School Employees Benefits Board
Meeting Minutes

January 29, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:00 p.m. – 5:00 p.m.

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

SEB Board Counsel:
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 1:05 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

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

Legislative Update
Dave Iseminger, ERB Division Director: I'm going to walk through the legislative process and describe what executive agencies do to analyze bills. I think it helps the public to realize the amount of work that agency staff are doing on these bills.

Slide 2: At the Health Care Authority (HCA) when a bill comes in, our central policy team works to divide bills among the different divisions of this agency. The Employees and Retirees Benefits (ERB) Division is the Division I oversee. We are designated a subset of all the bills being reviewed by the agency. We first do a high-level review to identify what might have a high impact or a low impact. In general, the difference between a high impact and a low impact is the fiscal impacts. If there is any fiscal impact, regardless of the amount, it's deemed a

high impact. If it's going to require rule making changes, then it would also qualify as high impact. As of last week, my Division had received 108 bills to review and that was just a subset of what this agency was reviewing.

I'm going to focus on the upper quadrant where our division was lead, meaning it was primarily responsible for the agency analysis on reviewing high impacts and getting support insight from the other divisions in the agency. ERB was lead for 27 bills. I want you to get a sense to the level of work that goes on, just within one division here at the Health Care Authority. Since we are in a biennial process, all bills from last session that weren't passed also come back to life. There are three from last session making our total roughly 30 bills.

Slide 3 represents the funnel of the legislative process. A bill must pass various steps. The Legislature, at the beginning of session, sets up a calendar that identifies different cutoff periods where a bill has to have passed a certain step in the legislative process for it to be eligible to continue on the process. At the same time, there's always an exception to every rule. If there's any bill at any point that's deemed necessary to implement the budget, if can be passed and reviewed by the Legislature at any point, but this is the general framework for those bills. At the beginning of the legislative process, there are hundreds of bills. As they get through the process, it funnels down to a very narrow subset. Where we are at this point is most bills go to a Policy Committee first and then move on to a Fiscal Committee. After that, they move to the Rules Committee, which helps to determine what goes to the floor for an actual vote by the entire chamber. Not every bill goes through that process. Sometimes a Fiscal Committee is a Policy Committee at the same time. Some bills go directly to fiscal. If it doesn't have a fiscal impact, it can jump the Fiscal Committee, but generally speaking, it goes through the process of Policy, Fiscal, and then to the Rules Committee for floor consideration.

After that, the process repeats in the opposite chamber of the bill’s introduction. If it passes both chambers, it goes to the Governor’s Office for consideration and signature.

There have been no cutoffs to date. The first cutoff is the chamber of origin Policy cutoff this Friday. The next cutoff is the Fiscal Committee in the chamber of origin on February 6. Then the process starts to funnel down and the current session is slated to end on March 8. Many bills are still alive. You can see from Slide 3 where they fall in the process. The three bills that are furthest in the process are those bills brought back from the 2017 session.

Slide 4 are bills I want to highlight that are potentially impactful to both this Program, the Public Employees Benefits Board (PEBB) Program, and then both Programs. Even if something is only addressing the PEBB Program, I want this Board to have a sense of the types of things the Legislature can look at and consider doing within these benefit programs. I will start with the SEBB Program.

There are five functional bills going through the process now. These are in no particular order other than numerical order by bill number.

House Bill 2408 - This bill would require any carriers of fully insured medical plans in the SEBB Program to also offer individual plans on the Health Benefit Exchange. Last year in our state, two counties almost didn't have carrier offerings in the individual market. Ultimately, there were carriers that stepped into those counties so there was at least one plan offering in all counties throughout the state. There's been concern about decreasing access on the individual market. Legislators have been considering leveraging the fully insured SEBB Program carriers, as ideally they will also have statewide coverage because of the geographic location of all school employees, and using that opportunity to have more qualified health plans on the Health Benefit Exchange. The bill is in the house and has had the most activity. It had a policy hearing last week and is scheduled for possible voting out of that Committee this week. The Senate companion bill was just introduced last week and hasn't had a hearing. We'll be monitoring that bill.

House Bill 2438 and its companion in the senate. This is agency request legislation. I sent you a copy of the agency request legislation. As the agency went further through the process, there were many areas needing technical clarification in the statutes that passed last session. We drafted a bill from the agency with permission from the Office of Financial Management and the Governor's Office. It includes all of the topics that I talked about at our last meeting, which also reflects the ability for the Health Care Authority to reimburse school districts for substitute teachers for your Board Member service.

House Bill 2655 is a bill that would add two members to this Board. It would add a representative from the School Directors' Association, as well as the Washington Association of School Administrators (WASA).

House Bill 2657 has a variety of different ideas, some of them mirror parts of the agency request legislation. It adds the concept of anticipated to work to the eligibility requirements. It gives the Health Care Authority the ability to reimburse school districts for substitute teachers. It includes this express reference to the three-to-one ratio from single subscriber to full-family coverage. The bill delays implementation of the SEBB Program until certain state funding requirements are met - a commitment to and funding of SEBB Program benefits at the same funding rate that is done for public employees in the PEBB Program, and ensuring the funding mechanism is based on a head count basis rather than an FTE basis. The legislation also states the funding solution could not be achieved by lowering the actuarial value of the PEBB Program plans.

A second key feature of this bill is the ability for certain school districts to be exempt from participating in the SEBB Program. The school district would have to offer benefits that are in an employee benefit trust and "are generally

equivalent" to both the cost and actuarial value of SEBB Program benefits. The statute would define "generally equivalent" as within 10%. In our fiscal note on that bill, we have identified at least three school districts that we believe could qualify. We're continuing to evaluate what school districts might meet those requirements. It's projected that those three school districts represent about 6% of the school employee population.

The bill also adds two additional voting Board Members to this body. It would add an additional member representing certificated staff and an additional member representing classified staff. A final area of that bill is allowing school districts to offer locally funded benefits to employees who work under the 630 hour requirement, which is the eligibility threshold for this body.

House Bill 2755 has a similar exemption ability for school districts. School districts must meet the "general equivalency" of actuarial value and cost benefits and have a thousand or more employees. We have estimated in our fiscal note that as many as two-thirds of the school employee population could work in a district that could qualify for the exemption.

All four of these SEBB Program bills were heard in the Senate and in the House. There is a planned executive session on Senate Bill 6241, which is the Senate version of the agency request legislation. There are discussions between the sponsors of the various bills about adding some concepts from the other three bills into Senate Bill 6241. There may be amendments that come out of Committee later this week.

Slide 5 are bills slated to specifically impact the PEBB Program. Again, I wanted you to have a context for things that the Legislature considers doing within the employee benefits program context.

House Bill 2869 is a bill that would put into statute the state and employee split of costs for health plans. Right now, under the statewide collective bargaining agreement for public employees, the split for the employer and the employee is an 85/15 split. The state pays on average 85% of the cost and the employee pays 15%. This bill would codify into state law that the split would be 80/20. There has not been a hearing on that bill.

House Bill 2452, and the Senate companion 6305, addresses retiree benefits. This does impact K12 retirees who stay in the PEBB Program under the current statutory framework. There's an explicit subsidy that the Legislature provides to retirees to offset some of the costs of their premium for their coverage. Right now, that level is set at $150 or 50% of the premium, whichever is less. This bill would increase the explicit subsidy to at least 50% of the premium. House Bill 2452 has not had a hearing. Senate Bill 6305 did have a hearing in its Fiscal Committee.

House Bill 2633 and Senate Bill 6213 expands presumptions for occupational diseases that currently apply to firefighter investigators, firefighter EMTs, and local law enforcement. You may ask how this impacts the PEBB Program. Survivors of these individuals have eligibility for retiree PEBB Program benefits, and access to the explicit subsidy if the person died from those occupational diseases. This is the type of thing that impacts eligibility requirements that, on its face, you may not immediately notice. Our agency staff is responsible for identifying these impacts in bills and raising those impacts for awareness in the Legislature. Both of those bills are moving in their respective chambers. The House Bill has passed out of its Policy Committee into its Appropriations Committee. The Senate version has moved to the Rules Committee for possible placement on the floor calendar.

Slide 6 lists bills that could impact both programs. Senate Bill 5179 relates to hearing aid coverage within programs administered by this agency. This bill would change the benefits level coverage in the medical plans offered to public employees. Right now, in the Uniform Medical Plan, for example, hearing aids are covered $800 every three years. This bill would set that coverage requirement to every five years or medically necessary, but at a to-be-determined in the budget amount. Last session when this bill was going through the process, the Senate budget proposed a $1,200 benefit and the House budget was silent. Ultimately, there was nothing signed in the final budget and the bill wasn't passed. This is an example of where the Legislature can specifically identify a dollar amount, both in state law or in budget, and directly set coverage criteria.

House Bill 2114 is often called the surprise billing bill. It is trying to address the situation where patients receive an unexpected bill from out- of-network providers when they access emergency room services. There were five or six versions of this bill last year and there are already two versions of it this year. This bill is currently on the House floor calendar for possible passage.

Senate House Bill 1421 relates to protecting sensitive information in state data systems. At the Health Care Authority, for example, we directly administer self-pay and retiree accounts. We receive payments, for example, checks. We image those checks and put them in our system. This bill changes what could be maintained in our system. This is another type of bill that impacts the operations side of the administration of benefits for both programs.

There are a variety of other benefit-type bills. An example is a pilot project for telemedicine and ensuring that telemedicine visits are paid at the same rate as in-person visits. These bills are in their earliest stages. I only brought the example of the hearing aid bill because it is very far in the process.

I will make sure the Board gets a copy of official versions of the SEBB Program bills as we go through the legislative process.

Overview of Benefits Portfolio

Scott Palafox, Acting Deputy Director for the ERB Division: I will continue where I left off in our December meeting, giving you an overview of our medical, dental, and vision benefits. We've shared a lot of information over the last couple months. Dr. Lessler talked about the triple aim: better health, better care, and lower costs. He talked about value-based purchasing and the initiatives that the Health Care Authority has embarked on with our Accountable Care Program and our Centers of Excellence Program for total joint replacement. Kim Wallace and Marcia Peterson defined some of the terms of self-insured and fully insured. I talked about our preferred provider organizations, health maintenance organizations, dental maintenance organization, and our consumer directed health plans. We also went into defining some of the cost-sharing as it relates to co-payments, coinsurance, deductibles, and out-of-pocket maximums. On a couple of occasions, I shared our procurement process and the different phases and activities associated with that. Last month I went into the comparison of life and AD&D benefits, short-term and long-term disability, and defined some of the cafeteria plan elements as it relates to prepayment tax, medical flexible savings account, dependent care and assistance program, and a health savings account.

Today I'm going to provide more information and define some other terms that are used in the health care arena. I'll talk about the third party administrator, pharmacy benefit manager, the Uniform Medical Plan (a self-insured plan), two fully insured medical plans, and dental plans. Similar to what I did in December, I'll compare the medical, dental, vision benefits, and cost-share information we were able to find on some of the school districts.

Dave Iseminger: We are going over the Uniform Medical Plan in more detail because if there is going to be a self-insured offering that's in the SEBB portfolio, it will need to mirror, the current UMP structure. With a self-insured plan, the state takes on the claims risks. We are spending a fair amount of time on that today to make sure you're aware of the ins and outs of that plan because any self-insured plan that you include in your offering would need to substantially mirror the current state plan.

Sean Corry: Could you explain what you mean by "mirroring?" Meaning that the benefits would likely be nearly identical, for example, to the current PEBB plan or mirroring in just general structure?

Dave Iseminger: Mirroring does not mean exactly all the same identical cost shares. But the framework of the network and the providers that are included, what's covered or not covered within the plan, and the clinical medical policies that are applied need to be pretty similar. Whether the coinsurance is 80% versus 85%, and more granular benefits coverage pieces, could have some variance, but the general structure would need to be similar.

