. We have already added to our staff. We recently hired a great fiscal analyst from Florida, Grace Fletcher. I don't think you all have had a chance to work with her yet. But she and Kim are a really great team and I know we'll be fine, even with Kayla's departure. In addition, we are teaming across the PEBB finance people and the SEBB finance staff, because there's a lot of intersection of the two programs. Don't be surprised if sometimes we end up with a slightly larger team at the Board table.

Slide 2 – Purpose. We will define and describe financial terms. The five terms we’ll discuss are: the funding rate, K-12 benefit allocation, K-12 benefit allocation factor (BAF), the Employer Medical Contribution (EMC), and the employee premium contributions.

Slide 3 – SEBB Program Funding Rate. This is a critical number and we'll be using it a lot. It'll be important to the K-12 districts and employers. It’s the per subscriber amount we will invoice and the employers will pay for each SEBB benefits-eligible employee.

That includes those who waive medical benefits. As a reminder, the reason that we collect a funding rate, even when an employee waives, is because the funding rate calculation has already taken into account an assumption about a certain percentage of benefits eligible employees waiving their coverage. Even if we didn't do it with this methodology, even if we used a methodology where we only collected for people who elect coverage, we would still need the same amount of money. The reason we do it this way is so we collect a slightly lower amount of money across a larger pool of people so we don't inadvertently create an incentive for an employer to withhold benefits from someone who actually is eligible. This is what we do in PEBB and the way we'll do it here.

Currently, the K-12 benefit allocation we're used to seeing in the budget bill is calculated on a different base and with different methodology than the funding rate we will use for the SEBB Program. We really encourage that we not try to do a comparison of the two statistics. Currently, I think the K-12 benefit allocation is in the $800s. I think it's $850 or something like that. The numbers we've been using throughout the summer are a SEBB funding rate of about $1,100. So, very different, but the statistics, again, different eligibility, different benefit package. They're very different statistics and you really can't compare the two.

Slide 4 – K-12 State Insurance Benefits Funding. In aggregate, this is the funding the state will send to school districts for health care. These will be in the budgets in the K-12 section, the education section. It’s based on a prototypical school funding model. It largely uses enrollment projections to produce a number of state funded FTEs. In addition, we take the benefit allocation factors, the BAFs, and apply those to convert this FTE base to a headcount base. We calculate those at the state level. Those are specified in the Collective Bargaining Agreement.

For state funded classified staff, we have a factor of 1.43. For state funded certificated staff, a factor of 1.02. You may be remembering some of the conversations we had this summer. OFM has done these calculations and the insight that we got and then we all, went, "Of course it's that way,” is that big difference between the factor used for classified staff versus the factor used to certificated staff. What you're seeing in classified staff, where districts have a little bit more flexibility around the educational model because they're not tied to classroom size requirements, that factor is larger. You're seeing the district hiring practices of using more than one person on what otherwise would be a single FTE slot. The resulting staffing values are multiplied by the funding rate. We typed out the formula here. It's really very simple. It's the number of generated FTE times the BAF times the funding rate. In aggregate, that results in hundreds of millions of dollars being driven out to school districts for health care benefits.

Pete Cutler: First of all, I mean, in terms of the difference in the ratio, I assume part of the factor is that there are a lot of classified functions, bus driving, for example, that don't logically involve a six- or seven-hour day. It makes sense, efficiency-wise, to have them part time. The other thing is, if I understand correctly, the result of this is every school district, their allocation will be based on the same 1.43, let's say, for the classified employees. It doesn't matter whether from past practice they have hired a whole lot of part time people or only a few. It's an average number. So, therefore, in a way, you'd have winners if you have districts that got by with more part-time positions

where there's less gap between the FTE and a headcount than districts that have a higher than average ratio of part-time people. They're going to have to figure out how to work with that. It'll be their issue to manage rather than something that's considered a basic education responsibility by the state. Thank you.

Megan Atkinson: Pete, you do raise a good point, and one that we wanted to clarify on the slide in one of our various edits as we got ready for the Board meeting. Those two factors are calculated at the statewide level. It wasn't calculated and we don't have a breakdown by district. I can't tell you what the variability is across the districts in the state. Obviously, we all know that each district does their educational program a little bit different. I would expect some variability. To Pete's point, some districts could win with these factors and some districts could lose with these factors.

Wayne Leonard: I probably have a bit more knowledge than most of the Board Members about some of this prototypical school funding model. But, like a lot of my members, a lot of the business officials are still estimating that going in the SEBB Program is going to cost their districts a significant amount of money above and beyond what the Legislature will fund. Some of it is related to other factors. For example, in many, many school districts, maybe 20% to 25% of their funding is categorical funding through federal grants or whatever. There's no additional funding for SEBB in those programs. That's correct?

Megan Atkinson: Correct.

Wayne Leonard: A lot of those programs are there to serve students in poverty or special needs students. This increase in costs on those programs will have a significant impact. I'm not sure the Legislature's aware of that. Because, if the costs aren't funded, there will be fewer people working in those programs.

The other thing that I don't think this is going to fund is potentially all the new employees that would become eligible under SEBB. We've talked about that a little bit before. My concern, for example, is certificated and classified substitutes that have historically not been covered by medical insurance. When I looked at my data in Mead School District, potentially, I could have another 100 people qualify for medical benefits, which would be an additional $1.4 million that I would have to find. When it's presented like, “well, you're going to have these great benefits and the employer's just going to pay the full employer allocation,” that's true. But the employer may not have money to pay for this. That's going to potentially result in a lot of layoffs and other program adjustments around the state, which I'm not sure is being fully appreciated by the Legislature.

Megan Atkinson: I'm not a K-12 funding expert. I don't want to get myself into an area where my ignorance quickly becomes apparent. When we go into the legislative session this year, these granular issues around how the state's education funding covers or doesn’t cover the staff districts have on the ground, I think will definitely rise up. From our perspective at the Health Care Authority, we're focused on the funding we need to run the benefit program. One of the things we have talked about, what is the total universe of the staff, the substitute issue, part time coaches, all of that. I think it will be very interesting. That sounds sort of a weak word, but sort of very interesting to see as we end up going through our enrollment period, as school districts apply the eligibility criteria, really how many people come in under the umbrella of the SEBB

Program and how that compares to what is recognized in the state funding. Again, I want to emphasize what I'm walking you through now is the state funding, so the state recognized staff.

Lou McDermott: Wayne, I'm curious on your modeling you did. Did you take into consideration the BAF going to 1.43?

Wayne Leonard: Yes. That benefit allocation factor jumping up is helpful. It's a lot higher than I thought it was going to be. But, since that only applies to the state prototypical school funding model, the generated staffing units, it doesn't --

Lou McDermott: It had some dampening effect, but not --

Wayne Leonard: Yes, it had some dampening effect, and typically, districts that have operated with full levies have more staff and impacted negatively under the new school financing model.

Districts that got more federal grants based on high poverty or based on students with special needs, could raise their levies even more. Typically they hire more people to work with that population of students. None of those programs are receiving additional funds. They're going to be impacted more negatively than other districts. It's not an equal impact across the state, from district to district.

Lou McDermott: And from your perspective, the higher negative impact will occur in areas that have larger issues with poverty and special needs students because they’re receiving more dollars and that’s not taken into consideration?

Wayne Leonard: Potentially. And those programs aren't receiving additional funding for employees' health insurance. They typically have more employees to work with those children, too.

Lou McDermott: Okay, thank you.

Megan Atkinson: I should point out that the current staff multiplier is 1.15. This is a significant increase for the classified staff side. But Wayne's point is well taken.

Slide 5 – SEBB Program Employer and Employee Contributions. Per the Collective Bargaining Agreement, the employer and employee medical premium shares will be calculated using an employer medical contribution or an EMC. This is a difference in the SEBB Program calculations than how we do it in the PEBB Program. For those used to the PEBB Program world, this is a different way of calculating the employer and employee medical premiums. So, the EMC is set to be equal to 85% of the monthly premium for the UMP Achieve 2 plan, or our self-insured plan, with an estimated 88% actuarial value. The employee will pay the difference between the EMC and the monthly premium, but they will pay no less than 2% of the EMC.

We’re doing a benchmarking methodology where we're benchmarking off of one of our self-insured plans, the 88% AV plan. Doing the employer/employee split at an 85%/15% split. This methodology is called out in the Collective Bargaining Agreement. We do have some modeling we've been using this summer and some numbers, again,

that I'll walk you through in a little bit. We don't have final bid rates. These numbers will change a bit, but the methodology and the percent split won't change.

The other point that I want to make on Slide 6 is that our premium tier ratios you approved will be used and applied for the premium contributions. Both the employer contributions and the employee contributions will benefit from the tiering ratios. I think that's a departure from what some school districts and some school employees have experienced. So, that employer contribution set on the employee-only tier is then multiplied by the tiering factor so as an employee enrolls more family members and the premium goes up, the employer contribution increases and the employee contribution increases. That 85%/15% split remains, and then the benchmarking off of the 88% AV plan remains as well as you move across the tiers.

Dave touched on this already, but dental, vision, basic life and basic long-term disability, the employee will pay zero. Or said differently, the employer will pay 100% of the monthly premiums.

Slide 7 – SEBB Program Funding Rate Dates. This table shows how we build up the funding rate. These numbers are based on modeling used during the summer. They do not reflect final bids because we don't have final bids. They also do not reflect a legislative action. Don't fall in love with these numbers, they illustrate the way the math works. The employer medical contribution at the first row in the blue, the modeling that we used this summer showed it's $616 per month. We multiple that by a ratio of adult units to subscribers. That's estimated currently to be 1.586. What all is in that number? It's a kind of important ratio. It is our assumptions around family mix. It's our assumptions around the percentage of the population who waive their coverage and the dependent mix, which we'll use family mix. But all of that is in that number.

Pete Cutler: Do you know how that compares with the mix in PEBB?

Megan Atkinson: We're using PEBB to inform this. I don't know if that's exactly the same ratio.

Pete Cutler: But some were similar. Thank you.

Megan Atkinson: Literally, if you multiply this $616 times the 1.586, you'd go down and get the $977. From there on, everything is on a PSPM or a per subscriber per month basis. We change the base there a bit as we go through the math and then get to a number that's used in budgeting. The medical premium contribution ends up being $977. You see here the employer fully funding dental, vision, basic life, and basic LTD. We have an assumption around the K-12 remittance, which we have to continue because we still have K-12 retirees in a PEBB risk pool versus having the SEBB actives in the SEBB risk pool. We still need that K-12 remittance for a little bit longer. We have admin and other costs. In that last line, we've got another footnote there on that $16. This modeling assumes repayment of the general fund state loan. That's the loan we're using for operating funds right now. Depending on what level of admin funding we have in the Governor's budget, that number could change. This is the modeling and the numbers used this summer. We will have updated numbers once we see the Governor's budget and once we get through final bids. Then further updated numbers possibly with a final legislative budget.

Pete Cutler: Two questions. On paying back the general fund state loan, do you know off the top of your head roughly how much the $16 is associated with that and how long? Is that a two-year period, four-year period, six-year?

Megan Atkinson: I don't know how much of the $16 is the loan repayment. I know that we have about $30 million to repay. I think it was about $26-$28 million. We assume that we get it repaid in that first biennium.

Pete Cutler: Oh, just a one biennium.

Megan Atkinson: It's a one biennium repayment. As we were building up and assisting OFM with building up the Governor's budget, we had one of these “that's funny in hindsight” moments where we realized that we wouldn't have K-12 district employer contributions coming in until January 2020. But we would need to operate the program July 2019 through December of 2019; and thus, we needed a second general fund state loan to cover those six months. Again, that $26-$28 million that we have for the current biennium, we do have a request into OFM that we needed a second general fund state loan to cover those first six months of the next biennium. I know that $16 doesn't currently reflect reality.

Pete Cutler: We can hope that maybe somehow the cost will be forgiven or spread over a longer period of time and that might free up some dollars for better long-term disability benefit or something similar.

Megan Atkinson: I think your point, Pete, is that it is important as we're comparing our SEBB numbers to the current K-12 allocation as well as if we end up comparing SEBB to PEBB. In the initial biennium, we will have a fairly substantial general fund state loan to repay. That will impact the SEBB funding rate. It's important to keep that in mind.

Pete Cutler: A second topic area, the K-12 remittance, dealing with the cost of retiree coverage. Am I correct that HCA's going to be sending a report to the Legislature sometime this month about the funding?

Dave Iseminger: Literally, we're supposed to send it tomorrow. We plan to discuss this report at the January meeting.

Pete Cutler: If it's official delivery to the Legislature, I assume that makes it public and can we get a link to it or something?

Dave Iseminger: A number of people are interested in that report. We post all of our legislative reports on the HCA website. We'll send something out to the Board that has a link to that report in particular.

Pete Cutler: Great, thank you.

Megan Atkinson: Slide 8 – Illustrative Example: Employer Medical Contribution (EMC) and Employee Premiums. Don’t fall in love with these numbers on this chart. They are for illustrative purposes. Look at the columns left to right. This is a hypothetical suite of plans. It shows you how the employer medical contribution, which is the green

highlighted row of $616. The $616 is the number we were using in modeling this summer in bargaining. But, again, we don't have bid rates so these are estimates. You can see how, as you move across the tiers, then let's just take this first one because it's the easiest one to go across, the employer contribution. In the employee only tier, you see the $616. You move across to the employee and spouse or partner tier. Then it becomes $1,232. Again, it's just the math. So, it's just the $616 times the tier ratio. And up at the top, we've got these tier ratios in the shaded gray area. So, the $616 times the two. That gives you $1,232. And then, as you just keep moving across, the times the 1.75, times the 3.0. So, you can see the employer contribution is growing as you move across the tiers. The math is really straightforward. With the example at the employee only tier, the plan A with a 90% AV. If they have a premium of $775, the employer's contribution is the $616. You just do the math and you end up with the employee contribution of $159. And then again, of course, if you move across the tiers the total premium, the employer contribution, the employee contribution, those all grow because you're multiplying all of them by the tiering factor.

We did highlight the SEBB UMP Achieve 2 showing the benchmark plan to where the math should work out to where the employer contribution, the $616 is 85% of the $725, that illustrative premium rate there. So, again, this is just to illustrate how the math will work. Should I mention these aren't the real numbers? But hopefully they are close.

[break]

Pharmacy 101

Molly Christie, Strategic Plan Project Manager, Benefit Strategy and Design Section. Today's presentation is a brief series we're doing in the 2019 Board season discussing the pharmaceutical industry and prescription benefits.

Slide 2 – Preview. In today's presentation, we will examine national prescription utilization and spending focusing on the specialty drug trend. I'll also touch on strategies drug manufacturers use to promote costly brand drugs.

Slide 3 – Prescription Drugs Are on Everyone's Agenda. In 2018, at least 45 states considered more than 1,140 measures on prescription drugs. I plan to cover some of those strategies in a future presentation, as well measures our state has been looking at. There were 160 new laws signed just last year in 44 states. Drug policy is likely to be a major federal issue. In the upcoming Congress, health care was one of the biggest concerns among voters in the recent midterm election.

Slide 4 – About 6/10 Amaricans Report Currently Taking at Least One Prescription. A lot of people take prescription drugs. In the most recent Kaiser Family Foundation health tracking poll, six out of ten respondents reported currently taking one prescription, and 25% of Americans say they take four or more. This is not a bad thing. This is helping keep us healthier longer. For instance, prescription drugs help many Americans with chronic conditions live healthy lives. More than half of the growth in prescription volume in the last five years has gone to treating common chronic diseases including hypertension, mental health, and diabetes.

Lou McDermott: I'm sorry, that number's pretty staggering. Does the data take into consideration kids because a lot of kids don't take medication. Is the number even worse or are kids excluded from that?