Scott Palafox: What is a TPA and PBM? A third party administrator (TPA) is an organization that processes claims and performs other administrative services. A pharmacy benefit manager (PBM) is the type of TPA that focuses on pharmacy network contracting, processing drug claims, and negotiating drug rebates. The Health Care Authority currently contracts with Regence Blue Shield as our TPA for UMP medical. Moda Health is the PBM for UMP. Some of the additional services provided by a TPA and PBM include account management, clinical support, customer service, paying claims, data analytics, provider network coverage, and handling claims appeals.

Slide 5 will give you a very high overview of the different plans HCA has for employees and their dependents. The left side of the chart is the medical self-insured, pharmacy self-insured, and dental self-insured for the Uniform Medical Plan and the Uniform Dental Plan. In the middle is the medical fully insured with Kaiser Northwest and Kaiser Washington; the dental fully insured with Willamette and Delta Care; Life with MetLife, LTD with The Standard; and then medical FSA and DCAP with Navia Benefit Solutions. At the bottom of the chart shows the TPA and PBM administering some of those benefits. Other benefits are administered by the carriers.

Slide 6: Uniform Medical Plan. The Uniform Medical Plan has the Public Employees Benefits Board (PEBB) Program's largest enrollment of membership. Currently, there are three different types of plans offered under the UMP name; UMP Classic, a PPO plan; UMP CDHP; and UMP Plus with the Puget Sound High-Value Network, and the University of Washington Medicine Accountable Care Networks. The UMP Plus has a lower deductible than Classic, Classic has a moderate deductible, and the CDHP a higher deductible. For UMP Classic and CDHP, both have the same national network and worldwide coverage. UMP Plus is a limited network with enhanced care coordination. For CDHP and Classic, members may live in any Washington State county to enroll. For UMP Plus, members must live in the nine covered counties of Washington State.

Year after year, the UMP received a very high health plan rating through the Consumer Assessment of Healthcare Providers (CAHPS) and assists in survey results. These surveys ask consumers and patients to report on and evaluate their experiences with health care. The surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as communication skills of the providers and the ease of access for health care services.

On Slide 49, we did put links to the UMP CAHPS scores for your information. Keep in mind that Dr. Lessler did share in a previous meeting that the UMP medical plans must follow the Health Technology Clinical Committee for coverage determinations.

The map on Slide 7 shows the coverage for Classic and CDHP across all 39 counties in Washington State and Slide 8 shows UMP coverage across the rest of the country, with the darker green showing the more populated areas and the lighter green the less populated. UMP also has coverage worldwide. We have members and their dependents throughout the world. It's a great choice for snowbirds, children attending college and universities out of state, and for those travelers that may be gone for most of their winter and summer breaks.

Slide 9 – The UMP Plus, Accountable Care Program was launched in 2016. It started in five counties along the I-5 corridor: King, Kitsap, Pierce, Snohomish, and Thurston; and expanded to four new counties in 2017: Grays Harbor, Skagit, Spokane, and Yakima. The Health Care Authority contracts directly with the Puget Sound High-Value Network and the University of Washington Medicine Accountable Care Network. The current UMP Third Party Administrator (TPA) supports UMP Plus by providing administrative services including sharing data. Both of these networks assume clinical accountability and financial risk for members. Benefits are designed to promote primary care and limit out-of-network use. For example, members receive no cost-share primary care office visits when seeing a UMP Plus care provider. The UMP Plus medical deductible and premium are lower than the Classic and there is no deductible for prescription drugs. The monthly premium contribution for both of these networks is the same.

Dave Iseminger: To help you understand how UMP Plus works compared to UMP Classic, there is a network coordinated specifically by Puget Sound High-Value Network, and then separately by the UW Accountable Care Network. But there is the Regence wraparound network from UMP Classic that fills in areas where there is specific provider-type carve out in our contract or to make sure there is wider access, especially in the context of some specialty services. An individual who stays within the network that's managed by UW or High-Value Network has a smaller cost share at the point of service than they do if they go into the broader Regence network. They do have a continued option to go outside of that narrower network that's managed by UW and High-Value Network if they so desire.

Scott Palafox: Slide 9 is a map that shows UMP Plus availability with the nine counties. Regardless of geographic limitations, all of the PEBB Program health care plans provide emergency coverage as needed.

Alison Carl White: I'm curious. I see Spokane on here but is it coordinated out of the Puget Sound High-Value Network or UW Medicine?

Scott Palafox: The Puget Sound High-Value Network.

Alison Carl White: Got it.

Scott Palafox: Slide 12: PEBB Program fully insured medical plans. Kaiser Permanente of Washington (KPWA), formally Group Health, besides their Medicare offerings, offers four different plans to PEBB Program members and provides a number of choices to suit their specific circumstances. They have Classic, Value, SoundChoice, and CDHP. It's a health maintenance organization (HMO) with coordinated care. SoundChoice is available in five counties in Washington State along the I-5 corridor: King, Pierce, Snohomish, Thurston, and Kitsap.

Looking at the deductibles, Classic has the lowest deductible with these plans. The other plans have higher deductibles but lower premiums. There are set co-pays for Classic and Value, coinsurance for SoundChoice and CDHP. Many health plans seek accreditation from the National Committee for Quality Assurance (NCQA). The NCQA seal is a widely recognized symbol of quality. Organizations incorporating the seal into advertising and marketing materials must first pass a very rigorous and comprehensive review and must annually report on their performance. For consumers and employers, the seal is a reliable indicator that an organization is well managed and delivers high quality care and services. KPWA consistently scored high and rated four out of five for the plan year 2015-2016, and 2016-2017.

Slide 13: Kaiser Foundation Health Plan of the Northwest (KPNW). Besides their Medicare offerings, they offered two full-service health plans at their branded full-service facilities. Kaiser Permanente of the Northwest is currently available in Cowlitz and Clark Counties. They have a Classic and a Consumer Directed Health Plan. The chart on Slide 13 shows they are similar with regards to their coordinated care, HMO-like. Classic has a moderate deductible, CDHP higher; co-pays for Classic, coinsurance for CDHP. Kaiser's NCQA rating for the last two years was 4.5 out of 5. KPNW and KPWA have a reciprocity agreement that allows members to utilize facilities across each plan.

The map on Slide 14 shows KPWA and KPNW availability by counties; the orange for KPWA and the two blue in southwest Washington for KPNW.

Dave Iseminger: I want to use Slide 14 to help illustrate something that I'll point back to when I present the resolutions at the end of the day. It’s important to realize that the 14 counties with no coloration on this map are counties in which there are PEBB Program employees who have access only to the Uniform Medical Plan Classic and Consumer Directed Health Plan. That will help explain later why the agency recommends a fully insured procurement to see if there are additional carrier options rather than simply relying on the PEBB Program medical plans for the fully insured side of the medical book of business. We believe that’s important with the widespread geographic diversity of school district employees. We also think you'll likely agree with us that it's important to seek additional options for school employees so that individuals in those 14 counties may have more options to pursue.

Scott Palafox: Slide 16: PEBB Program Dental Plans. PEBB Program portfolio benefits for dental includes three dental plans. There is the Uniform Dental Plan (UDP), which is a PPO self-insured plan. There are Delta Care and Willamette, both managed care plans. There is no deductible for the managed care plans and a $50 deductible for the UDP. There is no cost to members for all plans for most preventive services. The UDP has national coverage and the managed care plans have limited networks and enhanced care coordination. The UDP has a $1,750 annual plan maximum and the managed care plans have none.

Members must live in a Washington State county to enroll in UDP. There are some members in covered counties for the managed care plans. Unlike medical plans, national accreditation quality-assurance programs are not the same. However, the Health Care Authority has performance measures built into its contracts to ensure care is focused on metrics that are good indicators of possible consumer dissatisfaction. We do look at that and ensure their care is aligned. So far, all indications indicate our dental plans are receiving good marks as far as satisfaction. Just a note, the UDP and Delta Care plan are both administered by Delta Dental.

Slide 17 is a map showing coverage area of the Uniform Dental Plan (UDP). There is coverage in 39 counties across Washington State. Slide 18 is a map showing the counties with coverage for Delta Care, and slide 19 is the map of coverage for Willamette Dental for Washington State. It was pointed out before this presentation there may be some caveats to this one. We will make any corrections and update you.

Slide 20: Benefit Comparisons. In this presentation, there are charts followed by graphs that will show you the variation in our findings. This is not to imply that we know everything. We are trying to gain information about the school districts as well, and share that information. I will pause at the end of each section and ask for your reactions to the information we're sharing and whether or not you're hearing things from school members to help us continue our information gathering process.

Dave Iseminger: A couple additional points. You'll notice that the comparator will show a fifth school district. At the prior meeting, there were four comparisons. When I stepped away from that meeting, I felt like there should be an additional eastern Washington representation in the comparisons. You will now see Spokane School District added alongside Lynden and Seattle Public Schools, the Health Care Authority, and WEA select plans.

We have a rule here at the Health Care Authority! We do and say everything alphabetically. You will notice all the school districts in the comparators and all the charts are listed alphabetically.

As a reminder, we selected Lynden, Seattle Public Schools, Spokane Public Schools and WEA as the comparators for these charts for several reasons. First of all, there was a lot of documentation readily available. They were school districts who responded to the original benefits offering survey from the Health Care Authority, which allowed us to validate some of the information we were seeing in their plan documents. We were able to develop relationships with several of these school districts and the WEA to be able to understand and validate their information in the timeframe we needed to produce this information for the Board. We really do appreciate the support from Lynden, Seattle, Spokane, and the WEA, and being able to present this information to you with a high degree of confidence that we are at least describing the benefits correctly. These individuals also represent significant portions of the population. Lynden School District is not as large as Seattle, but we do know that there is a significant proportion of school districts that are on the small to medium size and we wanted to make sure to represent them as well.

Scott Palafox: Slide 21: Non-CDHP Medical Portfolio Overview. As I mentioned, the Uniform Medical Plan has a PPO plan called Classic and the Uniform Medical Plan Plus, which is an Accountable Care Program. KPWA has three HMO plans, Classic, Value, and SoundChoice, and KPNW has a Classic Plan. As you look at the chart, you can see how it compares with some of the other districts. This slide does not include any Medicare plans.

Dave Iseminger: Later you will see slides with the CDHPs. As the data was reviewed, it skewed the data and the visualizations so we carved out CDHPs to present separately from the non-CDHPs.

Scott Palafox: Slide 22: Medical Benefits Ranges Comparison. We selected a couple different cost-sharing pieces to review: annual deductible, co-payment, and coinsurance. There is quite a range with an annual deductible across all plans starting with about $100 and going up as high as $2,500 for the individual plans. Looking at the family plans proportionately as well. Primary care office visits are a smaller range but significantly different. They start at zero and go as high as $45. We selected one component, physician services surgeon fee, to show a comparison as it relates to coinsurance. There is a wide variety of splits from a 90/10 split down to a 60/40 split.

Dave Iseminger: As a reminder, a 90/10 split means that 90% of a claim is paid by the plan and 10% paid by the employee. We selected information on the next few slides from information available under the Affordable Care Act to help consumers compare plans across the market. There are summary benefit comparison documents (SBC) that need to be produced. We decided to leverage what's already out there and picked some of the key things in the SBCs for comparison points for the Board.

Scott Palafox: Slide 23: Medical Summary and Themes. The graph on this slide shows the variability in ranges. The graph on the left is the annual deductible range by group for individual. The graph on the right is for family coverage. Points are plotted for each of those entities listed on the bottom of Slide 22. The low ranges are the blue line and the high ranges are the black line. The color differentiation between them shows the variability between these entities.

Scott Palafox: Slide 24: Medical Summary and Themes (cont.). This slide is the same thing, but shows the co-pay range for office visits to the left and coinsurance ranges for the surgeon's fees on the right. The color coding on these graphs shows the variations and differences

Slide 25: Medical Benefits Ranges (cont.). This slide is the annual out-of-pocket limits comparison. They range from $1,000 up to $6,600 for individual plans and then proportional differences for the family plan. Slide 26 is the comparison of Slide 25.

Slide 27: Medical Consumer Driven Health Plan (CDHP) Portfolio Overview. The Health Care Authority PEBB Program benefits has one CDHP from each of the Uniform Medical Plan, KPWA, and KP Northwest. Comparisons are simpler on this slide. Lynden does not have a CDHP so it wasn't listed. Slide 28 is the comparison of annual deductible and coinsurance. There is not much difference in variation for the individual annual deductible, and $1,400 up to $1,750 proportionally for the family. For coinsurance at the bottom of the chart, there are splits of 90/10 down to an 80/20 split. Very little variation on this one.

Slides 29 and 30 show that information from a graph perspective. For annual deductible, the color scheme and differences between the two lines are not as variable as the ones you've seen so far. The bar chart on slide 30 is showing the coinsurance for the surgeon fees for the employer paid, which is in the green and the member paid share is in the red.

Slide 31 compares the annual out-of-pocket limits for the medical CDHP, with ranges from $3,500 up to $5,100 and proportional for the family. Slide 32 shows that variation.

Now that you've seen a lot of this medical information, what are your thoughts? What have you been hearing from school employees as far as questions or concerns about their medical benefits? Is the information we're providing you clear enough for you to be able to ask questions?

Terri House: My question from my district would be about employees being able to keep doctors, current providers, and things like that. They're a bit hesitant if they see a Uniform Plan directed towards choosing new providers and things like that. Do you have a little more clarification on that?

Scott Palafox: We're at a very young stage in this journey. As we pull in data, we'll be able to do a more thorough analysis as to what the differences are, where the holes are, and what we need to give more attention to. Our intent for the most part is to transition from one program to the other with as little provider disruption as possible for our new members. That is our intent. Until we start getting the data to see where the differences are, it will be difficult to know whether or not there will be an issue with that.

Dave Iseminger: One of the reasons why the recommendations and resolutions later have a fully insured medical procurement is to address some of those variances that'll happen across the state. We know there are many school employees accessing a fully insured medical plan that is not one of the carriers the PEBB Program medical plans currently has. We also know there are 14 counties where the only access currently on the PEBB Program side is the Uniform Medical Plan. By having that direction and commitment to go out for additional fully insured medical plan options, it may very well result in more carrier names that are familiar to school employees. There may be less disruption than people may be anticipating.

The idea behind having you consider offering the Uniform Medical Plan alongside is really as a supplemental benefit with any fully insured medical plans that are choices for school employees. There are roughly 4% - 5% of school employees in roughly 71 districts that are accessing PEBB benefits now. Many of them are in those 14 counties that only have access to the Uniform Medical Plan. That, too, would also minimize provider disruption from that segment of the population's perspective.

We heard about the concerns of provider disruption loud and clear in our focus groups as one of the frequently asked questions. It's just too early to say whether a specific provider is in a network that doesn't yet exist. We will keep that in mind as we move forward working on procurements for benefit offerings.

Lou McDermott: I think it's fair to tell people to find out what insurance their providers take so they are armed with that information when decisions are being made. There's some comfort in knowing that when things do change. Even in the PEBB Program we've had counties that were no longer served by one of our plans. It caused some panic to the members affected and we tried to help them figure out what other options they had in those counties. It's always a good thing to understand exactly what your provider does and does not take.

Pete Cutler: Is it possible to get from the Insurance Commissioner's Office or from the carriers themselves the full details of which providers are in the networks of those plans currently offered to school district employees, or are you going to have to wait for procurement to get that information?

Dave Iseminger: As it stands now, if you're referring to the K12 data that has been provided to the Office of Insurance Commissioner over the last several years . . .

Pete Cutler: No. It's when they file insured plans they have to provide data to the Insurance Commissioner's Office on their network adequacy. My understanding, and I may be wrong as this is a few years old, but that was included, the details of who's on the carrier as of a certain snapshot in time.

Dave Iseminger: I think the reality is, Pete, that we'll probably be doing procurements in about the same timeline that we would be able to get that data independently. We'll probably just double dip into the procurements to ensure that we're getting that information alongside the procurement selection process.

Lou McDermott: Like you said, I think there's a snapshot. We don't want to send something to our members telling them this is exactly how it is. We would want them to contact their provider to make sure they understood what was going to happen, if anything, because things change. New providers are coming in the network and providers are leaving the network all the time.

Pete Cutler: Thank you, Lou. I would agree that the networks are fluid. That is an important issue to address. Even if you did have a list it would not guarantee that your doctor would be there the next year.

Lou McDermott: It depends on their contracting cycle, when they're contracting with the carriers, at what time, etc.

Pete Cutler: And what choices they make.

Wayne Leonard: What I've heard from my constituents or from my employees is not necessarily so much about a concern about the benefits. I think in Spokane it'd probably be the same doctors and the same networks. I've been asked a lot of questions about will we still have the same choice or will we have fewer options. Will we have less flexibility in how we design some of the supplemental coverages? Administratively, will the Health Care Authority be able to enroll 140,000 people in an efficient manner, take the phone calls with the business offices, HR payroll offices, that kind of thing. They are nervous about whether the agency will have enough staff to handle the open enrollment process.

Dave Iseminger: I will say from a staffing perspective, we are hiring in phases. To date, we've hired about 13 SEBB Program staff. The original staffing model presented to the Legislature as part of the funding package had about 50 to 55 staff. It's phased over time to bring on additional people. This time next year we'll be training them for open enrollment. The staffing model is designed to supplement the existing staff with additional staff. They haven't been hired yet

because open enrollment's not quite here and we anticipate having adequate staffing by the time open enrollment is here.

Scott Palafox: Renee can attest to this because she handles our open enrollment activities. Open enrollment is always a challenging time for us. We use our resources to the best of our ability just to make sure that we can keep up with things. Sometimes it's even more challenging, depending on what changes are being made as far as the attention that's given to open enrollment. We continue to look at ways to be more efficient. Dave's remarks noted that we are looking at our organizational structure, figuring out what kind of FTEs will help support that. Not knowing how many variations there will be and the options that will be set forth for the SEBB Program, it's difficult to know what's needed. Right now we're on mark to be able to handle that. Only time will tell. And as far as the different options as we embark on procurements, we'll know a little more about what that may mean for school employees.

Sean Corry: I looked at these slides on Saturday. They came late last week. One thing that struck me, especially about the graphs that showed the ranges of things, is that it tells a little bit of the story but not the full story. I know you're not in a position to tell the full story because you're just receiving data. I know that Seattle, for example, just submitted data last week in detail. But on some of those graphs I drew lines because I know some of the enrollment information from Seattle and other districts in the Puget Sound area. For example, Seattle has over 80% of the employees and plans that have a deductible of $250 or less and a very small percentage in the high deductible plan. The range itself doesn't give any weighting to how employees actually enrolled. I know in the districts we work with around the Puget Sound area, it's not quite as dramatic but similarly balanced in that the substantial majority of employees are on plans with low deductibles and generally without much expense.

What I'm really getting into is the question of how these range graphs will be filled in with actual data once you are able to see what you've collected from the Washington School Information Processing Cooperative (WSIPC) and the districts, and whether the Board Members would have an opportunity in anticipation of your sharing it, an opportunity to tell you what kind of data we would like to see to inform the members, as well as inform constituents. Could you tell us the timing of that process and how we could/might give feedback?

Dave Iseminger: I do think that your points are well taken that the graphs presented don't overlay enrollment data. It simply represents the benefit variance and the plan structures of the plans that are available to individuals. We are getting different enrollment data that we'll be able to overlay and give this Board context for the information that the agency has presented to date. Now is the time to let us know if you want specific things presented to you. This is one of the forums in which you can make that request. Any of the Board Members

can direct those requests to me as the agency is working on the presentations for the next materials. We'll incorporate your request for data.

If there's something we can't get by the next Board meeting, we'll talk with you about what it is that we can get and see how we can supplement. If any of the Board Members have anything that they want to see or they want my staff to prepare at these meetings, just say the word and we'll do what we can to pull that stuff together. I'm clearly hearing a request for overlaying enrollment data on plan design at that point. We'll get to work on that. But any other pieces that any Board Member wants, you can bring it up now during these meetings or you can email me between any of the meetings. Or just give Connie a call and she'll set up a phone call for us to identify what it is and we'll put together any of the materials that this Board feels it needs to be able to make its decisions. Is there anything beyond overlaying enrollment so far that anybody wants?

Scott Palafox: Slide 34: Dental Portfolio Overview. The HCA dental plans are the Uniform Dental Plan (a Preferred Provider Organization plan) and two managed care plans with Delta Care and Willamette Dental. The comparison for these plans is listed on the chart.

Slide 35 compares the annual deductible, which shows relatively small differences. They range from zero to $50 for individuals and zero to $150 for the family.

Slide 36 compares coinsurance and co-payments. An example comparison using restorative crowns, some plans pay 100% and some have a 50/50 split with some of the other comparisons. The same for preventive screening. Some pay 100% paid and some have a 70/30 split. The chart also shows differences with the managed care dental plans.

Slide 37 is a chart that shows the difference of coinsurance percentages for the highest member cost. Slide 38 will show the lower member cost. There is little variation across that aspect of it. Slide 38, the lower member cost comparison shows 100% paid and 50/50 splits.

Slide 39 is a chart showing the annual plan maximums. The PEBB Program benefits has no plan max up to $1,750 and then the other ranges go up to $2,500 on the higher end of what we've seen to date. We didn't do a comparison of orthodontia but the PEBB Program dental plans do have orthodontia coverage with various member sharing associated with it. From the data received to date, this is a buy up for the school districts.

In reviewing the dental charts, it appears that the dental offerings show less variance. Do you agree or disagree? Do you have other thoughts?

Terri House: Is there a way to get the orthodontia breakdown per plan?

Scott Palafox: Yes, we can do that. Any other requests, comments? Are you hearing anything from school district employees?

Dave Iseminger: We see from the data there's much less variability both in offerings, as well as the more granular benefit design when it comes to dental compared to medical. I've seen a lot of heads nodding, which isn't as easy to capture on our transcript. So that's why I'm highlighting that now. Does this resonate with you in your experience with school employees?

Patty Estes: A lot of the information has been answering my questions and the constituent questions. I think me being able to share some of this information will answer their questions as well.

Dave Iseminger: That's a good reminder. These materials are on the Health Care Authority website along with the meeting schedule, the Briefing Book, and every prior archived meeting book. The SEB Board only has four so far, but those archives will be maintained for years. They will always be available for use by you and your members. But if there are other materials that you're feeling are necessary, we can produce them for the Board and make sure we're doing them with an eye towards your ability to use them with your constituents.

Katy Henry: I agree with Patty that most of my questions are being answered, but also with Sean. Once we have the data around the actual number of employees accessing which plans, that will probably answer even more of my questions.

Dave Iseminger: I agree with you. I would love to be able to overlay the enrollment data today. That's just not where we are at this point. I appreciate that's an important piece the Board is asking for and we'll make sure we're able to provide that overlay.

Scott Palafox: Slide 41: Vision Portfolio Overview. This is probably much different for us because vision is included in PEBB Program medical benefits. We understand there are some standalone vision plans for school districts, which is not familiar to what we have done. We are trying to get a better understanding as we go along. Hopefully the information we're providing in these tables will show that. Vision is a bit harder to show comparisons and create line charts and graphs to show the variations. Currently all we have is the data in these tables to talk about the differences.

The top half of the table talks about the portfolio vision benefits for standalone products. The Health Care Authority (HCA) does not have a standalone product to know how it compares to the other entities on this table. The bottom half of the chart talks about the vision benefit included in the medical plans, which HCA does have for each of its medical plans. On the far right, you can see from what we found with the WEA select plans, that they have standalone only.

Sean Corry: I'd like to point out, at least my own observation, that in that bottom row when we talk about separate plans in the medical plans, I think virtually all of them are just legacy, HMO-type requirements for vision exam in the medical plans. Virtually none of them have hardware coverage or contact lens coverage. It's the exam, but in addition to that, there's a full vision plan.