Molly Christie: I will look into the methodology. I remember seeing that it was American adult, but I'll confirm that and get back to you.

Lou McDermott: Okay. That makes me feel a little better.

Molly Christie: Slide 5 – Keeping Us Healther Longer. The world's population has a longer life expectancy than ever before in history. This can be attributed to breakthroughs in modern medicine. In fact, 2035 will be the first time in US history that Americans over 65 as an age group are expected to outnumber children under 18. It's a huge shift in our population demographics. This aging population was the primary driver of prescription utilization between 2012 and 2017, people aging into that 65 and over group.

Slide 6 –The US Spends a Lot on Prescription Drugs. Most good things are not free. I'll caveat this slide and say it's to provide an illustration for some big numbers and to provide context. It's not a value statement. I'll let you decide your own value and opinion. Our country does spend a lot of money on prescription drugs. In 2017, our prescription spending outspent the Gross Domestic Product (GDP) of Norway by more than $60 billion. That same year, gross prescription spending was about half of what we spent nationally on Social Security. The trends in prescription spending are expected to continue to outpace growth in total health spending through 2026.

Slide 7 – Particularly Compared to Other Health Services. Furthermore, prescription spending is surprisingly high compared to other health services. For a typical commercial health plan, almost 25% of a member's premium dollar goes to prescription drugs. That's more than any other category measured in this study, including hospital stays, doctor services, in-patient, and out-patient visits. This spending is high and it's rising, largely because of extremely expensive specialty drugs. For example, ten years ago, specialty medicines accounted for about a quarter of total pharmacy spending nationally. Today, they contribute about 47%. At the same time, specialty drugs represent only 2% of prescriptions dispensed.

Slide 9 – Specialty Drugs Bring Exciting Innovation. What are specialty drugs? They are breakthrough therapies that treat, and sometimes even cure, life-threatening or debilitating diseases. A specific example you may have seen on the news is about hemophilia and a potential cure on the horizon. Hemophilia is a genetic disorder that prevents proper blood clotting. For people with this disorder, it can be extremely painful and even minor injuries can cause life-threatening bleeding. Most people require constant injections to replenish blood clotting factors. On average, these medications cost $270,000 annually. There are about 20,000 people in the US on these drugs. But the good news is that recent research has demonstrated in mice that hemophilia could potentially be treated for life with a single injection. This new specialty treatment could be available in the next few years. That's an example of a specialty drug.

There is no common definition. Health plans come up with their own definitions based on different characteristics. But there are some very common characteristics that most

specialty drugs have. They're more likely to treat complex or rare diseases. So, for instance, many specialty medicines are considered orphan drugs by the FDA, meaning they treat a condition that affects fewer than 200,000 people nationally. Furthermore, specialty drugs often require one-on-one patient education and counseling, as well as special oversight by your doctor. They're often developed from living cells. These are called biologic medications, which require special handling and administration, oftentimes that's in the hospital through an injection or infusion. Specialty drugs are extremely costly compared to traditional drugs. They can average ten times the cost of traditional medications.

Part of this high expense is because most specialty drugs don't have generic equivalents. The FDA grants patents to drug manufacturers when they create a new drug. They have exclusive marketing and manufacturing rights. But oftentimes, those patents on average last 20 years. There are mechanisms that drug manufacturers can use to extend the life of those patents. Generics, on the other hand, are comparable to brand-name drugs in quality, strength, root of administration, intended use, all the things pharmacists look at when deciding what type of drug is appropriate for treating certain diseases.

Lou McDermott: Ryan, is it fair to say they have the same sort of active ingredients but there may be some differences in how it's put together with other compounds?

Ryan Pistoresi, Assistant Chief Pharmacy Officer. You are correct. Generics have the same active ingredients and approved by the FDA. They are the same in terms of their variability, so when you take a medication and the medication starts to work in your body, that generic works the exact same way. All the pharmacodynamics, all the pharmacokinetics need to be similar enough that they would produce the same effect. They are interchangeable.

Molly Christie: Thank you, Ryan. That's exactly what I was going to say. [laughter]

Slide 10 - … And Enormous Price Tags. In the past 12 years, average spending for specialty claims in employer health plans has grown four-fold. Pricing for these specialty drugs is based on what manufacturers think the market will bear. There is no complex process to pricing drugs. For example, the drug manufacturer Novartis has hinted that it might charge $4 to $5 million for a new gene therapy that treats type one spinal muscular atrophy. This is a rare genetic disease, oftentimes fatal, that affects about one in 20,000 toddlers. A single dose of this new medication could potentially prevent the disease if given shortly after birth. It would also be the most expensive and would set the record for the most expensive drug in history.

Slide 11 – The Specialty Drug Pipeline Shows No Sign of Slowing. Drug manufacturers are allowed to do this. They can set whatever price they choose for new drugs they develop. There's no limit for how much they can increase the price of a brand-name drug that they have a patent on. For example, the price of EpiPen rose from $100 in 2007 to $600 in 2016. There's no sign that we can see the specialty pipeline is slowing any time soon. Over the past 12 years, the number of specialty drugs approved by the FDA has almost tripled. Breakthrough specialty drugs may be available by 2022 that treat certain types of cancer, blindness, hemophilia, Alzheimer's disease, and certain neurologic diseases. This list is not comprehensive. There are more.

In 2017, there were over 35 specialty drugs approved by the FDA. Included were, the first medicine to treat all forms of Hepatitis C and CAR-T treatments, which engineer a patient's own immune system to fight cancer. In 2018, we're continuing to see new specialty drugs, such as a new class of drugs to prevent migraines and multi-drug resistant HIV.

Slide 12 – Manufacturers Spend Billions to Advertise Brand Drugs. Generics are usually substantially less expensive than brand-name drugs. For this reason, drug companies spend a lot of money on advertising and promotion to encourage brand loyalty by patients and prescribers before their drugs go off patent. These lower cost generics become available. In 2015, drug companies in the US spent $5.2 billion on direct-to-consumer advertising, which is up more than 60% since 2011. The United States and New Zealand are the only countries in the world that allow direct-to-consumer advertising for pharmaceuticals. In the US, these types of drug ads are one of the largest growing categories of advertising on TV. Drug manufacturers also target physicians to help sell their products. They use gifts, samples, and other forms of direct payment. In 2015, physicians received $7.33 billion in payments as gifts or for speaking on behalf of specific brand-name drugs. Globally, nine out of ten of the biggest pharmacy companies spend more on advertising than they do on research and development for new medications.

Slide 13 – All of This Advertising Encourages Brand Use. These marketing tactics are effective. That's why they use them. Studies have found substantial effects of advertising on brand-name drug utilization. You may have talked to your doctor after you saw an ad or you know someone who has. In the Kaiser Family Foundation poll that I mentioned earlier, 14% of people admitted to talking with their doctors after seeing or hearing a prescription ad on TV. In over half of those interactions, doctors prescribed that brand-name drug.

Lou McDermott: The thing that's interesting, when I watch those commercials, some of them don't even tell you what the drug treats. They're getting to the point where they say, “this drug’s amazing,” and leave it at that. They don't tell you what condition it treats. They tell you that little thing at the end about all the side effects, death being the top one. So interesting.

Dave Iseminger: And don't take it if you're allergic to it. That's my favorite part of the commercials.

Molly Christie: Interestingly, there have been studies showing that the long list of side effects actually helps improve the credibility of the drug because people think if all of those things could happen, it must be really effective. Nothing good comes for free. That's an interesting phenomenon.

To your point, Lou, drug advertisements can be very overwhelming and misleading to consumers. Drug companies don't have to spell out exactly how the drug works. They don't have to mention the cost, or note if there's a generic or another drug in a similar class with less risk. Drug ads can also encourage people to request high-cost brand-name medications when lower cost generics are available. Doctors often don't know

whether there's a generic medication available or what the price difference would be if there is a generic available. They want to treat your illness.

Drug advertising does impact physician prescribing practices. There have been medical centers across the country that have restricted promotional activities by drug manufacturers. They've found that doctors who are not exposed to these promotions actually prescribe less of those promoted drugs. Health plans, in response to this, encourage their members to select lower price drugs by requiring greater member cost share for the higher priced drugs. Manufacturers in response, provide copay coupons and waive the cost share or a large part of the cost share when you go to the pharmacy. You can get copay coupons online. Sometimes you might get them directly from your doctor.

You give the coupon to your pharmacist and your copay that's been set by your health plan is either reduced to, say, $25, or it's reduced to zero. The drug company is picking up the cost that you would normally pay. However, at the same time, the health plan is still paying their percentage of the cost of that drug. The health plan can't see on their end that you've paid zero of your cost share. You get the drug you need at a lower out-of-pocket cost, and it counts toward your deductible. However, your health plan is still paying more than they would be paying if you chose a generic version. This can lead to increased premiums for all members on that plan because the total cost to the health care system is higher than it would otherwise be if you had chosen the generic.

Estimates suggest that at least half of drugs with copay coupons have generic equivalents, or close generic substitutes, at a lower price. Copay coupons are also used in 42% of all specialty prescriptions. Most specialty drugs don't have generic equivalents. These are helping people that don't have any other option. However, 18% of all brand-name prescriptions with generic equivalents are filled through commercial medical plans.

Lou McDermott: Molly, as we go through subsequent presentations, are we going to talk about strategy plans used to combat that?

Molly Christie: Absolutely we are, yes. Slide 15 - … And the Impact Can be Significant. This does lead to a lot of additional spending. There was a study in 2016 that looked nationally at 23 drugs that had copay coupons, which led to $700 million to $2.7 billion in additional spending over a five-year period.

Slide 16 – Key Takeaways. A rapidly aging population and a high prevalent of chronic conditions means prescription utilization is not expected to decrease. It will probably continue to increase.

Specialty medicines are bringing promising breakthroughs but also extremely high prices. The specialty drug trend is the primary driver of prescription spending, both nationally and for employer plans.

Drug companies spend a lot of money on promotion and advertising to ensure brand-name loyalty over generics. This is not always at a benefit to patients or to the health system.

As I mentioned earlier, this is the start of a series of presentations on pharmacy. In January, we're going to talk about UMP pharmacy trends specifically so you get a better sense of what it looks like for large employer plans in Washington. In March, we're going to discuss strategies that employers can use to manage pharmacy spending to address some of these issues that are presented in this presentation.

Pete Cutler: Can I guess that the PEB Board is also having briefings and going into background on these topics?

Molly Christie: Yes. We are going to be covering similar topics in the PEB Board Retreat in January and during the next PEB Board season as well.

Pete Cutler: Prescription drugs are addressing chronic conditions tend to be used more by folks who are over 60, most of whom are retirees in the PEBB Program. That's what seemed to me a place where you'd be feeling a lot of pressure in terms of cost trends. But, since the question of how that retiree's coverage would be funded long term, it would be very helpful for this Board to stay on top of it for that group.

On a second point, it seems like we have two distinctly different types of drugs that are significant cost drivers. One of them is the specialty drugs. In a nutshell, the drugs are generally agreed to be addressing some of major medical condition, so adding value. But, for whatever reason, are extremely expensive in part because the cost of developing or marketing the drug can only be spread over a relatively small number of patients.

The other group are brand-name drugs where companies are doing their darnedest to insulate the patient from having to pay for choosing a much more expensive brand-name drug when they have a generic option that's presumably just as effective. The only entity that benefits from them picking the brand-name drug is the company that sells the brand-name drug. It seems like both issues need to be looked at, but the strategies in dealing with them are going to be different.

Molly Christie: Absolutely. I think that's spot on. The strategies around the specialty drug trend is getting into volatility and what we saw in 2015 with Hepatitis C. It just spiked. Those strategies are probably going to be on a federal level. There is less that states or large employers can do to manage that. What we're seeing them do is take more control of their plan to try and make sure they're getting the best value where they have the control to do that within their sphere of influence. We're doing interesting things in Washington, so I'm excited to talk about some of those things.

Pete Cutler: I'll be looking forward to hearing more.

Dave Iseminger: We wanted to start this series with the SEB Board because we're on at least year four of ongoing pharmacy discussions with the PEB Board. This is the first presentation in a longer journey. We've been talking about pharmacy issues, because of the retiree population that the PEB Board has to manage, for several years and different approaches they can take.

Pete Cutler: Since we're on the topic, I think Molly did an excellent job. It was really, really good information.

Paid Family and Medical Leave

Nick Streuli, Director, Legislative and Operations, Employment Security Department. Thanks for having me here today. Slide 2 – The Path to Paid Family & Medical Leave. This slide gives a brief overview of the journey the state of Washington had with the concept of Paid Family and Medical Leave. In 2007, the state actually passed a Paid Family and Medical Leave Program. However, they did not include a funding mechanism with it. The law sat on the books for years and years. In 2015, the Governor was able to secure some grant funding from the Department of Labor to do a study on how we could fund a Paid Family and Medical Leave Program. In 2017, the Legislature took up that concept and passed the Paid Family and Medical Leave Act. The bill that passed in 2017 was quite different than the program that was originally passed in 2007, and it tacked on quite a few additional benefits beyond what was in 2007.

It's 2018 and we're in the middle of implementing this Program. The Legislature gave us a very aggressive timeline. By January 1, 2019, employers begin deducting premiums from employees' wages. By 2020, benefits will become available for employees.

Slide 3 – Why Paid Family and Medical Leave? I like to remind people that almost every single person is going to experience, in their lifetime, some type of event this Program will cover. It's not just that birth, placement, or adoption of a child, but perhaps you have a sick loved one, perhaps your parents get ill, a sister, a brother, anything like that you will be able to take leave under this Program to take time off work and support them during that time. It's an essential benefit supporting folks when they need it most.

It's also a benefit to employers. It gives them a mechanism so people can take leave, take that time off work, and have an easier pathway to returning to work. One of the things you hear about quite often in today's world is, when one of these life events happen, the employee needs to take a break from work. It can sometimes be challenging for them to re-enter the workforce or return to that job. It can be challenging for the employer to find someone to replace them. With this Program, we think we're going to see a much higher percentage of people returning to the workforce after these life events occur. Of course, it's important because it also creates a shared cost mechanism between the employee and the employer to fund the Program.

Slide 4 – Who Does This Apply To? Every worker in the state of Washington is covered by this Program. There are two exceptions. We're not allowed to impose taxes on the federal government or their employees, so federal employees are not covered. The other group not covered would be tribal employers. Everyone else is covered by the Program.

Lou McDermott: Obviously, we have a large military personnel. So, all military personnel are not covered?

Nick Streuli: Correct. There may be some, depending on if they're contractors or how that works, but generally speaking, yes.

Slide 5 – Rollout Timeline. 2019 and 2020 are the are the two really big dates. Starting on January 1, 2019, all of the wages earned are going to be subject to the Paid Family

and Medical Leave premiums. We'll collect those premiums for all of 2019, and then, on January 1, 2020, benefits will become available. It was interesting to hear about your loan repayment. We similarly received a loan to start this Program and that is due at the end of the biennium. We also, out of those premium collections for the first quarter of 2019, have to pay back a loan. We have some commonalities.

Slide 5 – Paid Family and Medical Leave. There are two buckets of benefits. There is the family leave and there is medical leave. Family leave covers things like caring for your family members, birth or placement of a child, or certain military-related events. I say, "military-related events," we call military exigency leave. Let's say you are a military spouse and your spouse is going to be deployed. You would be able to take leave through this Program to help get everything set up and get ready for your household as your person is getting ready to deploy. Also, to spend some time with them before they actually deploy. That's one of the things that counts under the family leave side of the house.

On the medical leave side, it's really straightforward. It's just your own medical conditions. So, if you have some type of a qualifying condition that you are struck ill with that would count, you would be able to take leave.