Scott Palafox: Slide 42 breaks down the top layer of the chart with the standalone vision benefit and the bottom with the medical. Looking at the standalone vision, there's a slight variation in co-pays. Some of the districts have 100% paid with a one exam per calendar year. The bottom half of the table shows variations in co-pay.

Slide 43 compares frames, the standalone at the top of the chart and frames for the medical/vision benefit on the bottom. There is some variation in the standalone vision benefit among the districts. In the medical benefit, it's noted that hardware is not included in the vision benefit for some of the districts, whereas there's $150 allowance for the adults in the Health Care Authority PEBB Program benefits. Children's hardware is paid 100%.

Dave Iseminger: This might embody Sean's point and help us understand better what we were seeing with hardware not being included, that there are grandfathered aspects of a vision plan in the embedded piece.

Pete Cutler: This is kind of an embarrassing question to ask since I'm covered by these benefits, but this seems to imply that every two years there's a $300 benefit, $150 towards frames and $150 towards the lens. I always thought it was just $150 total. Can we get that clarified? I've certainly been missing out!

Scott Palafox: That's a good question. We'll confirm. I believe it is the total, but I want to make sure.

Dave Iseminger: As a heavy utilizer of our vision benefit, I'm pretty sure that you're right, Pete. We'll validate that and get back to you.

Scott Palafox: Slide 44 is a comparison of the lenses for the standalone vision and the medical vision benefit. Less variances for the standalone vision and the difference is noted for the medical vision benefit.

Slide 45 is the standalone comparison for contacts. There is little variation. Slide 46 is the comparison for the medical vision.

Dave Iseminger: Is this reflective of your understanding of vision benefits that exist in the K12 system? We are seeing overwhelmingly that standalone vision plans are the norm.

Lou McDermott: What are the advantages of a standalone vision benefit over having it included in medical as it relates to the Accountable Care Act (ACA)?

Dave Iseminger: Great question, Lou. Under the Affordable Care Act, there is a Cadillac Tax, which recently was delayed another two years. It was originally supposed to go into effect in 2017. It's now scheduled for 2022 for the first time. It fundamentally is a tax on the employer for having very rich benefits. The calculation of the Cadillac Tax has a couple of ways an employer can mitigate their liability. One of those is that vision coverage counts for taxable purposes if it's embedded in a medical plan, but it doesn't if it's outside of a medical plan. There are very few ways to mitigate one's Cadillac Tax liability. Some of them are in the benefit design structures. It could be advantageous for an employer to offer standalone vision plans, depending on their risk tolerance if the Cadillac Tax does go into effect. That might be one reason to offer a standalone benefit from the employer's perspective, the Board's perspective, or the Legislature's perspective.

Sean Cory: That's forward-looking. I'm glad you said that, but the districts have had standalone vision plans for a long time. Largely, the answer is, it's been a better deal, better network, better pricing, more responsive reactions from the provider groups.

Dave Iseminger: Lou's question was about the relationship with the ACA. I think there are certainly advantages to having an individual provider or an individual contract that lasers in on a specific benefit and having experts on a specific piece so it doesn't get lost of being just another line item of a medical benefit. Sean, your points are well taken from the market perspective that there's also a benefit to having it as a standalone and having that laser focus on the benefit structure.

Wayne Leonard: I'm aware of some districts in eastern Washington that have self-funded vision coverage. If vision coverage similar to this was not available as part of the plans, would they be able to keep their self-funded plan?

Dave Iseminger: Under the statute, the vision benefit is specifically carved out as a piece for this Board to study and develop a benefit. Hopefully we'll avoid that question by having the Board offer a benefit that has statewide access or has access to everyone in the state, being that maybe there will be multiple carriers that patch together to offer coverage across the state.

Wayne Leonard: It seems like since a lot of this coverage is for frames and eyewear, contact lenses, it just doesn't seem like it would be that big of a deal if they wanted to keep it.

Lou McDermott: Dave, does the statute, the way it's constructed, allow for supplemental offerings by the districts? If we had a vision benefit could they do an extra benefit if they wanted to?

Dave Iseminger: The current statutory framework doesn't allow a supplementation of the core benefits that this Board has the jurisdiction over.

Lou McDermott: I see. I think Dave's trying to say no in a very nice, polite way.

15 Minute Break

School Employees Demographics and Focus Group Insights

John Bowden: Manager, School Employees Benefits Section, Employees and Retirees Benefits Division. Previously, I provided information about the school employee benefit organizations; the school districts, ESDs, and charter schools. I provided information about the number of employees in each of those. I shared a map showing geographical areas, talked about the Board's responsibilities regarding the statutes, and provided historical data. Today I'm going to share information about school employee demographics and focus group results. The focus groups were conducted the end of December and the beginning of January.

Slide 2 has information about the employees. We learned that 98% of school employees are in school districts. The school employee demographic information comes from the S275, the personnel database maintained by the Office of the Superintendent of Public Instruction (OSPI) with information provided by the employers. It is information from the 2016-17 school year, which is the most recent available data. In terms of the employees in school districts, ESDs, and charter schools, the information is divided into four primary areas: the percentage of FTE of the employees, certificated and classified, certificated and classified by gender, and then two age categories, from 20 through 44 years of age and 45 and older. That split is about half of the employees on each side.

Slide 3: School Employees by FTE. In terms of the FTEs on the certificated column, about 92% of all certificated employees are full-time or more. The 1,685 number is employees that work four days a week. The 1,333 are employees that work four days on the 80% to 89%; the 60% to 69.9% are employees that for the most part work three days a week; and the 1,458 are half-time. One and a half percent of certificated employees are below the 50% mark.

Sean Corry: John, I have a question. We all know that there's a 630 hour threshold for eligibility in the new program. Could you draw a line for us on this graph about where those people are, knowing that some employees work full year and other school year years?

John Bowden: For certificated employees, when looking at the S275 data, it shows percentage of FTE. If you dig deeper, you will find someone who is 100% and might work eight hours a day, 180 days a year. Or in another district, it might be 7.25 hours a day, 185 days a year. There's a great deal of variation in what the FTE means. Roughly, on the certificated side, if they are above 50%,

they should qualify for benefits. The line is somewhere around the 40% mark for certificated.

For classified employees, the cut point on the 630 hours, is closer to the 30% mark. I hesitate to suggest a percentage because some classified staff really work 2,080 hours a year, 12 months, full-time. Then there are others, like paraeducators, that work in a classroom just when school is in session. We need more information about the number of hours that they work. There's not a set cut point that I could tell you right now.

For classified, the top part of Slide 3 shows that 14,256 employees work full-time or more, which is about 22% of the classified population. The largest group in classified is the 15,424 at that 50% to 59.9% FTE. There are a lot of classified staff in the half-time range. If you look at everything below the 50 %, one-fifth of the employees are less than half-time. That's a major difference between certificated and classified in terms of FTE percentage.

Patty Estes: I wanted to point out for funding purposes, one FTE, which would be the 100% or more, the school districts get money for, correct?

John Bowden: School districts get money based on the FTE that's associated with the prototypical or the mega school funding model. Not all of the employees shown here receive state funding. This slide includes all school employees regardless of the funding source. For those who do receive state funding, it's based on the funding model, not necessarily the employee FTE.

Patty Estes: Right. So if I've done my math correctly, with the 100% or more in classified, we've got 78% of our classified employees below that 100% mark and then only 8% in the certificated?

John Bowden: Correct.

Patty Estes: Thank you.

Pete Cutler: I may have missed this and I apologize if I did. You have a number for what an FTE is defined as for the purposes of the S275 report. Is it the identical definition for both classified and certificated employees?

John Bowden: No, it's not defined. For certificated, each school district can set the definition. It's bargained as to what is full-time. What's reflected in the S275 is the FTE that might have been bargained within that school district.

Pete Cutler: Thank you very much.

Wayne Leonard: I think in my district, and in a lot of districts, it's common to have a couple different FTEs. When you start talking about FTEs, there's FTE in

terms of how much you work and then there's a benefit FTE. Most of our contracts, the benefit FTE is based on 1,440 hours, 180 days for eight hours a day. You can see from the makeup of all the part-time employees, I think in my district, you're not even eligible for benefits unless you work four hours a day or more. And then you're only eligible for a prorated share of your benefit FTE. This is where there's a lot of concern about the affordability in terms of the 630 hours, which is essentially a three and a half hour a day person. What would be that contribution? Schools, because of the large number of classified employees, have a lot of positions that are locally funded off of local levies. And there's just been a major change in our school financing on how much levy authority schools now have.

John Bowden: That is a good point. The information presented here is on the work FTE not the benefit FTE. The S275 does contain both the work and the benefit FTE. But because of the 630 hours, I am only presenting the work FTE. We can take a closer look at differences between the two.

Lou McDermott: I want to make sure I understand what the ask is. Are you referencing an issue between people who don't have benefits before and will have them now, and folks who have them now and won't have them - which I would assume would be none - but wouldn't have them later and how much the school's contribution to that is going to be? All the differences, the before and the after versus who's covered, who's not?

Wayne Leonard: And how much our employer contribution would be, how much the state is going to fund, how much the local school district has to fund.

Lou McDermott: And the contribution. I see. Dave, does that get addressed in this legislative cycle? Will there be more understanding about what the schools would be receiving from the state if certain bills pass?

Dave Iseminger: I think there are certainly legislative proposals that will give more clarity by the end of this session on potential pieces of the financial puzzle.

Lou McDermott: Then based on the eligibility rules, do you think schools will be able, this year, to try and determine what the financial impact would be? Will there be enough information available to be able to start modeling that?
Dave Iseminger: HCA is having to build an enrollment and a financial model for purposes of legislative funding.

Lou McDermott: I understand, but to the individual districts who are trying to figure out what this means, is there going to be enough information for them to start calculating what the impact is going to be?

Dave Iseminger: Sitting here now, I'm not positive what level of detail will be available at which points. I'd be interested in learning from Wayne and other

Board Members at what point in the calendar year is the critical path from your perspectives on having different information on the financial pieces. I think there'll be more clarity as the year progresses. But whether it's in time for your local budget planning purposes, I'm not quite sure.

Wayne Leonard: I think that was at the very beginning of this. That was one of the key questions. Okay, 630 hours you're eligible. But what are you eligible for? How much then of an employer contribution are you eligible for? Those are questions we haven't talked about yet.

Lou McDermott: I'm interested in that. When you say, "What are they eligible for," so you're coming from a context of partial eligibility?

Wayne Leonard: Correct.

Lou McDermott: Does the statute contemplate at all partial eligibility?

Dave Iseminger: No.

Wayne Leonard: Excuse me. Maybe I said that wrong. It's not partial eligibility but it's --

Dave Iseminger: Pro-rated?

Wayne Leonard: Pro-rated money. You would have larger out-of-pocket contributions if you're a part-time employee.

Lou McDermott: You would have different plan choices. So if you were, depending on your eligibility, you could have the full meal deal where you might have a smaller co-pay.

Wayne Leonard: Or if you were a half-time employee and the employer contribution was $900 per employee per month, and you're a half-time employee, you would only receive $450.

Lou McDermott: Does the statute contemplate that?

Dave Iseminger: No, the statute does not.

Lou McDermott: So it's all or nothing.

Dave Iseminger: Yes. At least it describes it in a way, or the assumptions have been, that it's similar to the PEBB Program's model where you get the same contribution regardless of whether you meet part-time eligibility or full-time eligibility. You have the same access to the same level of benefits.

Lou McDermott: The same benefits suite.

Dave Iseminger: Yes, the same benefits suite.

Sean Corry: That was my understanding as well, that there's a 630 hour cutoff. It's either 100% or no percent. But getting to the question of locally funded employees, that's a big question. For Seattle, again, more than half of their employees are locally funded. So that issue is a big deal on how the money is going to work and where that money comes from. If it's not coming from the local levies anymore, it's got to come from the state or something else magical.

Terri House: I'm not familiar with other districts but we do pooling dollars. Depending on how many hours you work and how many days you work, you're higher up in the pool. The less hours you work, you get less pooling dollars towards your benefits. I have questions from people in our district that are part time. Will they be on an equal playing field now with this law's passage? As we read it, it's how, I believe it was stated here, everybody gets the same dollar value per month.