Slide 7 – Benefits. It's a weekly wage replacement and I like to describe it as a sliding scale. A low wage worker is going to receive a higher percentage of their wages replaced. The benefits in the early days will range anywhere from a weekly minimum of $100 all the way up to $1,000. That $1,000 is set to be readjusted, I believe in 2021 or 2022 to be 90% of whatever the state average weekly wage is at that time. That $1,000 weekly benefit amount cap will continually be readjusted based off of what the state average weekly wage is doing.

On the weeks of leave, typically you're allowed up to 12 weeks of leave. To get into the details on that, there are 12 weeks of leave allowed for family and 12 weeks of leave allowed for medical side. Let's say you have a qualifying condition for family leave and a qualifying condition for medical leave in the same year. You would be allowed to take up to 16 weeks, so only a combined total of 16, if you have a qualifying condition that counts on both sides within the same year. In certain circumstances, you would be allowed up to a cap of 18 weeks, but that's only if you experienced a period of incapacity related to pregnancy.

Slide 8 – Benefit Examples. This chart shows four examples of weekly benefit amounts. The first one, if an employee has an average weekly wage of $400, their weekly benefit amount would be $360. That is 90% of their wages replaced through this Program. The bottom one, if the employee's weekly wage is $1,800, they're going to receive the maximum benefit of $1,000. That's only 56% of their wages replaced. That gives an example of how that sliding scale works.

Slide 9 – Eligible for Care in Family Leave? Here is a list of who is eligible and who is not. Covered includes children, step-children, foster children, adopted children, grandchildren, spouses, siblings, parents, grandparents. For those of you familiar with FMLA, the state's Paid Family and Medical Leave Act, coverage is slightly broader in terms of the eligible family members. There are one or two of these that are not covered for the federal FMLA that are covered for the state Paid Family and Medical

Leave Act. On the other side of the equation, folks who wouldn't be covered: godparents, aunts and uncles, cousins, distant relatives, pets. Oddly enough, there was a discussion of whether or not pets counted.

Slide 10 – Begin. Here is the leave life cycle as we call it. The first thing we have to figure out, if you're going to be using this leave, is whether you meet the 820 hours of eligibility to qualify. Once you've met the 820 hours to qualify, you then must have a covered event. Your eligibility would be determined based on your type of event. If either your family member or yourself have a serious health condition, that would deem you eligible for the Program. This is where there starts to become dual tracks. Let's say the eligible event is an unplanned life situation, which I think is probably going to be the majority of folks taking this leave. The life event would happen and you would file your claim. If this is a planned event, you know you're going to have a child in several months, you could file your claim before that life event actually happens so everything is set up and ready to go when that event happens. Once the event happens and you start filing your weekly certifications, you would start to receive those weekly benefit payments.

Slide 11 – Eligibility. The Paid Family Medical Leave Act establishes that, in order to qualify for the Program, you must have worked at least 820 hours in what they call your qualifying period. Qualifying period is the first four of the last five completed calendar quarters. If you don't have the required 820 hours in the first four of the last five completed calendar quarters, we can look at the last four completed calendar quarters to determine if you have the 820 hours. But that's only if you didn't have them in the first side of that equation. What we look at in that qualifying period is all of your employment. Regardless of whether you worked for the Health Care Authority, or the Employment Security Department, or Starbucks, we take all of the employment that you had in that qualifying period and add up all of those hours to determine if you have 820 hours. It's not tied to a specific employer. In that way, a lot of folks are using the terminology that it's portable. There's a couple of examples on the slide. If you worked at least an average of 20 hours a week for 41 weeks, you would have the required 820 hours.

Lou McDermott: Is that for Washington employers or if you came from another state?

Nick Streuli: Hours worked in another state would not count. It's only for employment in the state of Washington.

The second example on Slide 11 is if you worked 40 hours a week, by 20 and a half weeks, you would have the required 820 hours. The lowest you could go, if you averaged 16 hours a week for the full 52 weeks within a year, you would be able to meet the 820 hour qualifying.

Sean Corry: Nick and Senator Fain made a presentation to our clients several months ago. The question I have relates to what you just talked about, the accumulated hours that might occur across employers. At the moment of claim, my question has to do with what that particular employer is responsible for doing in assisting and informing an employee who might have hours at other employers.

Nick Streuli: It's a really good question and I want to caveat everything I'm about to say with we are really focused as an agency right now in what is required for January 1, 2019, which has to do with the employer premium payments. There is some rule and process development to be done about the employee benefits.

Sean Corry: I need to interrupt because the first question I wrote down was what's the rulemaking progress?

Nick Streuli: The rulemaking process is going along really well and I'm going to cover that in a later slide that shows where we're at in the different phases of rulemaking.

Related to your first question, we're still working through some of that process but it's likely that, if the employee is currently employed, the employer that they're employed with is going to receive some type of a notice that says, an employee of yours has filed for Paid Family and Medical Leave. There are some requirements in the law that an employee give 30-days notice in certain circumstances prior to taking leave. We would likely ask the employer, if that applied, to let us know if that had been done. It's often in the employer's best interest to reply and let us know whatever information they do have. But, if an employer doesn't reply, there's no penalty on the employer. An employee doesn't have to be attached to an employer to apply for Paid Family and Medical Leave benefits. As long as they have the 820 hours in their qualifying period, they could be unemployed and receive this benefit.

Dave Iseminger: Nick, before you move on, will you describe why the number 820 was selected by the state?

Nick Streuli: During the legislative negotiations, this certainly was a contentious topic. The numbers discussed during the negotiations were related to the federal FMLA, which is, of course, 1,250 hours in order to qualify. And in order to qualify for unemployment eligibility, which is another program we administer at the Employment Security Department, it's 680 hours. I believe that 820 lands right in the middle of those two numbers. That seemed like a reasonable number.

Sean Corry: When filing a claim, will employees be required to use up existing sick or vacation time before getting the benefit?

Nick Streuli: No. In fact, an employer cannot require an employee to do that.

Patty Estes: With the eligibility, I know in previous conversations you've probably been briefed on, we talked about school employees not working for two months and how this plays into being able to meet the requirements. How would that work for the average classified school employee that does not work 20 hours a week?

Nick Streuli: It's difficult to say. If they worked an average of 16 hours throughout the 52-week period, they're going to meet the 820 hours. To give some background on how the hourly reporting requirement will work, if the employee is a full-time salaried employee, the employer is directed by law to report 40 hours on their quarterly wage reports. 40 hours per week. If the employee is a part-time employee or otherwise an hourly employee, they have to report the hours actually worked. In some cases, and I'm

not as familiar with the classified school employee, whether or not they would be considered full time or part time.

Patty Estes: Most of the time they're part time.

Nick Streuli: Most of the time considered part time. Then they would be actually reporting the hours worked.

Patty Estes: My only concern is, from mid-June to beginning of September, they literally do not work anything. There's a lot of employees that do that. That would leave pretty much the majority of that population without being able to use this benefit because that's almost an entire quarter they would not be working.

Nick Streuli: That would be unfortunate. But because we're looking at four quarters, I think it's possible, since we're taking all of the hours from that four-quarter period, there might be 820 hours in there. If they have other employment somewhere, let's say they're working at a Starbucks or somewhere else, those hours are going to get added into the calculation as well.

Patty Estes: Okay. Thank you.

Lou McDermott: And back to that example, I would imagine it's really dependent on what portion of the year they're asking for the leave. If it's near the end of the school year, they've got all those hours behind them. If it's at the beginning of the school year, more problematic.

Nick Streuli: I think because we're looking at a four-quarter period of time, it should be capturing all four of those quarters. It'll have the time where they weren't working, but it'll also have all of the time they were.

Dave Iseminger: I think we're all struggling with the ramp up. Once you reach 820 hours then there's your steady state. That's where the rolling average will end up happening if you have a cycle where you're not working in the summer or you're working in a different employment and it's stacking, you're always looking four quarters back. Lou, what you were just describing is in the start-up. There's not a start-up each year that you have to reach 820 hours. It's when your event happens, you do the four-quarter look back and that's how you determine the eligibility. Right?

Nick Streuli: Exactly right. Good discussion.

Patty Estes: What about employees that aren't necessarily tracked by hours but they are stipend employees? How is that being reported or is it required to be reported?

Nick Streuli: We thought we knew how we wanted to handle stipend employees. And then we learned nearly every employer has a different definition of "stipend" and they're all different than the dictionary definition of "stipend." So, we're looking at that. At a high level, we know in a general sense how to handle per diem. So for example, per diem is a reimbursement of costs incurred as you're discharging your duties. Those wages would not be subject to the premium in most cases. I want to qualify myself. In

terms of stipend, we really are still trying to sort that out. We will have some guidance coming out relatively shortly.

Pete Cutler: Am I correct that, for the unemployment insurance program, that stipends for coaching or whatever would be hours, the hours associated with that income should be reported for the unemployment insurance program?

Nick Streuli: It's going to depend on their definition of stipend. I believe you're correct, but I can follow up.

Pete Cutler: Okay. Because my sense is if you already have an insurance program that requires employers, for better or worse, to attribute a certain number of hours to a certain compensation, then presumably that could be what you use to piggyback off of. It does seem like policy-wise, the federal government for the Affordable Care Act when determining if somebody's working an average of 130 hours a month for a year, they went down the path of attributing hours to school employees for summer break periods. But that sounds like that would have to be something the Legislature might have to do rather than something being within the purview of the Department, given the statute the way it's written now.

Nick Streuli: Correct.

Pete Cutler: Do I understand, when you say it's four of the last five quarters, if somebody has worked for a full school year on a part-time basis, and it happens that when they're applying, that one quarter would be the summer months, they would have the option of picking the four quarters that did not include the summer months?

Nick Streuli: Since it's a four quarters, which is the full duration of the year, either way it's going to include the summer.

Pete Cutler: It's a four of five.

Nick Streuli: Well, it's which four are we using? Are we using the first four of the last five quarters, or are we using the last four completed? Either way, we're looking at four quarters.

Pete Cutler: And that's a good point. If it's all four quarters then, by definition, it included the quarters that were the employment period.

Nick Streuli: Exactly. But if, in that example, in the first four of the last five quarters they did not have the required 820 hours, we would then have the ability by law to look at the last four completed calendar quarters. Let's say for some reason last quarter they happened to work more or their hours got ramped up, then that would be a situation where we could pick up those hours.

Dave Iseminger: I think the word we're all missing is it has to be four consecutive quarters. It's either the first four consecutive of the last five or the last four consecutive of the last five.

Nick Streuli: Correct.

Dave Iseminger: It's not pick and choose four out of five.

Nick Streuli: And that concept is identical to the Unemployment Insurance (UI) Program. That concept was from UI. I do want to specifically call out the UI Program is a federal program that states administer. We tried to pick a number of similarities for ease of administration. There are places where the Legislature chose to deviate from the way the insurance program for unemployment insurance works and the way the Paid Family and Medical Leave Act will work.

Slide 12 – Premiums. The premium calculation is set in statute for the first two years of the Program. It is 0.4% of gross wages. That is split between the two different buckets of leave. One-third of that 0.4% is attributed to the family leave bucket. Two-thirds of that 0.4% is attributed to the medical leave bucket. The reason we did this break out is, in an analysis of the other states that have Paid Family and Medical Leave, they found about one-third of their claims were attributable to what we call family leave and two-thirds of their claims were attributed to medical leave. From there, the employee is responsible for 100% of the premium rate attributed to the family leave bucket.

On the medical leave side, the employee is responsible for a minimum of 45%. The employer is responsible for 55%. The employee being responsible for 63% of the Paid Family and Medical Leave premium and the employer responsible for 37% of the Paid Family and Medical Leave premium. From our perspective, when the employer does their quarterly reporting, we're looking to see if that split took effect. An employer is absolutely able to pay any portion of the employee's premium amount that they so choose. They can't deduct more than 63% from the employee's wages, but they can choose to deduct less and pay more of that premium amount themselves.

On the bottom of Slide 12 is an example of what that breakout would be for an employee who had $50,000 per year in wages. The employee that year would be responsible for $126.67. The employer would be responsible for $73.33. At the end of the day, the employer does act as the employee's agent, so the employer is responsible for transmitting the whole premium amount to the Department on that quarterly reporting basis. The Legislature also included in the law that small businesses with fewer than 50 employees are not responsible for paying that employer share of the Program. They are only responsible for deducting the premium amount from the employee and transmitting that to the Department.

Dave Iseminger: In that small business scenario, the employee doesn't have to pick up the employer's share. They just pay their 63%.

Nick Streuli: That's correct. They pay their 63% percent and the employer deducts that from them, but the employee does not pick up the employer share.

Slide 13 – Reporting. Since we also administer the Unemployment Insurance System, we tried to marry the two programs for ease on the employer. Employers will be required to report on a quarterly basis. Their reports and premium payments are due by the last day of the month following the close of the quarter. They're required to report to us the name, SSI or TIN of the employee, any of the wages earned, hours worked, and the total premium amount deducted from that employee. This is very similar to what they do currently for unemployment insurance purposes. The only difference being, in

unemployment insurance, the employee doesn't pay any portion of the taxes owed for unemployment insurance. They obviously don't have to report what they deducted from the employee because it better be zero.

Dave Iseminger: Nick, is there any requirement that the employer report to the agency on a quarterly basis, but they're collecting premiums out of each paycheck? Or can an employer have the discretion to take a lump sum out at the end of the quarter?

Nick Streuli: Very good question. That's something we addressed in rulemaking. An employer has to deduct on a pay period basis no less than monthly. If for some reason their pay periods are every six weeks, they would need to deduct at least monthly. But, if their pay periods are shorter than that, they have to deduct on a pay period basis. If they don't deduct, the employer then becomes responsible for that premium amount. They can't go back and take it from the employee.

Slide 14 – Paid Sick Leave and FMLA. Paid Sick Leave, Paid Family and Medical Leave, and FMLA are three programs that operate in a similar sphere. We've definitely been answering a lot of questions as we've been implementing about what the differences are between the new Paid Sick Leave law that came into effect with Initiative 1433, our Paid Family and Medical Leave Act, and the federal FMLA. At a high level, Paid Family and Medical Leave and Paid Sick Leave cannot be used at the same time. You can't be on leave and receiving Paid Family and Medical Leave benefits, and at the same time, collecting paid sick leave from your employer and using those paid sick leave hours. They can't be done together.

To Sean's question earlier, an employee may choose which of those two they would like to use. But an employer cannot require them to use all of their sick leave or all of their vacation leave prior to taking Paid Family and Medical Leave. And that is a difference between the federal FMLA and our Paid Family and Medical Leave Act. In the federal FMLA, an employer can require an employee to exhaust their leave balances prior to going on FMLA or while they are using FMLA. That cannot happen with the Paid Family and Medical Leave Act.

In most cases, the Paid Family and Medical Leave Act is going to run concurrently with FMLA. We are grappling with this section of the law. We want to make sure we get guidance because that term "concurrently" can mean different things. It's the only time in the law that requirement is mentioned. We are trying to get clarity.

Slide 15 - Outreach. We've been doing a lot of outreach across the state. Hopefully, you've heard some of our commercials, received our mailers, seen us on Facebook or other social media. But, specific to the education sector, we have been working with OSPI, we have done presentations for the educational service districts, and we have been working directly with WSIPC. That way they are ready when this comes into effect in just a couple of weeks.

Pete Cutler: I assume it's obvious this is not just for school employers and employees?

Nick Streuli: Tons of other outreach all over the place.

Pete Cutler: When I first saw this, I thought you were doing everything through ESDs.

Nick Streuli: No, we have done hundreds and hundreds of presentations to lots of associations and various other groups. You're going to see a big ramp up in our marketing right now. I think every week for the last several weeks, either KING 5, KOMO, or any of the other news outlets have run stories. We're really trying to get out there to make sure that everybody knows this is coming.

Slide 16 – Implementation in Phases. This slide helps answer Sean's question, which was how is the rulemaking going. Because this Program had to be implemented quickly, we needed to break down into small sizeable chunks what needed to be done when, so we could have those things done when they needed to be done. If we attempted to do all of the rulemaking for premiums and benefits in one large lump, we would likely not be finished with that today because it takes a lot of back and forth and negotiating. People would not be ready and we would not have information out there for folks to know what they need to do on January 1, 2019.

The rulemaking is broken into six phases. We are currently in the middle of an overlap period where we're wrapping up Phase 3 and ramping up Phase 4. So far in rulemaking, we've covered things like voluntary plans, Collective Bargaining Agreements, and premium liability. We're just now getting to some of the benefit application, and benefit eligibility stuff. We're also just beginning the continuation of benefits and fraud. All of that is happening simultaneously. Phase 5 of the rules is going to cover things like job protection, benefit overpayments, and some miscellaneous provisions. Those are some of the things that really aren't going to come into effect until deep into 2020 once these benefits are available, people are needing that job protection, on perhaps a benefit overpayment has occurred.

Finally, late 2019, we're going to do Phase 6 of rulemaking, which is appeals. Appeals are the last stop in the process. We felt like that was an appropriate one to tack onto the end.

We have achieved an important milestone already and I want to call it out because it was no shortage of work to achieve. The law allows employers to apply for “voluntary plans.” If an employer feels like they can provide these benefits that are as good or better than the state plan, through their own private company or through an insurance product provided that's on the market, they are allowed to apply for a voluntary plan. They would be exempt from the Program and they would provide those benefits to the employees in their voluntary plan program. In order to have a voluntary plan in place by January 1, 2019, we had to start accepting, processing, and approving or denying applications over the summer. In September, we actually turned on functionality in our IT system to allow those voluntary plan applications to be turned in. We had staff available to process them and work with employers to approve or deny them, so they can be in place come January 1. That was a big milestone.

Sean Corry: With respect to that, opting out, essentially?

Nick Streuli: Effectively.

Sean Corry: There's no exception for school districts, for example, public entities. It's available for school districts as well.

Nick Streuli: Correct. It's available for anyone.

Sean Corry: Thank you. I have a related question. A lot of school districts have some form of short-term disability or voluntary short-term disability programs available for purchase by individual employees. In those circumstances, can there be layering of benefits? Would you permit somebody to get up to 100% of pay from two different programs, for example?

Nick Streuli: So, you're saying, let's say they did a voluntary plan, provided the benefits one way, but then covered the delta in the wages from what the plan covered and what 100% of their wages were? Is that kind of the example you're throwing out?

Depending on the way, yes, it is an option. There are conversations happening about how that could even be broadened a little bit to allow employers greater flexibility to replace up to 100% of an employee's wages.

Pete Cutler: If an employer opts out, approved for a voluntary plan, does that mean the hours for those employees don't count towards the Program, don't count towards 820-hour standard?

Nick Streuli: They could not require more than 820 hours for eligibility in their voluntary plan program. They would have that same criteria or less. They could say, for our voluntary plan, we think 600 hours is right. And, because that's a more generous benefit than what we're offering in the state plan, that would likely be acceptable.

Now, if, let's say, an employee moves from a voluntary plan employer to a state plan employer, those hours are immediately portable and we consider them in the eligibility criteria for the state plan. Let's say they left that employer, there's no gap in coverage. Great questions.

Slide 17 – Employer Toolkit. This toolkit is on our website and we've sent to every employer in the state. It attempts to get them ready for January 1. We want to make sure all employers and, by extension, their employees, are ready. Employees are going to see something coming out of their paycheck, starting with that first paycheck in January. We wanted to make sure we were able to equip employers with the information they needed to communicate to their employees about what it is, why it's there, what it's going towards, and what benefits will be available in the future. The toolkit is very comprehensive. It includes a paystub insert, which is available on our website for download as well if an employer wants to put something in the employee's paycheck. It gives information about the Program. It also helps fill them in on what their responsibilities are, how the premiums work, reporting, and everything else. It has a readiness checklist. If you complete all these steps, you're ready to go

Slide 18 – More to Come. There's a lot more to come. We're working furiously to get the IT system ready to accept these reports from employers. We're trying to get that same IT system ready to accept benefit applications in 2020. The rulemaking, as I mentioned, is ongoing. We have customer care teams available if you have questions or want to call. Anyone in the public, that number is broadly published. Call, ask your questions, we're here to help.

Lou McDermott: Back a couple slides, if the employer is choosing to provide their own product, are there limitations in how much they can charge their employees? Can they transfer the full cost of the product to alleviate themselves from having to pay the employer premium?

Nick Streuli: They cannot. They could not deduct more from the employee than the employee would have had deducted had they been in the state plan.

Dave Iseminger: If I could summarize, essentially, a voluntary plan has to be at least as generous, if not more generous than what they would get through ESD's program?

Nick Streuli: At least as good or better. Exactly right.

Dave Iseminger: Nick, correct me if I'm wrong, does Washington's implementation of this program have a different flavor than many of the other states? Most other states that have implemented this, roughly five states, have a broad short-term disability benefit statewide that they could piggyback off and expand. Whereas, there was not a similar situation here. I think that's an important part of the conversation to realize. There was already a statewide benefit and it was transformed into this, versus the wholesale creation here in our state.

Nick Streuli: Yes. That's absolutely correct. We're the first state to take on both of these at the same time. Every other state, and there were some states that had a temporary disability program dating back to the 40s, of the states that have Paid Family and Medical Leave, of which we're the fifth, we're the first one to do both at the same time. We're certainly getting calls. I think we've had visits from more than a dozen other states or in some way interacted with them as they are exploring this same concept.

Dave Iseminger: We brought this conversation to the Board and asked the Employee Security Department to present because of the disability benefit conversation that we had back in September.

There was a question from the Board about could the HCA try to scope what the school employee population looks like that would be between the 630 hours that existed in the SEBB Program versus the 820 hours that exists under the PMFL. Our best estimates at this point, are there are about 3,600 school employees that would fall within that range. Important pieces to remember are there's no way from our data to account for people who have other employment outside of the school district. There may be people seeking part time employment, not for the purposes of getting benefits, but maybe a supplemental retirement income. They may not be interested in this type of benefit or in benefits in general. With the amount of salary individuals are making, they may be prioritizing other benefits and are not interested in a short-term disability benefit. The other big piece is that if they definitely aren't reaching 820 hours, isn't there a waiver process by which an employee can opt out of othe PFML Program.

Nick Streuli: Only for out of state. There is a provision in the law. It's called a conditional premium waiver. If you are, for some reason, working in this state but centralized normally in some other state and you're working in this state temporarily,

there is a conditional premium waiver if it's believed that you're not going to work the 820 hours. But that's only if you're from another state.

Dave Iseminger: Could you clarify for the Board, if an employee is definitely only working 630 hours they would pay their portion of the 0.4%.

Nick Streuli: They would.

Dave Iseminger: Even though they cannot possibly qualify for the Program. They have that premium obligation regardless of whether they meet the eligibility requirements.

Nick Streuli: Correct. It's that insurance system concept.

Policy Resolutions

Barb Scott, Manager, Policy, Rules, and Compliance Section. We have two policy resolutions for you to take action on today. Other than fixing a couple of typos on the slides from November and adding the word "eligible" to the title of Policy Resolution SEBB 2018-54, as well as hyphenating the words "employee-only," the policy proposals are the same as those introduced in November.

Examples have been included related to Policy Resolution SEBB 2018-53 – School Employees May Waive Enrollment in Medical. In providing two examples, we're hoping to answer questions received from stakeholders. As was mentioned on one of Megan Atkinson's slides, the funding rate calculation assumes a certain percentage of eligible employees will waive, which reduces the average amount of employer funding per employee. The proposed policy would only allow employees enrolled in other employer-based group medical to waive their enrollment in medical where there is an employee contribution. It would not allow employees to waive enrollment in benefits that are 100% paid by the employer. The term "employer-based group medical" would be defined and is intended to mean group medical related to a current employment relationship. It would not include medical coverage available to retired employees, and it would not allow employees to waive their enrollment in order to enroll in Medicaid.

In addition, not mentioned in this policy resolution because it is a federal requirement, employees are allowed to waive SEBB medical in order to have Medicare or Tricare be their primary coverage, including Tricare as a retiree. We received stakeholder feedback on this policy. One stakeholder expressed concern that the proposal does not support employees waiving enrollment in medical if they're enrolled in medical for a spouse's retiree medical plan. The same stakeholder suggested that the program could alternatively allow employees to waive enrollment if they're enrolled in other coverage that is equivalent to the coverage offered by the SEBB Program. We did not modify the resolution that's before you today because this particular policy is consistent with one the agency already has in place for the PEBB Program. In addition, it is intended to minimize the risk of adverse selection and not create administrative burden to evaluate whether the plan they're waiving for is equivalent to a plan offered through the SEBB Program. There would be a decent amount of administration required. This proposal doesn't include that idea.

Another stakeholder expressed concern that the policy doesn't allow employees to waive in order to be enrolled in Medicaid coverage, which is not an employer-based group medical plan. We didn't modify the proposal to allow for waiving for employees eligible under the Medicaid Program. At this point, I don't really have a complete idea of what that would look like. We did address this question with the stakeholder by letting them know that, if an employee and their family does meet Medicaid eligibility, they could continue to be enrolled in Medicaid. This proposal wouldn't prevent them from doing that. Medicaid would then be secondary payer on claims. But, without really understanding how this would function, I didn't include it in this particular policy proposal. We do have a meeting on the books with our agency partners in Medicaid to have a conversation about what that might look like and having conversations about the work they do specifically with school districts and how their determinations might be affected in the future. We'll bring that information back to the Board if you have any interest in that.

Dave Iseminger: You hear me say that rulemaking is an iterative process. This is the start. There are areas we can work on for the future, but this is a foundational start to build upon.

Barb Scott: Example #1 is of a school employee, a bus driver, who's eligible for the employer contribution. They're currently enrolled in medical coverage through their spouse, who is a Boeing employee. The school employee wants to waive his enrollment in SEBB medical and the question is whether this would be allowable under the policy resolution being presented today. The answer is yes. The Boeing coverage he's enrolled in qualifies as employer-based group medical. It's based on current employment of their spouse with Boeing.

Example #2 is an example of a school employee eligible for the employer contribution. She is currently enrolled in medical coverage through her spouse's Boeing retiree medical coverage. The school employee wishes to waive her enrollment in SEBB medical. The question, again, is this allowable under the resolution in front of you today? And the answer would be no based on coverage that's available to her spouse as a retiree from Boeing, not a current employment relationship.

Pete Cutler: Thanks, Barb. I do want to stress that I strongly support the general policy priority of keeping the administration simple. One of the problems or concerns we had as policy makers with the K-12 context before, there were hundreds of different plans. Trying to figure out how something compared to another thing got into a lot of details and was very time consuming. I fully support the idea of trying to keep it standard. It's very easy to administer in terms of deciding if somebody has robust enough coverage, in this case employer-plan coverage to permit them to waive coverage. Clearly, the policy goal is to make sure people have health insurance coverage and don't somehow, for whatever reason, take themselves out of that.

It's a policy of the state that we want people to have health insurance coverage if they're full-time employees, in this case of a K-12 district. The one question I do have is how does this standard compare in the context of the ability of somebody who retires and is eligible for PEBB retiree coverage? I know they have the ability to waive or put on hold. I'm not sure of the technical term.

Barb Scott: Defer.

Pete Cutler: Defer coverage if they have other coverage. I know, in that case, there is a focus on is it actuarially equivalent or robust enough because you don't want somebody going to a cheap plan that has minimal coverage, then waiting until they have an expensive condition, and then coming back into the PEBB Program. I'm curious how that standard which is applied to PEBB retirees compares to the standard that's being proposed here.

Barb Scott: The PEBB Program for active employees has a policy that looks like this. Part of the reason is they want to make certain the coverage that employees waive, if they're going to waive enrollment in the benefits that are offered by the state, the other coverage they're enrolled in is comprehensive enough in nature that there isn't an adverse selection, a risk of that within the PEBB Program. Same concept here with SEBB. You wouldn't want to create a situation where the other coverage that folks are enrolled in may not be comprehensive and then, when employees move back into SEBB coverage, have adverse selection occurring within the SEBB pool.

At the same time, the question really, as far as the retiree coverage goes within PEBB, the PEB Board put in place provisions for retirees to be able to defer enrollment when they're enrolled in employer-based group medical coverage. If an employee is eligible under the SEBB Program and also eligible as a retiree under the PEBB Program, there's a provision that the PEB Board has in place so they could defer that enrollment in the PEBB retiree coverage in order to enroll in their SEBB employee coverage. It's going to be cheaper, likely, to be enrolled in coverage where there's an employer contribution toward it than to be enrolled in coverage as a retiree under the PEBB Program.

We see that often even today with school district coverage. Folks will go back to work and defer their enrollment in PEBB retiree coverage. They come back to us later when they decide they really are going to quit working. The PEB Board has a number of different provisions even beyond employer coverage as an option for deferring. You can defer for Tricare enrollment. You can defer if you are eligible, under the most recent rulemaking for the PEB Board, if you are eligible for coverage under CHAMP VA as well.

Dave Iseminger: Pete, the one thing that I would add is under the deferral rule, it's comprehensive employer-sponsored coverage. There is no actuarial value test or evaluation of that. The only place there's any concept of a plan comparison is in the spousal surcharge, because the Legislature set that up as a comparison to the benchmark plan in the PEBB Program. To be able to explain how to do a plan comparison and the calculator is a challenge. To have to replicate that for all possible employer plans would be an administrative challenge.

Earlier, in my first presentation, it may have sounded like I was bashing the allocation worksheet. Actually, I think that allocation worksheet, much like our employer surcharge calculator, explains a very complex situation easily for people. I think the point is if we didn't have to do the calculator for the spousal surcharge or the allocation worksheet, it would make the whole process even simpler.

Pete Cutler: I want to assure you that I definitely do not want the Health Care Authority to replicate that actuarial equivalent standard in any other context, much less, particularly in this SEBB situation.

Dave Iseminger: One more thing I wanted to highlight for the Board and for the public is these examples are key pieces for helping train benefits officers who will be doing eligibility determinations. We had a suggestion since the last meeting to find a way to make it more user friendly on the website. I want to make sure you all knew that on the meetings and materials page, at the bottom, we have a dynamic chart that shows all the resolutions that have passed. For all of them that have examples, there are hyperlinks that go directly to the examples within the briefing books so that anybody who's trying to understand what the resolution really means has these illustrative examples on hand. I wanted to take an opportunity to highlight that and thank, I believe it was Fred Yancey who made that suggestion. Those types of suggestions are really helpful in getting the word out about what the Board means in its resolutions.

Lou McDermott: **Policy Resolution SEBB 2018-53 – School Employees May Waive Enrollment in Medical**

Resolved that, a school employee who is eligible for the employer contribution toward School Employees Benefits Board (SEBB) benefits may waive their enrollment in a medical plan if they are enrolled in other employer-based group medical.

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-53 passes.

Barb Scott: Policy Resolution SEBB 2018-54 would default employees into coverage that includes an employer contribution. It would not default the employee into any supplemental coverages. We received stakeholder feedback related to this policy. One stakeholder suggested that employees should be defaulted into a waived status rather than into coverage for medical specifically. We did not modify the proposed policy based on this feedback because of the potential that the employee would be uninsured. There was no other feedback from the stakeholders on that particular policy.