Dave Iseminger: Once you reach the eligibility threshold, you have access to the benefits.

Terri House: Correct. So are we interpreting that correctly?

Dave Iseminger: That is the working understanding of the 630 statutory hours. I think the other pieces are the funding questions that others are raising. From an eligibility standpoint, once you meet the 630 hours, you have access to the full suite of benefits.

Terri House: And we're working under the assumption pooling dollars will go away. You'll just get the flat rate per month.

Dave Iseminger: That is the current assumption, yes.

Terri House: And then that will go towards purchasing medical, dental, and vision, correct?

Dave Iseminger: And it can include an employer-sponsored life insurance, an employer-sponsored long-term disability, and an employer-sponsored short-term disability. It could be that dollar amount would be covering all employer paid benefits.

Katy Hatfield: This is not really a question. It's a clarification. Dave, could you explain a little bit more about a flat rate. Terri asked about a flat rate per month. Is that how you are anticipating this to work?

Dave Iseminger: On the PEBB Program side of the house, there's what's called a funding rate that the Legislature provides on a headcount basis. That allocation goes to state agencies and higher education institutions and is paid to the Health Care Authority on behalf of the eligible employees for the access to the suite of PEBB Program benefits. That's for all the employer-paid benefits. On the PEBB Program side of the house, that's 85% of the medical, 100% of the dental, and all of the amount for the life and long-term disability basic benefit. On the PEBB Program side, the basic benefits are considered the employer-paid benefits and that allocation goes through the agencies and covers those pieces.

Then there are payroll deductions for all the supplemental buy-up options, or sometimes direct billing from the vendor, depending on the vendors capabilities. When I talk about a single number, that's the kind of model currently being understood, and is somewhat described in the four-year outlook of the budget. It's a funding rate model that gives an allocation to school districts to pay to the Health Care Authority on behalf of those eligible employees for that suite of benefits. Does that provide the additional clarity, Katy?

Alison Carl White: Can you talk a little bit more about the funding mechanism? We're deciding a package of benefits is going to cost X amount of dollars. But that felt like new information in terms of a district needing to come up with some percentage of that versus, it felt like sort of a consolidation. I don't think I'm tracking that very well.

Dave Iseminger: Part of the working assumption is that the state is going to pay a to-be-determined dollar amount. The working assumption that individuals have placed either into the outlook budget is a funding model similar to the PEBB Program rate, which fully covers those portions for those eligible employees, the employer-sponsored portion of the benefits' package.

One of the questions that has come up, and some of this is addressed in the legislative proposals, is the difference between the benefits FTE versus a headcount. But on the PEBB Program side of the house, all of the funding is done on a headcount basis, so it doesn't matter if you, Alison, are .5 FTE and Pete is 1.0 FTE. The same dollar allocation comes across because you both have access to the same suite of benefits. The working assumption, at least in the four-year budget outcast, is a similar funding rate model. It sets one of those guardrails that came up from one of Pete's questions at a previous meeting, a guardrail for benefit design. There's going to be some sort of presumed allocation from the state that will be a guardrail within which you then, as a Board, decide how you want the benefit design to fit.

For example, that PEBB Program funding rate may be a split where 85% goes towards medical benefits, 10% goes towards dental benefits, and the other 5% is life and LTD. The numbers in this example are made up, not actual. You may look at that as a benchmark for the PEBB Program benefit portfolio. If you want

a richer medical benefit, you have to horse trade within benefit design to change benefit design on one benefit in order to enrich another part of the benefit because there will be a single dollar allocation that goes for all headcount through the districts over to the Health Care Authority. I'm making assumptions here, but does that give you more context, Alison?

Alison Carl White: I think so. I want to make sure I understand this. If you work 630 hours, then you qualify. There is no local match to that. The state through the SEBB Program is just paying for your health care. If you work less than 630, then --

Dave Iseminger: Yes. The concept of prorated --

Alison Carl White: And there's no option for a district to provide for that employee under 630 hours?

Dave Iseminger: Under current state law, no. One of the legislative proposals could, as an enrichment to the state eligibility, allow below 630 hours with purely local dollars.

Pete Cutler: I might have saved you a little bit of that pain because early on it occurred to me that we have some significant uncertainty after having read the statute. I don't read it as clearly saying you couldn't have differing employee premiums based on FTE. It's what Oregon does and the language is not clear to me that that's not a permissible option for this Board to decide. I would love to hear more about the reasoning. I don't really have a position about it one way or the other as policy, but I don't read the statute that way.

I also think clearly that you've done an amazing job of covering the financing mechanisms, but it is really tough for even those who deal with K12 funding and employee benefit funding to explain how the different pieces work. I think it's clearly of strong interest to many members of this Board to get a clearer sense of what dollars are going through. I mean, if it were state employees, it would be, okay, 630 hours, and that means you get covered. We'll send every agency a set amount a month for that benefit, or whatever the dollar amount is, for whoever reaches it. But that's not what happens in K12 right now. In K12, you have a total amount of FTEs. The assumed allocation model, whatever the technical term is. And unless you come to some way of getting those two to work together, we're going to be really uncertain about the fiscal impact of the decisions we're making. I would love to hear somebody from the fiscal world explain what they think at least the current law provides. Thank you.

Kim Wallace: I just wanted to clarify that there are active ongoing discussions. HCA staff, analysts at OFM, and legislative staff are actively reviewing the data and the implications with respect to the difference between the headcount approach and the current FTE state allocation model. We've level set with one

another to make sure that we understand what exactly the funding world looks like. When we say things like FTE, we want to know that we have a shared understanding of what FTE we're talking about and terms like state funded, basic ed, or district FTE, etc. I don't have the answer for you but we're aware that there is an important difference.

Some folks are using the word "gap." So there's serious attention being paid to the issue that is really on your minds, and that has just come up in this meeting. We're becoming quite well informed at HCA regarding the situation and what the implications are for various districts. We also know that it will not impact districts equally across the state because of the different staffing models and staffing needs that the districts have in place. This is not new to us, however, we don't have the answer or a number to share with you yet.

Pete Cutler: Do you have a rough idea if we're talking a couple months or maybe not until next session before you think you'll have an answer?

Dave Iseminger: The financial modeling that everyone's focused on is gearing up for collective bargaining, which begins as of July 1. Collective bargaining is a driving force that begins this summer to be able to have as much rigor in the financial models as possible for that. That's one of the benchmarks.

Kim Wallace: Good point. A milestone.

Dave Iseminger: I want to add that when I was describing the PEBB Program funding model, I don't want any of you to interpret that as the decision has been made and that is exactly how the SEBB Program model will work. But because so many comparisons are being drawn to how the funding mechanism works on the PEBB Program side, or what the benefits look like, I wanted to make sure you at least had a primer as to how that works. As people describe different aspects of it, know that a definitive policy declaration has not been made on behalf of anyone. I'm simply describing the funding model mechanism that is one many people compare to for the SEBB Program.

Sean Corry: I don't know that this is going to become a question. I just want to get things out from my own brain. So we have a 630 hour threshold in the current law. You're in or you're out at that. In a sense, in my perspective, it doesn't matter whether it's an FTE or not, or what the definition is. It's a 630 hour threshold.

Two aspects interest me. One is the significant difference in funding for PEBB Program employees compared to what is driven out from the state to districts for benefits now. It's over $100 a month, I think, difference times 12 months times 100+ thousand employees. That becomes quite a number. And lastly, back to Wayne's question 15 minutes ago, which is how do we think about employees who are funded by the districts with local money and whether there's going to be

a requirement to match, whether it's going to be taken over by the state. That's really important not only for our understanding of what happens at districts but also what funding is going to be available for benefits themselves. Thank you.

Kim Wallace: I would just say duly noted because that is a very key part of the discussions going on, the definitions and shared understanding, etc, understanding the implications and impact, financially with regard to covering the locally funded staff for portions of FTEs.

Sean Corry: Do you have an estimate statewide of how many employees at school districts are locally funded?

Dave Iseminger: We'll follow up with that because my rule is if we have to guess, we don't say. We don't guess. We know.

Wayne Leonard: Historically, the state has funded their formulas. And some formulas have an FTE and there are other formulas that don't have an FTE. For example, our transportation formula for operating our school transportation is based on some crazy formula with miles driven and all sorts of things. I'm sure at some point there's a factor in there for benefits but there's no FTE associated with it. Our school lunch program is funded by what kids pay for lunch and what the federal government reimburses us for a lunch. There's no FTE in that formula. Some school districts can cover their direct costs in terms of salary and benefits and food costs with their school lunch program, others can't. So historically, the state formulas have been dramatically underfunded in terms of the number of FTE. I know the Legislature thinks the new model will improve that, but there's a lot of concern from the school business officials that it won't.

Kim Wallace: I'm going to take notes here with regard to your comments so at our sessions coming up with the K12 analysts, our counterparts that we're working on this with, I'll have my notes with me and raise these particular issues.

Patty Estes: Dave, I know that you were talking about the comparison between PEBB and SEBB Programs. Doesn't the legislation give us some direction to not mirror, but look at, PEBB Program benefits as an example and does it specifically say where we need to look at PEBB Program benefits? I can't remember.

Dave Iseminger: The magic word in statute is "leverage," which now is the word of the year for many people. But the statute actually does say "leverage" and coordinate with the PEB Board and their benefits. It does not specifically go into any more granularity than looking for opportunities to leverage the PEBB Program side of the house, the PEBB Program, and coordinate with the PEB Board.

John Bowden: Slide 4: Certificated School Employees. This slide divides the certificated employees into ways to look at them demographically. From Slide 3,

you know that most of the employees are one FTE or more. An important takeaway on this slide is that about three quarters of all certificated employees are female and one quarter are male. They are pretty evenly split between the 20 through 44 years of age and 45 and older. However, there is a slight lean toward 45 and older. A little less than one third of all certificated employees are females less than 44 years of age and slightly more than one third of all certificated employees are females 45 or older. So predominantly female and full time. That's important for benefits and in terms of looking at cost shares later on knowing that certificated are full time, which contrasts with the classifieds.

Slide 5: Classified School Employees. This slide shows that about three quarters of all classified employees are female. A predominance of employees are less than full time. About one fifth of the employees are female in the 20 through 44 years range, and a little less than half of the classified employees are females 45 years and older. Each icon on the chart represents a thousand employees.

Slide 6: Focus Group Design and Participation. Six focus groups were conducted around the state toward the end of December and early January. Three groups were specifically with certificated and other licensed employees like therapists, and three were with classified employees. Invitations were sent to 76 school districts in the surrounding locations of these focus groups. Seventy school employees participated in the six. They were from 26 different school districts and one ESD. The participants roughly match the demographics that I showed you in terms of the S275. The meetings lasted two hours and participants were paid to attend.

Dave Iseminger: We do have a vendor who's putting together a report on the findings of the focus groups. Once it's finalized, we'll make sure the Board gets a copy of the final report, assuming there's no proprietary information, which I don't anticipate.

John Bowden: The three classified focus groups took place in Tukwila, Olympia, and Yakima and three with certificated employees took place in Spokane, Seattle, and Vancouver.

Katy Henry: How was the invitation sent to participants? Solely through the school districts?

John Bowden: Yes. We contacted superintendents and HR, benefit specialists, and payroll staff within the surrounding districts and asked them to share the information with their employees. We did it quickly but we tried to get it out as best we could. I also talked with representatives from WEA and Public School Employees and asked for their assistance in getting the word out.

Katy Henry: So there's no consistency in how the districts contacted their employees?

John Bowden: Correct. I don't know how they shared the information. HCA put together an email and a piece that could go out in a newsletter, with a phone number and URL to contact us if they were interested in participating. We don't know what happened at the school district.

Slide 8: Focus Group Questions. We asked questions about transitioning to the SEBB Program, what have they heard about SEBB, and how do they think it might affect them. We asked about concerns they may have regarding eligibility and what factors in plan development do they think this Board should consider or give a little added weight to. We also asked about cost containment, access to quality care, offering wellness and preventative programs, and leveraging and coordinating with the Public Employees Benefits Board.

We asked how employees get their information, what are the best sources, who do they trust? We asked about other benefits and the importance of those benefits to them. And we asked if they had other comments or final advice that HCA or this Board should consider.

Slide 10: Focus Group Insights. We learned that only about one third of the participants have heard anything about the SEBB Program or the Board. Participants wanted to know who is serving on the Board and what your qualifications might be. That information is on the website. We will work at getting that information out more. There's some anxiety and skepticism about the transition and there's concern that this Board may not understand or represent the employees' needs. Employees do want to see some consistency in the care and ability to maintain relationships with current providers. That was mentioned earlier and we've heard that from other sources as well. There's fear that the school employee benefits will cost more but provide fewer benefits.

There were eligibility concerns about preexisting conditions as to whether or not they would be covered when the transition occurs. The fear is that if you give up what you have under one plan, you may not be eligible to be covered under the next plan. Current federal law requires that preexisting conditions be covered.

There was also a concern about whether current domestic partners would be covered as dependents. Within the statute creating the program and the Board, it's for state-registered domestic partners. There's an RCW that states where you can find a definition about domestic partners. The state, not knowing who asked this question or what the current level of coverage is in that particular school district, I couldn't answer. But state-registered domestic partners is probably more restrictive than what this person was concerned with.

Lou McDermott: When you say "more restrictive," from whose perspective?

John Bowden: Probably from the employee interested in knowing whether a domestic partner would be covered. The school district might have a more liberal

domestic partner eligibility than what would be required under the statute creating the SEBB Program.

Sean Corry: Using Seattle as an example, covering domestic partners from essentially the very beginning of that kind of coverage, eligibility is not restricted to state-registered partners. It's a simple declaration of partnership with terms that they have to sign for eligibility for partners. I know the districts that my firm works with, generally the definition for eligibility purposes is much less stringent than the state-registered requirement. I think I might be able to get from some of our districts the number of people percentage. I know the WEA program had a more liberal definition of eligibility for domestic partners. I would think that statewide it's a pretty big number and I don't know what that means.

Dave Iseminger: At a future meeting, we'll have Barb Scott, our eligibility specialist, talk about this particular issue. There are legal risks that have been discussed over the years as the law has changed and we want to ensure extra liability is not being taken on. At this point in time, there is this acknowledgement that there have been domestic partner registries that have been created around the state long before the state came up with its iteration of a state-domestic partnership. We'll be visiting this one in more detail as we go forward with eligibility. We at least wanted to acknowledge that under current state law, it is specific to state-registered domestic partners and I'm positive that Barb Scott can help the Board learn more about some of the ins and outs of that particular aspect of eligibility as we go forward. For purposes of state law, it does say "state-registered domestic partners" and uses that defined term at this point.

John Bowden: Participants discussed various aspects of plan development. They were concerned about the cost of plans, particularly the co-pays and deductibles. Many participants wanted to make sure the Board understands that there are differences in salaries and wages between certificated and classified, and urban and rural areas.

They want to make sure that there is choice available to them and fear that health coverage will become more and more limited. They are concerned there may be decisions that narrow choices or networks on the east side compared to the west side. There might be fewer providers on the east side.

Participants would like access to massages and chiropractic treatments. This came more from classified employees that have jobs that may cause more physical wear. They also want the Board and HCA to understand the value of preventive care, how it lowers costs for both the employee and the entire system.

Slide 15: Communications. Employees want clear and direct information about why there was a transition to SEBB. Emails and websites were mentioned as important for educating employees, but in-person meetings are best. I have been meeting with various associations and individual members and will be doing

more of that. Participants also suggested that we use robocalls to let them know when something is showing up in the mail.

Dave Iseminger: We don't currently have a robocall system at the Health Care Authority, but I know that Renee Bourbeau's excited to learn more about it.

John Bowden: We also heard there is a preference to ensure the medical and what's considered mandatory now are covered, and to be cautious on the additional benefits if they increase cost or reduce health benefits. The final comment was that the participants were very grateful they had the opportunity to share their experiences. When the report is finished, it will have a lot of very good information from those who participated.

Slide 17: Next Steps. We're going to use the information from the focus groups to refine a stakeholdering plan that we're already working on, and to further develop communication strategies. We wouldn't have thought of robocalls until we saw that as a way of gathering more input for benefit design. We will continue to look for opportunities to talk with people and further explore some of the information or comments provided to us, and then to solicit feedback for rules development on some of the topic areas presented.

Katy Henry: How has feedback from PEBB Program participants been garnered in the past? Have you gone and done similar focus groups?

Dave Iseminger: We usually do focus groups after a major product launch and communication focus groups. I'm sure things will be similar in the SEBB Program population that employees aren't shy about sharing their opinions. We also handle constituent inquiries. Constituents will ask their legislators and our legislators will want us to answer to them. We take a lot of different feedback. We'll get feedback from you at Board meetings. Members will come and provide public comment that gives us another window into concerns. The Health Care Authority lives at the Cherry Street Plaza and people tend to know how to contact us. We do affirmative focus groups especially when we're doing major product launches.

Benefits and Insurance Key Concept: Actuarial Value

Kim Wallace: There's one key concept we wanted to talk through in further detail, the concept of benefit of richness. How many benefits? How much in benefits? What are we able to design and fund? Actuarial value is a mechanism, a metric to consider richness when considering medical benefits.

Slide 2 simply defines actuarial value or AV. The AV is the estimated percentage of claims cost paid by a medical plan as opposed to paid by the member through their cost-sharing, like deductibles, coinsurance, or co-payments. Basically, it's how much of your medical costs the plan is covering. For a note about consumer directed health plans, when the employer or the state contributes an amount of

money to the health savings account, that amount of money is included in the AV calculation. An important note, however, is the monthly employee premiums - the amount out-of-pocket that the employee is paying for their health benefits even without receiving any care, are not part of the AV calculation. The AV is really about the claims cost and the medical cost that a person is incurring when they seek care.

Slide 3: Why is Actuarial Value Important for the SEB Board? The AV provides a way to measure benefit richness and compare coverage under different medical plans. For example, a plan with a higher AV covers more of the cost for a typical member than a plan with a lower AV. The plan AVs affect the cost of the plan. Currently, there is proposed legislation that suggests the possibility that the SEBB Program medical plans may need to have AVs that fall within certain ranges.

Slide 4: Actuarial Value: Ranges or Tiers. The Affordable Care Act created a tool called the Federal AV Calculator, or the Calculator, to determine the AV of plans offered on exchanges like the Washington Health-Planfinder. That calculator separates the AVs into four metal tiers or ranges. The plans offered on exchanges must have AVs that lie within distinct tiers. For example, in 2018, the values are: Platinum, which is the highest or the richest plan range, with an AV range between 86% and 92%; then Gold; Silver; and then Bronze.

The box in the right corner notes that the AVs for PEBB Program plans range from 83% to 90%, with some of the AVs falling between the tiers. I want to make a special note about that comment “between the tiers.” You'll notice that Platinum is 86% to 92% and Gold is 76% to 82%. What happened to 83% to 85% or 85.9%? The Affordable Care Act specifically set up these distinct tiers to help people understand what they were shopping for. “Can I afford a Gold or maybe I need to be Silver." The designers didn't want those AVs to be so close together that there wasn't a clear distinction that a person could make. The value proposition couldn't be assessed clearly so they defined these tiers in an attempt to make clear differences. The metal tier is defined by a very specific range. Based on proposed legislation, the Board may or may not be guided, or required, to pay close attention to the exact tier range.

Sean Corry: You talked about proposed legislation. We're talking about state legislation?

Kim Wallace: Yes.

Sean Corry: Is there a bill number?

Dave Iseminger: I think Kim's referring to a couple of different ways this comes up. There are two bills that create exemption criteria, exemption periods, or ways for school districts to be exempt from the School Employees Benefits Board

Program if the offerings from the school district are within 10% of the actual value of SEBB Program plans. So, depending on what you set your SEBB Program plans at, that will set the benchmark for school districts being able to be exempt from the programs.

The other way this comes up is in House Bill 2408 and its Senate Bill counterpart, which is the bill that I was describing where a SEBB Program fully insured carrier would have to offer coverage on the individual market. It references the type of metal tiers a carrier offering SEBB Program plans would have to offer on the individual market.

There isn't a bill that says you must offer a 90% AV. There is a reference in House Bill 2657/Senate Bill 6288 that delays implementation of the SEBB Program until various funding requirements are met. One requirement is that the funding solution for the SEBB Program can't be reached by lowering the PEBB Program medical plan AVs. That's the other way that it comes on the various bills.

Wayne Leonard: You mentioned that the monthly employee premium is not included in this AV calculation. But everybody knows that a Platinum plan costs more than a Gold plan costs. Does this take into account if a plan is running a deficit or a surplus?

Kim Wallace: In what dynamic? What the impact on the premium would be?

Wayne Leonard: Maybe future premium increases.

Kim Wallace: This does not.

Wayne Leonard: So this is just a measurement of how much benefits this plan would cover?

Kim Wallace: Yes, for a typical member. It's theoretical but a helpful theoretical reference.

Wayne Leonard: If I think of an actuarial value of an unfunded pension liability, it's not the same kind of discussion as this actuarial value.

Kim Wallace: It's a longer conversation to explore what's similar and what's different. Do you want to do that?

Wayne Leonard: No.

Kim Wallace: AVs can be calculated using different methods or tools. This can introduce variation in the results and set up apples to oranges comparisons. Actuaries have been calculating actuarial value for quite some time predating the

Accountable Care Act (ACA), but the ACA established the Federal AV Calculator. Given that there are specifications about how data are entered into that calculator and instructions, etc., it does provide a more standard reference.

You may hear districts, ESDs, your charter school, your constituents talking about AV. That's interesting and important to consider, but who derived the AV they are describing? Did they use the Federal AV Calculator? That would be interesting to note. There can even be variation in terms of how a person inputs certain information into the calculator. There can be some variation introduced simply by choices that are made, interpretation; but nevertheless, I don't want you to take away from this that AV is so squishy that it's not useful. I do want you to understand that being concerned about every decimal point on an AV calculation is probably not worth it.

The second note here is that while the AV was established for the individual insurance market to give a relative picture of benefit richness to help people choose amongst the plans on exchanges, it is a reasonable proxy for benefit richness for group plans like will be in the SEBB Program.

Pete Cutler: Thank you very much for the explanation. It was very helpful. I'm trying to confirm, is it true that the AV calculation is just a function of the percentage, and I think of it as the expected benefit cost paid by point of service patient contributions. So co-pay or whatever. And so it doesn't matter whether you have a really, really wide range of services that you provide or a more narrow range. It doesn't measure whether you have a rich plan per se. It just measures of the plan benefits that you do offer, what percent is the employee paying of the expected claims cost through their contribution versus the employer contribution?

Kim Wallace: Yes. So the wider array of coverage services, let's say chiropractic and massage or no chiropractic and massage, that does not affect the AV.

Pete Cutler: Affects the cost but not the AV.

Kim Wallace: Yes.

Pete Cutler: Great. Thank you.

Eligibility and Enrollment Policy Development

Barb Scott, ERB Division's Policy and Rules Section Manager. This presentation is to provide you with information regarding the process we will use for development and adoption of Board policy resolutions, topic areas you can expect us to bring to you as we develop policy over the next several months, and the timeline for development of SEBB Program rules. We will begin developing three policy resolutions today from the list of topic areas that I will describe. The

final piece of information we will provide today is how individuals can sign up for the rule development process.

The process we will use for developing policy that is within the Board's purview will include bringing a draft resolution to the Board for discussion. This is when we want to engage in dialogue and get insight and guidance from you. We will then incorporate changes that come out of that process and those discussions. We'll send that language out to stakeholders in order to get their feedback and their insight as well. After considering that feedback, we will develop a final policy resolution and bring it to you for action: adoption through an actual vote of the Board. These resolutions will later be incorporated into SEBB Program rules.