Sean Corry: Sorry for missing this in November if it came up. But which plans are chosen for these people who need to be slotted into coverage?

Dave Iseminger: The question for the Board is the foundation of into coverage or out of coverage. Until the Board sets premium contributions and we know the full service areas and exactly what plans are available, we can't answer that question. We will engage in the discussion with the Board when that information is available. This is to get the Board to set the foundation and rules that it will be into coverage, and then we'll work on the specific plans in a couple of months.

Sean Corry: Do we intend to change the language of this particular resolution once that is determined? Because the resolution itself doesn't indicate any selection process. It's just that there'll be coverage.

Dave Iseminger: Correct. If there is something for the Board to take action on, we would bring a subsequent resolution related to that. If it's within the agency's authority, we would convey in our communications what the final plan is. We believe it's within the agency's authority, but we will certainly be discussing with the Board all of the implications of different plans, both in public and sometimes in Executive Session for the more proprietary things. This is to set the foundation. The reality is, as we get into the rulemaking process, we're about to finish rulemaking one and will have a short rulemaking two. There won't be time to codify things in rules after a certain period. We won't have the information to get into the specific plans until after that rulemaking has been essentially completed. The plan names won't exist in rule 2020. It will instead exist in the communications and be informed by Board discussion. Today is about being clear there will be coverage. Which coverage, specifically, will be in subsequent discussions.

At this time, we don't anticipate this resolution would have to be changed or revisited. Do you have a particular concern?

Sean Corry: Thank you. When there's a determination how this is going to work, the resolution itself isn't clear to say that this is going to happen. There's no indication in the resolution what the process is. It's this open, "you're going to get some coverage" language that's just confined to that. It's figured out someplace else and it's not addressed here. It doesn't direct one to that process or that decision making.

Dave Iseminger: I'll go back to my "I" word: iterative. This is the first step in the journey of defaulting into coverage. I know what plan people would go into is an important concept. We haven't laid all the breadcrumbs for all the iterative process of future ones. I guess I'm just struggling with what your suggestion is.

Sean Corry: So, this is simply a placeholder?

Dave Iseminger: Not a placeholder. It's just the first step in the journey.

Barb Scott: What this does is let employees know, and it especially lets employers know, there is a process this Board will put in place that determines what's going to happen as far as the enrollment actions they'll have to take if an employee fails to make an election of coverage. The action will be taken to enroll the employee in coverage and will not leave them uninsured. It specifically states they will be enrolled in medical coverage, dental coverage, vision coverage, and the basic life and basic long-term disability coverage. What we don't have information on today is which medical plan, which dental plan, and which vision plan. That's the piece Dave is explaining we will know later. At this point, we want to at least be able to assure folks that employees will be enrolled in coverages.

Lou McDermott: What we're saying is, this falls under agency purview. The agency believes it has the authority to decide which plan is defaulted into. The agency will discuss that with the Board, but it's the agency's belief that HCA can select a plan.

Whether or not there is a default concept, we believe falls within the Board's purview. We will discuss the methodology with the Board. I do believe in PEBB, the methodology is you will be defaulted in the largest plan that is available, who has the largest membership, or something like that, which is the Uniform Medical Plan. Barb, what's the exact language?

Barb Scott: The PEB Board uses the Uniform Medical Plan as the default plan because the plan is available nationwide. It wasn't defaulting an employee into a product that wouldn't be usable for them based on where they're geographically located. The other options, even on the dental side, the default is the Uniform Dental Plan, which has the largest provider network and is available, again, across the state. They didn't have to look at what's available in each geographic area in order to select which plan. We didn't choose other plans because they aren't available statewide or nationwide for every employee. Especially with higher education, we have folks who are out of country. Using the Uniform Medical Plan allows for coverage even for those employees.

Dave Iseminger: The way Barb used the word "Board," “we,” and "they," we're all stumbling over. I don't believe we've ever identified Board resolutions where the PEB Board made a resolution that said enrollment shall be in UMP and we're not bringing that to this Board. We're trying to do the same process with both Boards. There will definitely be robust conversation with this Board. I can't stress that enough because I don't want people to be worried the agency is going to do something without Board input. When we have information available about exact service areas and what the premiums are looking like, we'll engage in conversation with the Board and get the Board's insight about the appropriateness of the default plans. Then, the agency will make the decision and proceed with implementation.

Pete Cutler: I like the idea of having that discussion down the road. Off the top of my head, my initial reaction is I would support the general same approach in terms of looking for the plans that have the broadest network, that have the most enrollment, and trying to parallel that.

Having said that, I'm not sure I agree. With all due respect, I think that is a policy decision and I think, by inference, it is something that would be a logical thing to have the Board make. I'm not going to worry about it because it's very clear to me we'll have the discussion. If it's decided that a resolution would be appropriate, I can envision very easily how that could be a separate resolution tied into this one that we have in front of us today. I'm quite happy to go ahead with this one today.

Lou McDermott: **Policy Resolution SEBB 2018-54 - Default Enrollment for an Eligible School Employee Who Fails to Meet a Timely Election**

Resolved that, the default election for an eligible school employee who fails to timely elect coverage will be as follows:

- Enrollment in employee-only medical coverage;
- Enrollment in employee-only dental coverage;
- Enrollment in employee-only vision coverage;
- Enrollment in basic life insurance; and
- Enrollment in basic long-term disability insurance.

Pete Cutler moved and Patty Estes seconded a motion to adopt.

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-54 passes.

Wellness Program

Justin Hahn, Program Manager, Washington Wellness, Benefits Strategy and Design Section, ERB Division. At the October Board Meeting, we presented an overview of worksite Wellness Programs and provided a demonstration of the online portal that we used to track, monitor, and reward participation. Today, we're going to walk through the approach we are planning to use for the SEBB Wellness Program and tee up some important decisions that the Board will need to make.

Slide 2 is the language from the Collective Bargaining Agreement on wellness. It says, "The SEBB Program will offer a Wellness Program to eligible employees who enroll as a subscriber in a SEBB medical program in 2019 for plan year 2020…"

Slide 3 – Implementation Plan. We are currently planning internally. The plan is to use the existing HCA wellness vendor, Limeade, to implement the SEBB Wellness Program and be ready for open enrollment in October 2019.

Slide 4 – SmartHealth Demonstration. In October, we provided a three-minute demonstration on the SmartHealth portal. I want to describe more about the background approach, strategy, and details of the program.

Slide 5 – SmartHealth Overview. SmartHealth is our online health and wellness portal. It's mobile-friendly. It's a population focused health and wellness behavior change tool. We see it as our biggest tool for wellness that we have within the PEBB Program, where it exists now. It's an intuitive engagement experience personalized through the well-being assessment, which is the 200 questions that individuals who utilize the platform answer based on four different focus areas: physical health, emotional health, financial health, and work-life balance. Based on your well-being assessment responses, you get a tailored experience on this platform. Through the activity rating, for each activity, you can do a thumbs up, thumbs down. That indicates things you're interested in, things you're not interested in, and weighs those against the things your interests. It puts it into a formula.

The well-being assessment is National Committee for Quality Assurance (NCQA) accredited. There are points-based health activities incentivized by extrinsic and intrinsic incentives. They use a gamification methodology to incentivize people to participate. There's also an extrinsic $50/$125 incentive that's been described before. Those are just some of the things that get you over the hump and interested in the Program.

There are intrinsic incentives. We currently have a year-long campaign about what's your "why." We are evolving that into calling it "pursue your purpose" for this coming

year. It’s to identify what your "why” is, what your purpose is, and then use SmartHealth to support that purpose.

It also offers alternatives for those with a disability or who don't have internet access. There are things in place to address that. It's an opportunity to bring all health and wellness management programs under one umbrella where health plan benefits like flu shots and dental visits can be promoted. It’s very flexible. The goal is to make changes for life and not just once a year.

Pete Cutler: Can you remind me, on the very first slide about population-focused health and wellness. I'm embarrassed to admit, I'm not quite sure what “population-focused” means in this context.

Justin Hahn: In this context, we work with individuals, but we're using this tool for the whole population and tailored to working with individual by individual with something constructed from the ground up for that individual.

Pete Cutler: Is it fair to say that the population would be all the covered PEBB Program lives and now going forward it would include the SEBB Program lives? It's not the whole state of Washington or anything, it's just the folks that are actually within the Program.

Justin Hahn: Correct. The population is those that have access to the portal.

Pete Cutler: What is a pulse survey?

Justin Hahn: A pulse survey is a pop-up box. I think they want to correlate it in that way because they do come up pretty often. It's just a little survey. It's similar to when you're navigating through the internet with your browser and a little right-hand corner thing pops up and says, "How are you liking this experience?" One to five stars.

Pete Cutler: In terms of the bringing the health and wellness management programs under one umbrella, I'm a Kaiser now member. I filled out a health assessment for them, plus I did the assessment for SmartHealth. I like SmartHealth, that it covers a variety of different aspects. But it did seem it would be ideal somehow if they were coordinated or connected because maybe my doctor would benefit from knowing the things that I have on my SmartHealth assessment and vice versa. There's hard data. There's actual blood pressure readings, etc. on the Kaiser one. I'm curious, is there any hope of having greater coordination or connection between those two? Not just Kaiser, but any of the other health plans that we might be dealing with?

Justin Hahn: That's a good point and an ongoing issue we're continuing to talk about. At this point, they're not correlated. With three different health plans, there are some challenges to it.

Pete Cutler: I'd imagine, with looking at possibly six or seven plans, it would be all the more complicated with school employees. It's something to think about as a potential goal.

Dave Iseminger: On population-focused health, although individuals are interacting with the system, the data staff are analyzing is on the entire population. We can't see how individuals answer questions, but we can look at agency trends. There can be a focus within that agency or in that sub-part of the population. We have the ability to do that. That gets back to this data, we're collecting it under an employer hat versus the health assessments that the plans are doing. They're doing it under the provider hat. There are some legal intersections there with being able to coordinate. That is something we're always trying to be cognizant of.

Alison Poulsen: A lot of folks don't want their wellness assessments being in the hands of their insurance carrier. It creates a high level of anxiety when our intent is to help get to healthier behaviors.

Justin Hahn: Thank you. Slide 6 – SmartHealth Activity Categories. Our wellness focus is to improve population health by looking at the population that we serve that has access to this online portal by keeping healthy people healthy, reducing health risks, and managing ongoing or chronic conditions. These three buckets include all people wherever they happen to be on their life path. As you drill down, it gets more specific and relevant to the individual experience.

Slide 7 – Activity Examples. This slide shows activities in those three categories. There are some individual activities, team activities, and some cross over from one column to the next. Under keeping healthy people healthy, drafting a gratitude list is one activity. I participate in this daily, waking in the morning, writing down or at least thinking about those things that I'm grateful for. Under the same heading is stepping it up together, two million steps, which is a steps challenge with groups. It's a team challenge. SmartHealth is smart enough to have individuals group together and it tends to be between five and ten folks per group. Through positive peer pressure and encouragement, we divide the two million steps for this month and that means 10,000 steps per day per person, whatever you want to talk about or maybe it's 5,000 steps. More doable for a lot of people. And the people encourage each other. It's not just an interaction with yourself and the platform, but you have the opportunity to include more people.

Under reducing health risks is preventive dental exams. That encourages you to go see the dentist, get a preventive check-up, and see what's going on. That's a verified activity that has been confidentially reported back from the provider to Limeade, which is the provider of the portal. You get the points after the billing happens and the reporting goes back to Limeade.

Lou McDermott: Pete, back to the population health comment, when we look at our plan and where we're like other books of business, where we're less, where we're more, one thing we noticed is we had a lot of people not going for annual dental visits. What was unfortunate, folks with children were also not bringing their kids in. If you don't go in for your annual, there's a tendency not to bring in your kids for their annual. When we noticed that, we asked the wellness folks to go ahead and see if they could incorporate some sort of carrot in the benefit so you would go in for your annual. We did see the overall numbers of dental visits go up. It wasn't isolated to Pete. We noticed the trend didn't seem good, we threw in an incentive, saw the number go up, positive things happening.

Pete Cutler: Thanks. That is actually a very good example because I could see here something was identified on a population basis as beneficial to try and figure out some way to incentivize something on a population basis rather than individual. Thanks for that example.

Justin Hahn: Under the “manage chronic conditions” column, there is a focus on tobacco cessation. Depending on your coverage, you get a message about benefits under your plan that are available to you. On the PEBB side, we've actually turned this on for everybody because it's not just you that may be using tobacco products, but it may be somebody in your family who's covered under the medical plan. The same with the Diabetes Prevention Program. That's an evidence-based program through the CDC that we're able to promote. We're actually rolling out, the beginning of January, a virtual Diabetes Prevention Program, which we're very excited about that we're going to be advertising and promoting on the platform.

Slide 8 is a mockup of activities a SEBB SmartHealth participant could see and could join on their way to earning the incentive. There is World Diabetes Day, stick to a bedtime routine, join the SmartHealth community, which is a place to go and post pictures and talk about your experience with SmartHealth.

Lou McDermott: One other thing about the experience that's nice that we've discovered in the PEBB Program is that, with different medical plans, there are different benefits available. They might use different smoking cessation company to provide their benefit. Because we give an eligibility feed to Limeade, we tell them which plan you're in. You don't see stuff that's not applicable to you. It makes the experience much easier to show you stuff that's applicable to you. That's tough sometimes to figure out.

Justin Hahn: Slide 9 is an example of a fictional SEBB Program member who is active in SmartHealth. She's 55 years old, a 25-year school employee, lives in King County, and recently diagnosed with diabetes. She loves to cook and is interested in becoming more active. She takes her well-being assessment, she sees a program that's being promoted to her for chronic condition management, and she clicks on that, learns more information, and gets involved with that. Under reducing health risk, she participates in the local farmer's market recipe exchange activity. She knows that activity is important for management of her diabetes. It's also important for anybody. And so, she joins the Washington Walks activity.

Slide 10 – Earning Points. Points are assigned based on the duration of the activity and the intensity. Difficult activities are worth more points. They're tracked in multiple ways, including claims, and importing data from tracking apps such as FitBits and things like that for walking and self-reporting. SEBB Program subscribers will need to earn the required number of points to qualify for the incentive. Activities will start and be completed within the activity timeline. There are distinct activity timelines within the incentive deadline.

Slide 11 – Decisions and Considerations Eligibility. There are two key decisions that the SEB Board will need to make. First is eligibility. SEBB Program subscribers eligible for medical benefits will be eligible to participate. Within the PEBB Program, where we offer SmartHealth currently, the PEB Board made the decision to allow use of only the

portal for spouses and state-registered domestic partners. That portal-only means you have access to the program, but you are not eligible for the extrinsic incentives. There is some value in encouraging families in wellness behaviors. We've seen, anecdotally, one spouse is doing something, the other spouse deciding to do it as well. There is positive peer pressure and encouragement. But there is a cost associated with anybody who is eligible for the program. We estimate that for a calendar year, its approximately $800,000. Does the Board want to allow spouses and state-registered domestic partners to participate in the online portal?

Pete Cutler: I want to confirm, was that $800,000?

Justin Hahn: Yes, approximately per year for access.

Sean Corry: I have a question about that. From what pool of money does that $800,000 or whatever these expenses, the rewards come from? Is it coming from the premium pool that everyone therefore pays in their little share?

Lou McDermott: Yes, as well as the employer, correct? If it's an 85%/15% split of the $800,000, the employer's picking up 85% of that.

Dave Iseminger: Remember the various pools that go into the big pot of money is the funding rate that's funneled through the prototypical model of the districts, the amount of money forwarded to the Health Care Authority from that prototypical model, in addition to the amount the school districts will pay for the locally funded position, and all employee contributions. The vast majority of that is obviously an employer pot of money. That comes into the large fund for the SEBB Program, just like there's a separate large fund for the PEBB Program. There are different allocations for different funds. The administrative account is used by HCA to administer the program. There's one for the TPA funds for the Uniform Medical Plan, one for the TPA funds for the Uniform Dental Plan. All of that is baked into that one slide where it was $16 administration. All of the admin fees from everybody is the admin line. The admin line involves not just admin for this agency but admin in general.

Patty Estes: Do we have any kind of utilization from the PEBB Program on the spousal or state-registered domestic partner? Do we have any numbers?

Justin Hahn: Yes, we do. It’s considerably lower. In regards to the PEBB Program and thinking about registered, we have approximately 46% of eligible PEBB Program subscribers currently registered and 5% are for spouse/state-registered domestic partners. That’s approximately 66,000 on the subscriber side and about 3,000 on the spouse/state-registered domestic partner side.

Wayne Leonard: I've been somewhat skeptical of Wellness Programs that we've instituted in our district because it seems like the healthy people all participate and the ones that probably need it the most don't participate. But, if we were going to allow spouses to access this, do you have data that suggests we would save more than $800,000 in medical claims?

Justin Hahn: I do not have information about that. We can look into that but it's a difficult equation to make from participation in the program to return on investment

savings or ‘x’ amount of dollars. That is the perennial, golden question. We have lots of data and interesting things in between those two markers that we can share. I can provide that information and additional research as necessary. Whatever the Board would like.

Pete Cutler: While you're preparing the background fiscal analysis, a question would be that $800,000, is that based on the assumption that everybody who is a SEBB Program member that has a spouse or state-registered domestic partner, this program would pay an administrative fee to Limeade for all those spouses? Or would they only pay the administrative cost for those who actually registered with the SmartHealth Program?

Justin Hahn: It is for people that are eligible to access the portal, those would be eligible subscribers in the PEBB context, as well as spouses/state-registered domestic partners. It's a per subscriber per month for eligible.

Dave Iseminger: It's based on eligibility, not actual access and utilization of the program.

Justin Hahn: Exactly. Proposed Policy Resolution SBBB 2018-55 – Eligibility for Participation in the SEBB Wellness Program. The spouse or state-registered domestic partner of an eligible school employee may participate in the SEBB Wellness Program activities, but is not eligible to receive an incentive payment.

Dave Iseminger: As always, we'll bring back more information based on the questions you've asked. Is there anything else on this particular resolution that anyone wants us to bring back? It will go out in the normal stakeholdering process that all the other resolutions do.

Justin Hahn: Slide 13 – Decisions and Considerations Deadline. This slide talks about 2020 and beyond. I want to distinguish the difference between those two. We recognize the SEB Board is different from PEB Board. We have considered SEBB Program employee needs with regards to the incentive deadline. The second consideration for the Board to consider is how long subscribers will have to earn the incentive, what we call the incentive deadline for the calendar year. We recommend that the program launch each year in January, and that SEBB Program members have until the end of November to earn enough points to be eligible for the $125 incentive in the following year.

Lou McDermott: I know when we first launched the program in the PEBB Program, we cut it off June 30 because of concerns with modeling and trying to guess how many people were going to get the incentive. Are actuaries saying because of the PEBB experience, we're feeling confident enough in the modeling that it won't have a substantive impact on rates or anything?

Dave Iseminger: In the PEBB Program, originally, the deadline was set at June 30 because of actuarial concerns and trying to estimate. In conversations with OFM and the Legislature making sure there could be as robust a model as possible, after a year or two of experience was under the belt, those concerns were lessened. The PEB

Board moved the deadline to September 30, and that's where the PEBB Program's deadline is now.

When we looked at the September 30 deadline, it's the first 30 days of school. It's probably not the best timeline. When we recommended to the PEB Board moving from June to September, we had conversations with carriers about how well it would work to be able to describe what incentive people had earned during open enrollment for the next plan year, and working with carriers to make sure the data was integrated. That's where we landed on the September deadline. That was about three years ago.

Because we were worried about September 30 for your population, we went back to the carriers and asked what else we could do. We tried to push as far into the calendar year as possible to be as far from the start of the school year as possible. Administratively, a period for all of the data to catch up, so when somebody shows up in the emergency room on January 1, the data is there and they're not asked to put down a credit card to pay for the deductible that's actually reduced because of what they did in SmartHealth. That's where that gap comes up in December. There's been an iterative process of learning about the program. Here, based on the four to five years of experience with the PEBB Program, we are saying, "We think with all the players in the sandbox, we can recommend a deadline of November 30."

Slide 14 – Proposed Policy Resolution SEBB 2018-56 – Deadline for Completing Wellness Activities. The important piece on this slide is the November 30 deadline would be rooted in when your medical benefits began. It's a sliding scale because, under the federal wellness rules, we're also trying to balance having equal access to the program. At some point, you have to have a deadline. For those people who, in this scenario, begin benefits after the month of September, they have a truncated period in which they can work on access to the benefits. They still have to earn points. But we work with Limeade to identify a way for people to participate in a robust way and have a quality experience, but also still have the ability to earn the incentive.
,
The reason we can have a deadline of December 31, in the second clause, is the vast majority of people are taken care of by the November 30 deadline date. You get 95% of the people who have benefit effective dates prior to October, and all that data works through the system. There is a small number of people where a catch up can happen with the data closer to January. We couldn't work with carriers to have everybody have a deadline on December 31 and still have everything work on January 1.

Lou McDermott: What I'm hearing is no, it's not a problem.

Dave Iseminger: Correct.

Pete Cutler: I certainly support having the period of time that persons can engage in activities in order to qualify for the incentive, having that run as late into the year as is administratively feasible. The fact that the carriers and the agency feel like they could take it through November, I think is excellent. Can I, as PEBB Program member retiree, can I hope for a similar extension, although, actually, it's not going to be very important because I'm going to be on the Medicare Program next year?

Dave Iseminger: Obviously, both programs are going to learn from each other. Now that we know carriers are less concerned with the November 30 date because of the work here, we'll be having similar conversations with the PEB Board if they want to extend the deadline. We knew that September 30 would be a challenge here and so we engaged in those conversations.

Pete Cutler: Great, thank you. I feel very strongly that the only way a reduction in deductible can be implemented through a Wellness Program is through a vote of this Board. I do not believe collective bargaining statutes allow for a Collective Bargaining Agreement to make that happen unilaterally. I have nothing against that if that's the will of the folks, especially those who actually are in the school districts. But I think the resolutions should be worded to provide that the Board approves that there be this incentive payment in the form of a reduced deductible and then have the timeline language. I just want you know that's a personal concern.

Eligibility & Enrollment Policy Development

Barb Scott: This presentation comes with some explaining because we have errors within it. I hope to navigate you through it.

I'm introducing two policy resolutions today. Slide 4 - Proposed Policy Resolution SEBB 2018-57 – Maximum Number of Months that Self-Pay Coverage is Allowed. This resolution allows employees to continue enrollment in SEBB benefits on a self-pay basis for a maximum of 29 months during an approved leave of absence. The 29 months would include the number of months allowed under COBRA. It's our understanding that many districts currently allow staff who are off on an approved leave of absence to self-pay for their coverage for a period of time in addition to the maximum number of months that are required to be offered under COBRA coverage. Typically, for an employee who loses eligibility, the number of months that they would be eligible for based on that event is 18 months under COBRA. The agency, in our administration, we plan to offer 18 months of COBRA coverage. What this would do is allow something that is beyond the minimum requirement under the federal regulation.

The PEBB Program has a 29-month provision in place today. This slide reflects the same 29 months. We did have some earlier conversations with the WASBO workgroup in trying to understand what exists out there today and what they're used to administering. They said it really varies by district as to how many months is allowed within contracts for employees to self-pay for the coverage. The 29 months that you see here is what is used under the PEBB Program. The PEBB Program's policy related to this predates COBRA. It goes all the way back into the 70s. That 29 months does happen to align to the maximum number of months that an employee could possibly get under the federal regulation based on a disability determination under a specific title.

Dave Iseminger: The federal requirement is 18 months. The Board could be more generous to allow self-pay longer and it would be easy to plug into the system what the agency already has to have the Board take that discretion and move it to 29 months.

Barb Scott: Yes. If we haven't already said it, we have been allotted enough staff that we will administer COBRA here in house at the agency. Our systems are set up to be able to handle this.

Pete Cutler: From an actuarial point of view, in terms of the PEBB Program, does the program track the claims history of individuals who go on COBRA or on similar continuation coverage, and how that compares with the claim history of active employees of the same age group?

Barb Scott: I would expect that we do have some data around that. I know that generally, those folks who continue coverage, especially under COBRA now, employees who are continuing it during an approved leave, the data may look different than it does for actual COBRA coverage. But most group health plans will say that those folks who enroll in coverage under COBRA are a little bit more expensive.

Dave Iseminger: We'll clarify at the next meeting when we bring this resolution back for action, the slice and dice data abilities of the agency. I believe we do have those abilities, but we'll go into more detail in follow up.

Pete Cutler: It may be that the numbers are so small that even if it's a higher average claims cost, it's still de minimis in terms of the overall funding.

Dave Iseminger: I can tell you, Pete, that in the PEBB Program, across the entire population, it's about 382,000 lives. The self-pay population is around 1,000.

Pete Cutler: Yes, but it would be good to -- as my budget analyst kicks in and says, "I just want to see numbers. I just want to be sure." Thank you.

Barb Scott: Slide 5 – Proposed Policy Resolution SEBB 2018-58 – Continuation Coverage for Dependents Not Eligible Under the SEBB Program. On this policy, the words "a spouse/state-registered domestic partner or child" all those words should be stricken, and instead add, "The dependent." The Proposed Resolution should read:

The dependent of a SEBB eligible school employee who is enrolled in medical, dental, or vision under a school employee's account on December 31, 2019 who loses eligibility because they are not an eligible dependent under the SEBB Program may continue enrollment for a maximum of 36 months on a self-pay basis.

Barb Scott: We are bringing this to you because staff are starting to work on the rules. The first phase of rulemaking is complete. We've been through public comment, the public hearing process, awaiting a formal filing of the adoption notice by our agency. Staff have finished your phase one rules for this program. They're working on phase two rules and thinking through the transition of employees from school district eligibility in existence today to those who are moving to SEBB coverage and also to populations that will not be eligible under SEBB. This policy is addressing a very specific population that we had conversations about when we talked about dependent eligibility for the SEBB Program. The dependent eligibility includes spouse and state-registered domestic partners. That leaves a group of dependents, those domestic partners who are not state-registered and their children, for us to consider how we're going to communicate with them and what the transition is going to look like for those families.

With that said, COBRA at the federal level requires continuation coverage for federally recognized spouses and federally recognized children. Domestic partners aren't federally recognized spouses and their children wouldn't necessarily always be federally

recognized either. Because of that, they're not deemed qualified beneficiaries under COBRA. When they lose eligibility under school district plans, they don't have to be offered COBRA coverage. Different than a spouse or a child of an employee who loses coverage that's federally recognized. This policy proposal would extend eligibility for COBRA-like coverage, a maximum of 36 months on a self-pay basis, for those dependents who are currently covered under a school employee as of December 31, 2019 and who loses eligibility because they are not an eligible dependent under the SEBB Program.

The 36 months we're suggesting on the slide is equivalent to the number of months that is required to be offered to a spouse who loses eligibility under an employee under a group health plan based on COBRA or a dependent child who ages out. The wording on the slide is very specific that it wouldn't go beyond the maximum of 36 months. We may have folks already being provided continuation coverage under the district programs based on those contracts that is equivalent to a spouse who loses coverage. It could be a dissolution of a partnership, or if there is a child who wasn't a federally recognized child under COBRA that aged out based on the limiting age, which is typically age 26 for all group plans.

Dave Iseminger: I wanted to bookend this and tie it up even a little more. When the team was looking at the impacts and transitions for school employees and dependents, we went back and thought about the feedback from the very first resolution. Resolution 2018-01 was about setting the eligibility to spouses and state-registered domestic partners and there were concerns that various Board Members raised about that loss of coverage based on the current, more liberal domestic partner policies in some school districts. The genesis of this resolution was the concern you raised. It provided an opportunity to bring to the Board another way to allow an option for coverage for those people who don't meet the new SEBB eligibility requirements.

Sean Corry: Thank you, Dave. To clarify, for those districts which offer COBRA, say with air quotes, to dependents "who might not qualify," when the switch is made in January 2020, the point being that, for those who lose eligibility at that moment from their group plan at the school district, they would be offered COBRA coverage through the Health Care Authority system for 36 months.

Dave Iseminger: COBRA-like coverage. I don't know that you can call it COBRA.

Sean Corry: I used air quotes again.

Dave Iseminger: Yes. By passing in this resolution, it would authorize that scenario. For a maximum length of some people, if their first month is January 2020, they could make it all the way to December 2023. If they already are an existing COBRA subscriber, it would be less than that. But the maximum length of the breadbox would be 12/31/23.

Lou McDermott: But for the more liberal eligibility criteria to the more conservative, it would be three years starting on 1/1/2020.

Dave Iseminger: Yes.

Pete Cutler: Just to be real picky, it really wouldn't technically be continuing enrollment because actually, they'd be going off the school district plan into the SEBB Program. So, just for what that's worth.

Lou McDermott: From their perspective, yes.

Dave Iseminger: We'll take a look at the word "continue" on the next to last line.

Wayne Leonard: Barb, did you say they would not be eligible for COBRA coverage under our old plans?

Barb Scott: That's correct. Under the current district plans, if there is a provision that is currently offering them COBRA-like coverage, if that's what they're current experience is with those plans, there's no federal requirement for them to do that. It does not exist because they are not COBRA-qualified beneficiaries under the federal regulation. When those plans go away, when they terminate, there really is no plan to offer them.

Dave Iseminger: There's the difference between the federal recognition and requirement that gives an employee COBRA protections versus the ability a district could do what we're recommending here, which is to be more liberal and offer the opportunity for self-pay coverage. But the difference between requirement and individual discretion to offer that self-pay is a distinction to keep in mind.

Barb Scott: I'm going to add one more thing to it to help add a bit of clarity. A group health plan is required under COBRA. A governmental plan, like SEBB, is under the Public Health Services Act, but it functions in the same way. You have to offer COBRA coverage to those deemed qualified beneficiaries. The group health plan, those rules require that COBRA coverage be offered for a specific number of months based on a loss of coverage, a qualifying event that causes a loss of eligibility under the group health plan. Typically, those are 18 months and 36 months.

There is a set of events that can occurs that would cause COBRA coverage to terminate earlier than the 18 months that must be offered, typically, to an employee who loses eligibility under the plan or the 36 months that would have to be offered to a federally recognized dependent who loses coverage under the plan. One of those early termination events is that the group health plan itself is terminated. For school districts, there won't be a group health plan left come December 31, 2019. If they have no other participants in their plan, I don't know that they would want to continue to cover just COBRA members. I don't know what the district plans are thinking about that. But, if there's no plan left, then that’s the question.

Dave Iseminger: We'll have more about COBRA administration and other aspects. This resolution is about offering an additional opportunity for those people who won't meet SEBB eligibility requirements. We can go into a large rabbit hole about COBRA administration. We have many more months to do that.

I want to say two things to wrap up. First, the Governor's budget has come out. Although the devil's in the details and, we'll talk about it at the next meeting, the Collective Bargaining Agreement is fully funded. That's good news for everybody.

Preview of January 24, 2019 SEB Board Meeting

Dave Iseminger: We'll talk about the Governor's budget in more detail, what's happened in the first ten days of the legislative session, and the K-12 retiree report. We're planning a demo of the front end IT system in its current development state. We'll be talking more about our communications plan and roll out for members. Barb will bring the four resolutions introduced today for action and will present additional resolutions.