Not all policy decisions fall within the Board's purview. Some are within the Health Care Authority's authority to decide, for example, those related to the state's salary reduction plan. Some are required because of state or federal regulation, for example allowing employees to waive enrollment so they can enroll under Tricare or Medicare. Those are both dictated by federal regulation.

A sampling of decisions that clearly fall within the bucket of decisions we will bring before you are:

- The effective date of coverage for employees following hire. For example, you could set a policy that coverage is effective the first day of the month following the month that they become eligible, or you could choose a different date.
- Policy decisions related to employee eligibility. For example, you could adopt a policy that an employee who is *anticipated* to work 630 hours is eligible.
- Policy decisions related to dependent eligibility, spouse, domestic partner, child, and enrollment-related policies. For example, the PEBB Board adopted, a policy that if the employee doesn't select a medical plan within 31 days of becoming eligible then the employee is going to be enrolled by default in the Uniform Medical Plan as a single subscriber.

This list will grow, but my goal here today is to provide you with an idea of the policy decisions that I'll bring before you over the next several months and to help answer your questions related to those.

Slide 5 was included in the presentation so you could see where the list on Slide 4 originated. The RCW anticipates that family coverage will be offered. In a few slides, we will start to look at draft policy resolutions for dependent eligibility.

Dave Iseminger: There are various bills that are proposing to modify some of the words that are on the slide. For example, the Health Care Authority's agency requests legislation, as well as other legislation, adds within romanette (d)(ii), an employee must be *anticipated* to work at least 630 hours, because our understanding is that was the intent of the Legislature rather than people having

to actually work 630 hours. If other things change, we'll make sure that the Board is apprised of that after session is over.

Alison Carl White: I have a question to the state-registered domestic partners and Sean's question. Is that within our purview to have a more generous definition of that or are you saying the legal liability is limiting that?

Barb Scott: We'll be covering that in just a few slides. I'd be happy to come back to that conversation then.

Slide 6 shows the timeline we expect to follow for rule development realizing that there are two streams of work going on that affect each other. One is the work that you'll be doing on making decisions about eligibility and enrollment policy. We will do that in the form of resolutions. At the same time, those resolutions are going to affect the timeline and the work that's being done to draft the framework of eligibility and enrollment rules that are necessary to administer this program. That's why I'm showing you the rule making timeline because your timeline for making policy-related decisions is going to be driven in part by the rule making timeline. That's why you're seeing this at the same time. Two streams of work that interact.

This timeline for rule development is based on our experience. For the development of eligibility and enrollment rules, we plan to divide the effort into two phases with the goal of getting a significant portion of rules for the SEBB Program in place by the end of this calendar year. Some of those rules will be downstream from the Board's adoption of policy resolutions. Staff are in the process of identifying the topics that we'll need to cover with you throughout this upcoming year. We plan to finish the first rule making efforts by fall of 2019. The staff person working on this has been working on PEBB Program rules for several years now. He's quite capable at pushing things through the system, so you might expect to see some heavy agendas as far as policy work that will need to be accomplished to support the timeline.

Slide 7 shows the formal process for rule making. This slide is a high-level work plan for phase one: rule making. Staff are starting to draft rules on February 1, 2018. They plan to finish Phase 1 by January 2019. Staff will file a CR102, which is a formal document that goes with draft-proposed rules and has to be filed in order to put them out for public comment. Staff plan to do this in mid-October 2018. Staff will provide you with a high-level overview of the proposed rules prior to filing that document so you'll have knowledge of what rules are being put through with that particular filing. The actual rules themselves won't be put before you for a vote. You'll be voting on policy resolutions, but the Health Care Authority has the separate authority for rule making.

Terri House: Can we go back to (d)(ii) on page five? I'm a classified employee. Some of our classified employees, I'll use transportation as an example, a bus

driver may lose time for a month or two and may be benefits ineligible then because they would fall under that 630 hours. If he was a bus driver who drove three and a half hours a day and lost part of his route and dipped down to two and a half hours a day, how would that work out in the law if that happened mid-school year, let's say.

Barb Scott: We have experience with that in a number of different areas. We have a good amount of experience with part-time faculty, as well as with seasonal employees and how benefits are handled when there are changes in the work that the employee is doing, or whether or not hours are looked at from multiple sources. A lot of those decisions will be made by this Board. We have a staff person who is trying to look at those different situations, the different employment patterns, that there are in the different districts in order to try and identify the different types of circumstances that we're going to need to address within these rules. You should expect to talk about a number of different things, like how to deal with hours that might be coming from multiple sources of employment within districts. I would expect that you'll see all of those brought to you over the next year.

Dave Iseminger: The short answer is those are some of the policy decisions you'll be making as to exactly how to count hours, so to speak, at least on some level.

Barb Scott: I don't have an answer for you today because I haven't heard your thoughts yet on that. But I am looking forward to it.

Dave Iseminger: The other thing I want to add for you about Slide 7 is you're not expected to know the ins and outs of rule making. The takeaway for the Board is to see that this is a very formal process. There are a lot of statutory deadlines of what needs to happen before a certain date. This agency does rule making all the time and we take care of compliance with the rule making process from beginning to end. We will make sure that you chime in on the necessary policy decisions that inform the rule making process and report back to you about those pieces. We take care of stakeholdering. We run the entire gamut for rule making and we have dozens of these plans all the time. Slide 7 is a window into how we ensure compliance at this agency with the statutory requirements for the rule making process.

Wayne Leonard: I have a follow-up question on Terri's comment. Right now, every school district in her example would define the medical eligibility on that. And a lot of that, if the driver's time changes, they change monthly, depending on their route, depending on if a special needs student is coming to school or not, or whether a McKinney-Vento kid that lives outside the district or whatever. But right now, a lot of how that's determined is tied up in collective bargaining agreements with the drivers. If this Board is going to be making decisions that right now every individual school district makes via collective bargaining, I think

there's going to need to be more lead time to the school districts to get that information out.

Barb Scott: At the end of this presentation, I'll talk about how we'd like them to engage with us so that we can make sure we are providing you with the information that is well-informed to support your decision making as you go forward. Today in the work that we have done with the PEB Board, we have dealt with a number of different types of employees that provide service where there is fluctuation in need for their services. A good example of that will be firefighters here within the state of Washington, as well as folks who do things like monitoring streams for fish flow.

We have enough experience to know that there are going to be a number of different patterns that occur. That is why it was important that we consider how to create stability around that by adopting policy that would support an anticipation of effort of work that is needed, and determining eligibility based on that, rather than using a look back to see what the actual work pattern was. So that is why one of the things on this list and one of the things that we have in proposed legislation is to base eligibility on what is anticipated to occur. Then we can address if there are drops, how do you deal with that? Or if there are changes that are permanent changes going forward, how do you deal with that as well? Does that help?

Wayne Leonard: I think so. So you mention that this Board will be making those decisions, but aren't we just providing a framework for local school districts to have some kind of flexibility in making some of those decisions?

Barb Scott: At this point, eligibility falls directly within this Board's purview. As we move forward with looking at eligibility, we would have to look closely at what you could hand off at the district level compared to what the Board needs to put in place. I can't tell you that there are no pieces as I sit here today, but I can't tell you that you could hand over eligibility and have that differ district by district, bargaining unit by bargaining unit.

Lou McDermott: I think what Barb's trying to say is no. The local districts are not going to have enhanced flexibility beyond the rules. We all understand that people are people and when the rules are laid down, there may be slight variation of the way it gets operationalized. From our perspective, the eligibility rules will be the rules and they will apply statewide.

Dave Iseminger: And this agency is charged with ensuring that eligibility is applied consistently across the school districts in the same way that this agency is charged with ensuring consistency across state agencies and higher education. What will happen in real time, and this is why the PEBB Program rules are dozens of pages and yours right now is one slide, is there will be issues that come up. Somebody has a person who's counting fish in April and now

they're counting shellfish in July and I'm not sure how to stack those. It doesn't quite fit the rules. How do we deal with that? HCA analyzes that and brings any policy revisions needed to the PEB Board to account for those situations that are coming up within the employing entities.

Lou McDermott: And then the rules are updated to reflect that nuance. It's an evolution over time.

Pete Cutler: If I could jump in having worked with retirement systems in the past, my sense at a high level is the school district relationship with determining eligibility is now going to be much more like it is with retirement eligibility where retirement system says these are the rules, here's the framework. You obviously make those decisions, but you don't get to bargain at the local level about which people are covered by PERS, or SERS, or TERS, or whatever.

Wayne Leonard: Maybe I could give a more specific example. In Terri's example, it was a driver whose hours changed throughout the course of the year. You mentioned that if we reasonably anticipate that someone would have 630 hours of time per year then we could determine they're eligible. At the end of the year, we could do a look back and they didn't get 630 hours in but they were still eligible. Or if we have drivers whose routes change, I would anticipate the driver's union coming with a two-hour minimum route time in the morning, two-hour minimum in the afternoon. Then we're all at least four hours, we're all eligible.

Barb Scott: You'll have some guardrails that you will have to create your eligibility within. For example, basing eligibility on what is anticipated to occur, you will be able to then make certain that employees know when they're going to be eligible and they know when they would not meet the eligibility. The Board would not be able to set a policy that would then allow for a look back and to take benefits away if an employee didn't meet that threshold because there is a federal prohibition on rescissions of coverage. When it comes to that type of policy decision, I would explain to you that it's not something that you would be able to put in place as far as look back and take away.

The PEB Board has a number of rules that deal with changes in eligibility, changes in position. I'm expecting that you will need similar policies in order to address some of the real situations that will occur. Those will be ones that we'll bring to you over the next several months.

Pete Cutler: I just want to tell you, I love slide seven. I think it's way cool and I really appreciate that you put it together.

Barb Scott: One of the things I'm going to say before we get too deep into this is that you should note that your policy resolutions will be numbered. They will all be "SEBB," then you will see the calendar year, and then we will number them

sequentially as they are brought to you throughout the year. That's how we track them. As Lou mentioned earlier, policy tends to evolve over time. As you look at a policy, it will help us to bring back what you had passed before and relook at how that changes or needs to evolve based on what you're looking at two, three, four years down the road from here. You'll see that numbering sequence for policy resolutions going forward.

Slide 8: Proposed Policy SEBB 2018-01 – Legal Spouse and Domestic Partner Eligibility Criteria. As I explained when we covered Slide 5, RCW 41.05.740 (6) (d) anticipates family coverage will be offered. It requires that the Board address coverage for dependents including criteria for legal spouses, children up to age 26, children of any age with disabilities, mental illness, or intellectual or other developmental disabilities, and state-registered domestic partners as defined in RCW 26.60.20. I would like your feedback on this policy that allows an eligible school employee to enroll their lawful spouse or their state-registered domestic partner. Eligibility for domestic partner coverage aligns in this draft policy to state-registered domestic partnerships, which would include legal unions other than marriage validly formed in another jurisdiction based on the requirement in state law for reciprocity.

Sean Corry: Is this an example of a policy framework that is not hard and fast with respect to law? Meaning if we all voted to have a definition of domestic partner that is broader than state registered, or however it has been articulated, in theory, we could do that and that could become rule, right?

Barb Scott: Yes, in theory you could have a policy that is broader than this. What I would tell you is that the law has changed over time as far as marriage is concerned. The state registry evolved as have other laws that cause us to allow for reciprocity. In our experience with the PEB Board's eligibility, the PEB Board did have eligibility early on for domestic partnership coverage that allowed for coverage for partnerships established through a declaration that met certain qualifications. What we found with that eligibility was that as marriage laws evolved, the original eligibility allowed for domestic partnerships by the PEB Board did not align to the state registry and they ended up creating a risk for claims of adverse discrimination by opposite sex partners. So if you start to consider a policy that crosses into where that would become a concern, we would make sure to bring that to your attention.

Sean Corry: Thank you for that. I think maybe I framed that a little too specifically with respect to domestic partners. But more broadly, if this Board wanted to propose policy, and therefore try to influence rule making with respect to anything that's not strictly confined by law, we would be able to do that?