Lou McDermott: I really want to thank the Board for all the work they've done this year. I wish you a happy holiday, safe travels, and we'll see you next year.

Next Meeting

January 24 2019
9:00 a.m. to 5:00 p.m.

Meeting adjourned at 12:44 p.m.

TAB 4

Washington State Health Care Authority

March 7 Board Meeting Follow Up

Dave Iseminger, Director
Employees and Retirees Benefits Division
April 10, 2019

Washington State Health Care Authority

Member Communications Follow up from March 7 Meeting

Links to SEBB articles:

- https://www.seattletimes.com/opinion/time-to-offer-health-care-for-all-public-school-employees/
- https://www.seattletimes.com/education-lab/with-a-price-tag-of-900-million-washington-state-will-soon-take-over-all-school-employee-health-care-plans/
- https://www.seattletimes.com/opinion/editorials/new-health-plan-is-a-step-toward-equity-for-school-employees/

Washington State Health Care Authority

Member Communications Follow up from March 7 Meeting

Link to SEBB toolkits:

- www.hca.wa.gov/sebb-factsheets

Washington State Health Care Authority

SEBB Finance Follow Up From March Meeting

Megan Atkinson, Chief Financial Officer
Financial Services Division
April 10, 2019

Washington State Health Care Authority

Illustrating Tier and Member Ratios

	Column A	Column B	Column C
	Employee Counts	Premium Tier Ratio	Member to Employee
Employee Only	40	1.00	1.00
Employee+Spouse/Partner	15	2.00	2.00
Employee+Child(ren)	15	1.75	3.00
Employee+Family	20	3.00	4.00
Waived Coverage	10	0.00	n/a
Total Benefit Eligible	100	1.5625	n/a
Total Covered	90	n/a	2.1667

- The prior slide is showing the numbers Ben presented during his illustration of the differences between the ratio of adult units per employee and the ratio of members per employee.

- The Premium Tier Ratio is used to convert the Employer Medical Contribution (EMC) to premium into a per employee Funding Rate. HCA collects the Funding Rate for all benefit eligible employees, and this includes those employees who waived coverage.

- The Member to Employee Ratio is used to describe the population covered by a medical plan. Since employees who waive coverage are not covered by a medical plan, we exclude these individuals from the calculation of the ratio.

- These values are to illustrate the concept and calculation of the various ratios. We have also included a slide of the current SEBB Program assumptions. The actual enrollment will vary from these assumptions and quite possibly by a significant amount. As the SEBB Program is changing the landscape of benefits for school employees, how these benefits are selected is the biggest unknown for the Program.

Illustrating Average Ratio of Adult Units per Employee

- Sum of Column A * Column B
  - $$\frac{(40*1.00) + (15*2.00) + (15*1.75) + (20*3.00) + (10*0.00)}{100}$$
  - $$\frac{40 + 30 + 26.25 + 60 + 0}{100}$$
  - 1.5625

For this illustration, on average there are 1.5625 adult units of premium that will be purchased per benefit eligible employee.

Illustrating Average Ratio of Members per Employee

- Sum of Column A * Column C without waivers
  - $\frac{(40*1.00) + (15*2.00) + (15*3.00) + (20*4.00)}{90}$
  - $\frac{40 + 30 + 45 + 80}{90}$
  - 2.1667

For this illustration, on average there are 2.1667 members covered for each enrolled employee.

Washington State Health Care Authority

Current SEBB Program Assumptions

	Column A	Column B	Column C
	Employee Counts	Premium Tier Ratio	Member to Employee
Employee Only	60,691	1.00	1.00
Employee+Spouse/Partner	22,019	2.00	2.00
Employee+Child(ren)	21,384	1.75	2.69
Employee+Family	28,025	3.00	3.97
Waived Coverage	11,695	0.00	n/a
Total Benefit Eligible	143,814	1.573	n/a
Total Covered	132,119	n/a	2.070

Washington State Health Care Authority

Questions

Megan Atkinson, HCA Chief Financial Officer

Financial Services Division

Megan.Atkinson@hca.wa.gov

TAB 5

Washington State Health Care Authority

SEBB Finance
2019-2021 Budget Update

Megan Atkinson, Chief Financial Officer
Financial Services Division
April 10, 2019

Overview

- Review of the SEBB Net Funding Rate vs. SEBB Funding Rate
  - Based on 2020 Final Not-to-Exceed (NTE) Rates for medical, dental, and vision
- Monthly Funding Rate Comparison
  - House Budget vs. Senate Budget
- Funding Rate Assumptions
- Flow of Funding Rate
- Decision Packages

Washington State Health Care Authority

Net Funding Rate vs. Funding Rate

HCA modeling as of 3/1/2019

SEBB Funding Rate Components	FY 2020	
	HCA Update - 3/1/2019 (Net Funding Rate)	HCA Update - 3/1/2019 (Funding Rate)
EMC (PAUPM) [1]	$578	$578
Ratio of Adult Units per Employee [2]	1.573	1.573
Medical Premium Contribution (PSPM) [3]	$907	$907
100% Dental Premium (PSPM)	$91	$91
100% Vision Premium (PSPM)	$10	$10
100% Basic Life Premium (PSPM)	$4	$4
100% Basic LTD Premium (PSPM)	$2	$2
K-12 Remittance (PSPM)	$67	$67
Admin and other costs (PSPM) [4]	$32	$32
Surplus Spend [5]	-	($18)
Total Cost (PSPM) [6]	**$1,114**	**$1,096**

Source:
Legislative Budget Funding Rate Scenario - 3/1/19

Notes:
1. PAUPM - Per Adult Unit Per Month
2. 1.573 adult unit factor is a modeled assumption for the SEBB eligible employee population, including enrollment of dependents and employees waiving coverage.
3. PSPM - Per Subscriber Per Month
4. Admin and other costs includes GF-S loan repayment by June 30, 2021
5. Surplus spend from GF-S loans
6. Values are rounded within modeling

Washington State Health Care Authority

Monthly Funding Rate Comparison

	House Budget		Senate Budget	
Funding Rate	**FY20**	**FY21**	**FY20**	**FY21**
HCA - SPM Suggested - 3/1/19 [1]	$ 1,096	$ 1,127	$ 1,096	$ 1,127
2019-21 Operating Budget Proposal	**$ 1,081**	**$ 1,111**	**$ 994**	**$ 1,056**
Difference	*$ (15)*	*$ (16)*	*$ (102)*	*$ (71)*

Note:

1. SEBB Projection Model Suggested Funding Rate from 3/1/19 Leg Budget Scenario

Washington State Health Care Authority

Funding Rate Assumptions – as of 4/3/19

House Budget	Senate Budget
2019-21 Biennium	**2019-21 Biennium**
GF-S Loan Repayment Assumptions: - Loans would be repaid by June 30, 2022 (end of FY2022). Reduces the SEBB funding rate by approximately $6 for FY20 & FY21. **Premium Stabilization Reserve (PSR) Funding Level Assumptions:** - Gradual PSR build from 3% in FY20 to 7% by FY24 for Medical and 1% in FY20 to 4% by FY23 for Dental. - Assumes approximately $3M in PSR starting fund balance from PEBB K-12 population moving over into SEBB Reduces the SEBB funding rate by approximately $8 and $3 for FY20 & FY21, respectively. **Inflation Assumption:** - Medical Trend Inflation of 5% for CY2020 and CY2021. Reduces the SEBB funding rate by approximately $1 and $7 for FY20 & FY21, respectively.	**GF-S Loan Repayment Assumptions:** - Loans would be repaid in the 2021-23 Biennium **Funding Rate:** - SEBB funding rate was derived off the most recent PEBB Modeling basis: *PFPM (PEBB Financial Projection Model) 6.0 Net Funding Rate.* Adopting the PFPM 6.0 net funding rate reduces the SEBB funding rate by approximately $102 and $71 for FY20 & FY21, respectively.
Engrossed Substitute House Bill 1109 - 3/29/19	*Senate Striking Amendment (S3636.2 to ESHB 1109) - 4/3/19*

Washington State Health Care Authority

Flow of Funding Rate

House Budget	Senate Budget
2019-21 Biennium	**2019-21 Biennium**
K-12 health benefit funding will be allocated by OPSI to the districts and districts would send payments to HCA.	K-12 health benefit funding will be allocated directly to the School Employees' Benefits Insurance Account rather than being passed through the districts by OSPI.

Washington State Health Care Authority

Decision Packages

Decision Packages	Fund	Governor's Budget 2019-21 Biennium	House Budget 2019-21 Biennium	Senate Budget 2019-21 Biennium
PL-09 Online Decision Tool	492	150,000	-	150,000
PL-28 Employee Retirees Benefit Staff	492	1,049,000	1,049,000	1,049,000
PL-29 SEBB Dependent Verification	492	512,000	512,000	512,000
PL-34 Pay1 Replacement [1]	492	150,000	-	-
PL-31 SEBB TPA Payment - FSA/DCAP	474	937,000	937,000	937,000
PL-31 SEBB TPA Payment - UDP	475	6,000,000	6,000,000	6,000,000
PL-31 SEBB TPA Payment - UMP	494	10,349,000	10,349,000	10,349,000
PL-30 Centers of Excellence	494	1,102,000	1,102,000	1,102,000

Notes:

1. $150,000 appropriation for an independent assessment and evaluation of options for Pay1 replacement

Fully Funded
Not Fully Funded

Washington State Health Care Authority

Questions

Megan Atkinson, HCA Chief Financial Officer

Megan.Atkinson@hca.wa.gov

TAB 6

Washington State Health Care Authority

Legislative Update

Cade Walker, Executive Special Assistant
Employees & Retirees Benefits (ERB) Division
April 10, 2019

Washington State Health Care Authority

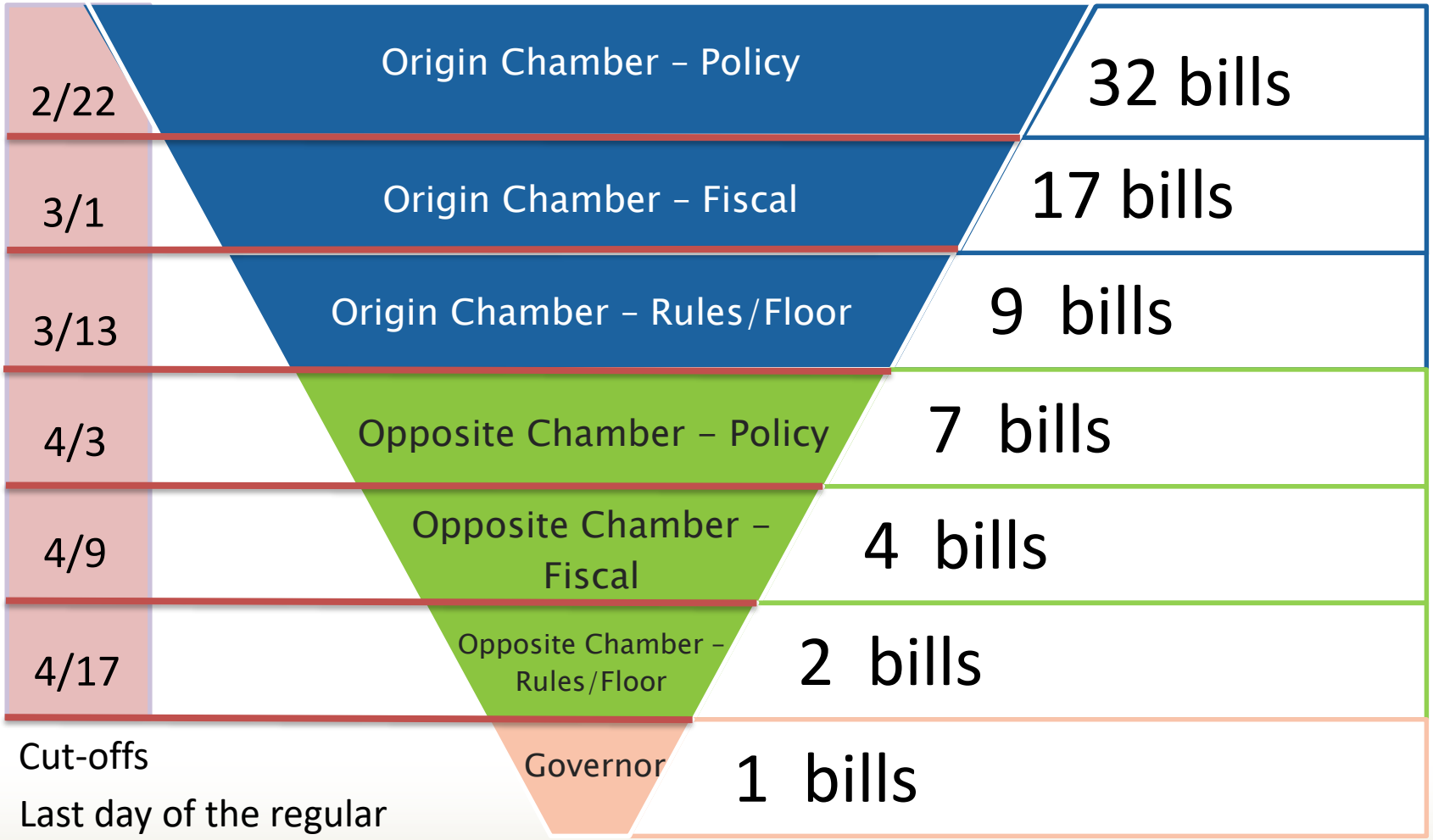
Number* of Bills Analyzed by ERB Division

	ERB Lead	ERB Support	
High Impact	32	32	64
Low Impact	77	120	197
	109	152	261

*As of 3/29/19

Washington State Health Care Authority

Legislative Update – ERB high lead bills



Cut-offs

Last day of the regular session: **4/28**

Washington State Health Care Authority

SEBB Program Impact Bills

- HB 1547 - Concerning basic education funding (levy lid)
- HB 2096 - Concerning educational service district health benefits

Washington State Health Care Authority

PEBB Program Impact Bills

- HB 1085/SB 5469 - Concerning premium reduction for medicare-eligible retiree participants in the public employees' benefits board program
- HB 1414/SB 5335 - Paying state retirement benefits until the end of the month in which the retiree or beneficiary dies
- *HB 1220/*SB 5275 - Adding a non-voting representative from the Office of the Insurance Commissioner to the PEB Board

Washington State Health Care Authority

ERB Impact Bills

- *HB 1065*/SB 5031 - Protecting consumers from charges for out-of-network health care services
- **HB 1074**/SB 5057 - Protecting youth from tobacco products and vapor products by increasing the minimum legal age of sale of tobacco and vapor products
- **HB 1099** – Providing notice about network adequacy to consumers
- *HB 1523/SB 5526* - Increasing the availability of quality, affordable health coverage in the individual market
- *SB 5889* - Concerning insurance communications confidentiality

Washington State Health Care Authority

ERB Topical Bills

- Reproductive health:
  - *SB 5602* - Eliminating barriers to reproductive health for all
  - HB 2154 - Abolishing abortion
- Pharmacy:
  - *HB 1224* - Concerning prescription drug transparency
  - *HB 1879/*SB 5806 - Regulating and reporting of utilization management in prescription drug benefits
  - SSB 5184 - Concerning prescription coverage and the use of mail order services
  - *2SSB 5292* - Concerning prescription drug cost transparency

Questions?

Cade Walker, Executive Special Assistant
Employees and Retirees Benefits Division
cade.walker@hca.wa.gov

TAB 7

Washington State Health Care Authority

Policy Resolution

Rob Parkman, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
April 10, 2019

Washington State Health Care Authority

SEB Board Policy Resolution

- SEBB 2019-08 Terms and Conditions for RCW 41.05.740(6)(e)

Washington State Health Care Authority

RCW 41.05.740(6)(e)

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

(e) Establish terms and conditions for a school employees' benefits board organization to have the ability to locally negotiate eligibility criteria for a school employee who is anticipated to work less than six hundred thirty hours in a school year. A school employees' benefits board organization that elects to use a lower threshold of hours for benefits eligibility must use benefits authorized by the school employees' benefits board and shall do so as an enrichment to the state's definition of basic education;

Washington State Health Care Authority

Policy Resolution SEBB 2019-08
Terms and Conditions for RCW 41.05.740(6)(e)

Resolved that, for school employees whose eligibility is established under RCW 41.05. 740(6)(e), all SEBB Program rules within chapters 182-30, 182-31, and 182-32 WAC apply except for provisions within those rules governing benefits that are not authorized in SEBB 2019-03 to be offered to RCW 41.05.740(6)(e) employees.

Next Steps

Incorporate policy resolutions into SEBB Program rules.

Washington State Health Care Authority

Questions?

Rob Parkman, Policy and Rules Coordinator

Policy, Rules, and Compliance Section

Employees and Retirees Benefits Division

rob.parkman@hca.wa.gov

Tel: 360-725-0883

APPENDIX

Washington State Health Care Authority

Proposed Policy Resolution SEBB 08 Terms and Conditions for RCW 41.05.740(6)(e) (as presented March 10, 2019)

For school employees whose eligibility is established under RCW 41.05.0740(6)(e), all SEBB Program rules within chapters 182-30, 182-31, and 182-32 WAC apply except for provisions within those rules governing benefits that are not authorized in SEBB 2019-03 to be offered to RCW 41.05.740(6)(e) employees.

TAB 8

Washington State Health Care Authority

Eligibility & Enrollment Policy Development

Rob Parkman, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
April 10, 2019

Washington State Health Care Authority

Introduction of Policy Resolutions

- SEBB 2019-09 Error Correction Recourse
- SEBB 2019-10 Error Correction Premium Responsibilities

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

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

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

(i) The effective date of coverage following hire;

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

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

(f) Establish penalties to be imposed when a school employees' benefits board organization fails to comply with established participation criteria; and

Washington State Health Care Authority

Proposed Policy Resolution SEBB 2019-09 Error Correction Recourse

If a SEBB Organization fails to provide notice of benefits eligibility or accurately enroll a school employee or their dependents in benefits, the error will be corrected prospectively with enrollment in benefits effective the first day of the month following the date the error is identified, unless the Health Care Authority determines additional recourse is warranted.

Washington State Health Care Authority

Proposed Policy Resolution SEBB 2019-10 Error Correction Premium Responsibilities

If a SEBB Organization errs and enrolls a school employee or their dependents in SEBB insurance coverage when they are not eligible and it is clear there was no fraud or intentional misrepresentation by the school employee involved, premiums and any applicable premium surcharges paid by the school employee will be refunded by the SEBB Organization to the school employee without rescinding the insurance coverage.

Washington State Health Care Authority

Next Steps

- Incorporate Board feedback in the proposed policies
- Send the proposed policies to stakeholders *(after today's meeting)*
- Bring recommended policy resolutions to the Board to take action on at the May 16, 2019 Board Meeting

Washington State Health Care Authority

Questions?

Rob Parkman, Policy and Rules Coordinator

Policy, Rules, and Compliance Section

Employees and Retirees Benefits Division

rob.parkman@hca.wa.gov

Tel: 360-725-0883

TAB 9

Washington State Health Care Authority

UMP Pharmacy Benefit Proposal

Marcia Peterson, Manager
Benefit Strategy and Design Section
Employees and Retirees Benefits Division
April 10, 2019

Considerations

- All SEBB Program members will experience a change in their benefits in 2020, and it will be less disruptive to those members who choose UMP and get used to the new UMP formulary once, than to have it change in 2021 or 2022.
- K-12 Retirees who move from UMP plans in the SEBB Program to UMP Plans in PEBB Program coverage will have continuity in their formularies if they're on UMP.
- The more consistent the UMP benefit is for both populations, the less likelihood of confusion when members are looking for information on cost shares.

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

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

- Nonformulary drugs are covered only when medically necessary and all formulary drugs were ineffective or are not clinically appropriate for that member, and
- Multi-source brand-name drugs, including those in refill protected classes, are covered only when medically necessary and all formulary drugs have been ineffective or are clinically inappropriate for that member, and

Proposed Policy Resolution SEBB 2019-11 Self-Insured Value Formulary (*cont.*)

- Members who have been taking a non-formulary drug are required to switch to the formulary drug, unless:
  - they receive or have already gone through the exception process and been approved, or
  - their drug is within one of the refill protected drug classes which include: antipsychotics, antidepressants, antiepileptics, chemotherapy, antiretrovirals, immunosuppressives, and immunomodulatory/antiviral treatment for Hepatitis C.

Washington State Health Care Authority

A high-level look at the Current UMP Pharmacy Benefit Tiers

Current Tiers
Preventive
Value
1 (select generics)
2 (preferred drugs)
3 (non-preferred drugs)

Similar effectiveness

Lower Cost

Higher Cost

Washington State Health Care Authority

Current UMP Pharmacy Benefit Tiers

Tier	Member Coinsurance[1]	Member Out-of-Pocket Max[2]
Preventive	No coinsurance or Deductible	$0
Value	5% coinsurance No deductible	$10
1 (select generics)	10% coinsurance No deductible	$25
2 (preferred drugs)	30% coinsurance Deductible applies[3]	$75
3 (non-preferred drugs)	50% coinsurance Deductible applies	$150 – Specialty drugs[4] only No cost-limit for non-specialty drugs

1. All network pharmacies retail & mail order
2. Network pharmacies only; MOOP reflects 30-day supply; total MOOP is $2,000 per person per year
3. UMP Annual Prescription Drug Deductible is $100 per person
4. Filled through UMP's specialty pharmacy, Ardon Health

Washington State Health Care Authority

Copay coupons contribute to increasing premium costs

Generic Drug X cost per year: **$165**

Tier 3 Brand-Name Drug Y cost per year: **$3,800**

	Generic drug ($15 copay)	Tier 3 Brand drug (50% coinsurance)	Tier 3 Brand drug + Copay Coupon
Member pays	$15	$1,900	***$0***
Plan pays	$150	$1,900	***$1,900***

Washington State Health Care Authority

Copay Coupons are easy to find

Concerta Coupon & Discounts

Save on Concerta at your pharmacy with the free discount below.

Concerta is the brand name of the generic medication methylphenidate and is used to help control the symptoms of Attention Deficit Hyperactivity Disorder (ADHD). The price of Concerta ranges from a low of $300 for thirty 18mg tablets to almost $370 for the same number of 54mg tablets. To help with controlling c ... Read more

Concerta Discount

Savings with HelpRx discount up to:

75% Off

Privacy Protected

Never Expires

Claim your free Concerta discount

1. Click the "Get free coupon" button to receive your free Concerta discount
2. Print, email or text message your coupon
3. Present your coupon the next time you fill your prescription

Get Free Coupon →

(No signup required!)

CVS pharmacy Walmart Kroger Walgreens

Concerta Information:

- What
- How
- Precautions
- Side Effects
- Missed Dose

What is Concerta?

Concerta is classified as a central nervous stimulant of the amphetamine class. It is prescribed to decrease restlessness and increase attention in those who are afflicted with Attention Deficit Hyperactivity Disorder (ADHD), and is one facet of a program coordinated with psychological, educational, and sociological therapy. It is believed that methylphenidate blocks the reuptake of dopamine and norepinephrine into presynaptic

Washington State Health Care Authority

Proposal: Pharmacy Benefit Tiers – UMP

Tier	Member Coinsurance[1]	Member Out-of-Pocket Max[2]
Preventive	No coinsurance or Deductible	$0
Value	5% coinsurance No deductible	$10
1 (select generics)	10% coinsurance No deductible	$25
2 (preferred drugs)	30% coinsurance Deductible applies[3]	$75
3 (non-preferred drugs)	30% coinsurance Deductible applies	Specialty drugs[4] only—$150 No cost-limit for non-specialty drugs

The Value Formulary would eliminate the Tier 3 drug category. Members would either pay 100% for the cost of these drugs, or they would need to go through an exception process and show medical necessity in order to have them covered.

Example

Lyrica	Gabapentin (generic alternative)
• Treats nerve pain • Tier 3 Drug • Member pays $214 for a 30-day supply	• Treats nerve pain • Tier 1 drug • Member pays $1.78 for a 30-day supply

Washington State Health Care Authority

Current UMP Pharmacy Member Examples

Don

- Is prescribed Lyrica to treat fibromyalgia
- Tries gabapentin, the alternative, but it doesn't work for him
- Requests an exception – approved
- Gets Lyrica at the Tier 2 price of $75 for a 30-day supply

Dave

- Is prescribed Lyrica to treat fibromyalgia
- Tries gabapentin, the alternative, but it doesn't work for him
- Is not aware of the exception process
- Gets Lyrica at the Tier 3 price at $214 for a 30-day supply

UMP Pharmacy Benefit

Current Design

- Open Formulary
- Tiered pricing and coinsurance to guide members to lower cost alternatives
- Exception process to allow some members taking Tier 3 drugs to pay less

Challenges

- Members may not be aware that there are less expensive alternatives
- Tiered pricing isn't enough to steer members to lower cost alternatives
- Copay coupons negate impact of tiered pricing – and cost the plan
- Members who are prescribed Tier 3 drugs may not be aware of exception process

Washington State Health Care Authority

Uniform Medical Plan Proposed Value Formulary

Where does the "value" come from?

- Medicines that cost more, but may not work better than lower-cost alternatives, are not covered

What does this mean for members?

- Access to medicines in every covered therapeutic class
- Possibility for lower out-of-pocket costs at the pharmacy
- An exception process for non-formulary (non-covered) drugs if determined to be medically necessary by the member's physician and the plan

*Antipsychotics, antidepressants, antiepileptics, chemotherapy, antiretrovirals, immunosuppressives, immunomodulatory/antiviral treatment for Hepatitis C

Washington State Health Care Authority

Member is notified their previously covered drug is now non-formulary

Continue using non-formulary drug
Pay 100%

OR

Use formulary drug
Pay applicable copay

OR

Request exception*

Try the lower cost drugs; is there a medical necessity?

Approved
Continue using non-formulary drug
Pay Tier 2 copay

Not Approved
Continue using non-formulary drug
Pay 100%

OR

Not approved
Use formulary drug
Pay applicable copay

* Members who have previously gone through an exception process for the non-covered drug will not need to repeat it. Also exempt: protected drug classes.

Washington State Health Care Authority

Member is newly prescribed non-formulary drug

Use non-formulary drug
Pay 100%

OR

Use formulary drug
Pay applicable copay

OR

Request exception

Try the lower cost drugs; is there a medical necessity?

Approved
Use non-formulary drug
pay Tier 2 copay

Not Approved
Use non-formulary drug
pay 100%

OR

Not approved
Use formulary drug
pay applicable copay

Washington State Health Care Authority

Refill Protected Drug Classes

- Antipsychotics
- Antidepressants
- Antiepileptics
- Chemotherapy
- Antiretrovirals
- Immunosuppressives
- Immunomodulatory/antiviral treatment for Hepatitis C

Generic drug: A medication created to be the same as an existing approved brand-name drug in dosage, form, safety, strength, route of administration, quality, and performance characteristics. Generic medicines work the same as their brand-name counterparts.

Therapeutic alternative drug: A drug that is not chemically identical to another drug in the same therapeutic class, but has similar effects when given in therapeutically equivalent doses.

Proposed change

- It is simpler, more consistent with other plans, offers more value
- Addresses an equity issue in the current pharmacy benefit by allowing for a lower copay if the member goes through the exception process
- Could save members money at the pharmacy when there is a less expensive alternative

Proposed change (*cont.*)

- Could protect the plan from extreme volatility in drug pricing
- Allows members already taking drugs in refill protected drug classes to remain on their drugs
- It could help control the trend and premium prices and keep the drug spend at a manageable level
- This is the best time to do this to avoid member disruption a year from now
- Continuity for K-12 employees moving to the PEBB Program benefits when they retire

Washington State Health Care Authority

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

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

- Nonformulary drugs are covered only when medically necessary and all formulary drugs were ineffective or are not clinically appropriate for that member, and
- Multi-source brand-name drugs, including those in refill protected classes, are covered only when medically necessary and all formulary drugs have been ineffective or are clinically inappropriate for that member, and

Proposed Policy Resolution SEBB 2019-11 Self-Insured Value Formulary (*cont.*)

- Members who have been taking a non-formulary drug are required to switch to the formulary drug, unless:
  - they receive or have already gone through the exception process and been approved, or
  - their drug is within one of the refill protected drug classes which include: antipsychotics, antidepressants, antiepileptics, chemotherapy, antiretrovirals, immunosuppressives, and immunomodulatory/antiviral treatment for Hepatitis C.

What will happen if either Board chooses not to adopt the Value Formulary this year?

- Existing tier structure benefit design will remain unchanged for both programs
- Could result in inequity for members who don't understand how to get a lower copay exception
- Exposes plan to more risk from extreme pricing volatility for new drugs
- Harder to implement in following years because it will require another change for members

If the UMP Value Formulary is going to go into effect on

January 1, 2020

SEB Board will need to approve no later than

June 12, 2019

Washington State Health Care Authority

Questions?

Marcia Peterson, Manager

Benefit Strategy & Design Section

Employees & Retirees Benefits Division

Marcia.peterson@hca.wa.gov

Tel: 360.725.1327

Appendix

Terms

- **Drug class:** A group of drugs that have similar properties or work in similar ways.
- **Formulary:** List of covered drugs selected according to their safety, efficacy, effectiveness, and cost.
  - Open formularies include all medications, including brand-name drugs and generics (usually at different cost-shares).
  - Closed formularies include a limited list of drugs, usually excluding brand-name drugs with generics and/or therapeutic alternatives.
- **Generic drug:** A medication created to be the same as an existing approved brand-name drug in dosage, form, safety, strength, route of administration, quality, and performance characteristics. Generic medicines work the same as their brand-name counterparts.
- **Multi-source brand:** A brand-name drug that is no longer under patent protection and has one or more generics available.
- **Preferred drugs:** Drugs that have been selected for inclusion on the Washington Preferred Drug List (PDL) according to safety, efficacy, effectiveness, and cost. These drugs have a lower member cost-share than non-preferred drugs. The Washington PDL is used by UMP and the Department of Labor & Industries.

Terms

- **Substitution:** Replacing a brand drug or biologic with a generic or interchangeable biosimilar. Required under Washington State law.
- **Therapeutic alternative:** A drug that is not chemically identical to another drug in the same therapeutic class, but has similar effects when given in therapeutically equivalent doses.
- **Therapeutic drug class:** A group of drugs that can be used to treat a certain medical condition or conditions.
- **Therapeutic Interchange Program (TIP):** Allows a pharmacists to substitute a therapeutic alternative drug for a non-preferred brand-name drug in certain cases.
  - **Refill Protection:** Refills for drugs in the following classes are protected from therapeutic interchange: antipsychotic, antidepressant, antiepileptic, chemotherapy, antiretroviral, immunosuppressive, and immunomodulator/antiviral treatment for Hepatitis C (for which an established, fixed duration of therapy is prescribed for at least 24 weeks but no more than 48 weeks). Drugs in these classes are subject to automatic substitution when a generic equivalent is available (see Substitution, above).