Lou McDermott: I think what you're getting at is how big is the playground. There are some components of the law that are more precise and some that are not. The bigger you open that door, when the Legislature does its funding model,

and whether or not the funding model takes into consideration that wide open door or a narrower door from their perspective, is the dollars you're going to have to work with. What I'm trying to say is, if you want to open that door wide open, then you might have to close another door to make sure you're operating within the funding model. So, yes, you could take various components of the benefit and expand those. But at the same time, you'll have to restrict something else. That's a consideration. The Board has power in this arena, the Health Care Authority has some power in this arena, and the Legislature has some power. The trick is for all three to line up in a benefit design and an eligibility design. That's the easiest way to explain that.

Sean Corry: The answer is yes within confines.

Lou McDermott: Correct.

Dave Iseminger: I think Barb hopefully answered the questions about the difference between the state-registered domestic partners and why the recommendation is to align with the state registry because after marriage laws changed in the country, there was significant reverse discrimination concerns for non-state registries. The state-registered domestic partnership ensures that opposite and same sex couples in domestic partnerships are treated equivalent.

Barb Scott: Slide 9: Proposed Policy SEBB 2018-02 – Dependent Child Eligibility Criteria. This policy recommendation is shaped by a number of RCWs, as well as the federal requirement that group health plans providing dependent child coverage offer the coverage until the child turns 26 years of age. We are recommending children include biological children where parental rights have not been terminated and children based on establishment of a parent-child relationship as described in RCW 26.23.101. That RCW covers circumstances such as a woman giving birth, except in explicit circumstances such as when acting as a surrogate with a valid surrogate parentage contract in place; the husband of a woman who gave birth if the child is born during the marriage, or within 300 days after the marriage was terminated by death or divorce unless proven otherwise; and it specifically clarifies that a sperm or egg donor is not a parent of a child conceived by means of assisted reproduction unless specific criteria are met.

We have some experience with dependent verification processes. The tie to this specific RCW is intentional in order to help address some of the questions that we see brought forward. We also include step-children, legally adopted children, children from whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child, children of the subscriber's state-registered domestic partner, children specified in a court order or divorce decree, and children of any age with a developmental disability or physical handicap that renders the child incapable of self-sustaining employment and

chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age of 26.

Pete Cutler: Do I catch that if in a divorce action a court says the child, even if the custody of a child is going to go, say, to the wife, and the husband's the employee, that the court can order continued coverage under the non-custodial parent?

Barb Scott: Yes.

Pete Cutler: Great, thank you.

Lou McDermott: Actually, they usually do order that in the court order. They require that the spouse continue insurance.

Dave Iseminger: That would be an example of bullet number four on Slide 2 of Proposed Resolution 2018-02.

Barb Scott: Slide 11: Proposed Policy SEBB 2018-03 – Extended Dependent Child Eligibility Criteria. This policy allows an eligible school employee to enroll extended dependent children that satisfy the criteria of being in the legal custody or legal guardianship of the employee, the employee's spouse, or the employee's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order, and the child's official residence with the custodian or guardian, and the child is not a foster child for whom support payments are made to the employee, the employee's spouse, or the employee's state-registered domestic partner through a state department of Social and Health Services foster care program.

Dave Iseminger: Barb, could you plain talk an example of what this means?

Barb Scott: Yes. If an employee has guardianship of their grandchildren, then those grandchildren, as long as they meet the definition of "child," so the age requirements, then that employee could include that child on their coverage for benefits. The PEBB Program has a good number of children who are covered under this eligibility and that's why I bring this policy before you as well, assuming that school district employees also have some of these situations.

Dave Iseminger: Although a few of these policies are very aligned with the PEBB Program eligibility criteria, that does not mean that Barb is going to bring all PEBB Program rules to you. We started with an area we thought would be fairly aligned to help you get used to the process.

Barb Scott: There are a lot of rules, though.

Dave Iseminger: We will bring to you those that we believe have similar characteristics in the population. We've spent years refining eligibility rules on one side of the house and we see that as part of the consolidation effort to leverage this agency's experience with things like eligibility rule making. This will not be a month-by-month parade of PEBB Program rules asking you to ratify them if there's no justification for the SEBB Program population.

Wayne Leonard: I have a question on the Slide 10. I was glancing back and in terms of the age of 26, that's a federal law? I have two children and a few years ago, one was still covered under my plan, being 25. The other one was in medical school and had to go off my plan and go on Medicaid while she was in medical school. I was still paying the same premium but I couldn't cover both my children because one was older than 26. Would there be any kind of exception to cover dependents still in college?

Barb Scott: The answer is no. In RCW 41.05.095, the Legislature has specifically stated in subsection 2, “coverage must terminate upon attainment of age 26 except in the case of a child who is and continues to be both incapable of self-sustaining employment by reason of development disability or physical handicap and chiefly depended upon…” I won't read the rest of it because it mirrors the disabled dependent eligibility on your slide. You don't have the ability to be more generous in that case.

Slide 12: Next Steps. We will incorporate any feedback you have related to these policy proposals and then send them to key stakeholders seeking feedback from them in the month of February. We'll bring these particular policy resolutions back to you to take action on in March.

Dave Iseminger: At that time, we'll also describe stakeholder feedback so you have a concept as to the types of things that were discussed in the intervening month with stakeholders.

Barb Scott: Slide 13: Rule Making Notices and Stakeholder Input. We have sources for folks interested in our rule making activity. If individuals want to engage and are interested, they can receive notices related to SEBB Program rule making activity by subscribing to the SEBB Program rule making notice GovDelivery email subscription at the path on this slide. The types of information they will receive includes copies of proposed rules and the actual documents filed with the Office of the Code Reviser.

Lou McDermott: If somebody was looking on our website and looking at our materials, would they have a hyperlink or is it just a copy of a PDF?

Barb Scott: I believe that this is a hyperlink. In addition, this information is available on the SEBB Program page on our website. There is a little green area

that you can click on, or a specific link out there, that they can click on in order to sign up for GovDelivery messages.

Dave Iseminger: And Connie just confirmed that the hyperlink should be active in the Briefing Books posted online.

Proposed SEB Board Resolutions

Dave Iseminger: The proposed SEBB resolutions build upon the discussions of presentations that staff brought before this Board earlier in this meeting and at the last meeting. These resolutions are recommendations related to the statutory wording of leveraging the PEBB Program portfolio and coordinating with the PEB Board. These recommended resolutions are for a very macro level way of preceding with benefits. They are not decisions about specific cost-shares within a benefit design or even the specific value of a life insurance benefit, for example. Right now, the agency needs to proceed with going out into the market and doing procurements for vendor contracts to be able to support ultimate granular benefit design. What these resolutions are designed to do is to check our understanding based on what we have seen in the comparator analysis that we've done on a benefit-by-benefit basis and presented to the Board. Is this a reasonable way to look across all of the different benefit ideas? Is the Board comfortable that the ultimate benefit design could come from a vendor contract that the Health Care Authority already has, and could be similar to, the PEB Board benefit? Is the Board comfortable with HCA going forward and leveraging that contract or do you believe there is more information to be gathered from the market to possibly have a different benefit offering at the end of the day?

You would not be endorsing a specific benefit design next month when voting on these resolutions. You are not going to be saying it's a $35,000 life insurance benefit. You're not saying 85%/15% cost-share within a specific medical plan. At this point it's giving us the necessary tools and insight to be able to proceed with the procurements necessary to get contracts in place for specific benefits.

As we go into these resolutions, you can see all the ways resolutions could possibly be written. Staff could have drafted many permutations of them, but I think you can get a sense from the overall package of resolutions as to the way they can be written.

I will explain why HCA recommends each resolution. I would love to hear your insight on the direction of these resolutions because ultimately, we will be bringing these back at the March meeting for you to take action on and hopefully endorse.

Slide 2: Proposed Resolution SEBB 2018-04. This resolution is related to fully insured medical plans and is based on the comparator information we gave you, recognizing that the contracts the Health Care Authority holds does not offer a choice of fully insured products to all counties and that school district employees

are in all counties and spread across the state. We think that the geographical diversity, coupled with the 14 counties of which there aren't PEBB Program fully insured medical plan products, certainly suggests to us that HCA should be going out for procurement and looking for additional carriers that have widespread coverage offerings around the state.

This resolution simply says that the SEBB Program shall perform a fully insured medical plan procurement seeking multiple carriers with widespread coverage offerings. We are not anticipating that you're asking us to only contract with a carrier who has benefits in all 39 counties. The reasonable result of the procurements could be that carrier A has 25 counties and carrier B has 25 counties that are different counties, and together we end up with 39 counties. This resolution is not drafted in a way to suggest that only a carrier who can provide complete statewide coverage would be eligible for consideration of the benefits offering.

Slide 3: Proposed Resolution SEBB 2018-05. This resolution is related to self-insured medical plans. Because it's a self-insured plan and the state ultimately has the claims liability risk, this Board won't have the final say as to whether the state will take on that claims liability. But in order to further the discussion about whether or not to offer a self-insured plan, this Board's direction would be helpful. Because we have longstanding contractual relationships that our third party administrator (TPA) leverages for provider networks, we would be able to access benefits of the self-insured plan that the state has cultivated over the past decades. If you are having the self-insured plan, you would want something that is similar and leverages those aspects of the state's Uniform Medical Plan. Passing this resolution would also allow the conversation about whether a self-insured plan is within the financial risk of the state. The UMP model and its financial model is well understood and would provide stability to those conversations.

Proposed Resolution SEBB 2018-05 simply says that beginning in 2020, the SEBB Program would offer a self-insured plan that leverages features of UMP, describes some of those features, and then acknowledges that there are final financial decisions to be made by other parts of the authorizing environment.

Sean Corry: Quick question with respect to four and five. In combination, in a sense they seem to be the same thing. We will look to offer insured plans where we need to, to make sure that we're going to have insured plans across the state. So we shall perform procurement. And the next one is will offer the self-insured medical plan. Could you help me understand them together?

Dave Iseminger: The key difference between them is there would not need to be a procurement for anything related to self-insured. The state and the Health Care Authority already have contractual relationships in place to be able to immediately leverage that within the portfolio for SEBB Program benefit offerings.

On the fully insured side, we're acknowledging that there may be additional carriers who could participate and provide coverage to other counties in the state that aren't within the PEBB Program portfolio. We believe that we need to go out for procurement. The key distinction between these is one would necessitate a procurement, and the other is saying we believe a procurement isn't necessary, but we do want a self-insured plan within the benefits offering. Acknowledging from the state's perspective, it would need to be one that leverages the current existing self-insured plan.

Pete Cutler: Am I correct that the Health Care Authority is in the process of doing a procurement for the TPA for the current PEBB self-funded plan?

Dave Iseminger: Yes, Pete. The current TPA contract with Regence has a maximum end date of December 31, 2019. We have been in the process of a procurement for several years now. We released a procurement in November of 2016 and are near the finish line of that procurement, but not quite done. We will be completing that procurement very soon. The winner of that would go on to administer the Uniform Medical Plan for the PEBB program beginning with administrative services on 1/1/2020. If there is a self-insured plan for the SEBB Program, the winner would also administer that plan assuming it is of a similar structure.

Pete Cutler: Would this Board get an update on that in the summer or whenever the procurement is completed?

Dave Iseminger: Yes. Slide 4: Proposed Resolution SEBB 2018-06. This proposed resolution addresses dental plans. It is saying that for fully insured dental plans, if the Board leveraged the fully insured plan offerings in the PEBB Program, a procurement would not be necessary. This is the HCA recommendation because there is little variation when it comes to both plan design and carrier offerings in the state for dental. As we are prioritizing different pieces to proceed with the launch of these benefits, it would be reasonable for the Board to start with the dental benefits in the PEBB Program and get into the cost-shares and exact different levels within the benefit. In general, the carrier options and the general structure of the design that exists in the PEBB Program and then revisit in 2020. The Board can come back and say this was good for the launch, but we want to revisit after the initial launch.

Slide 5: Proposed Resolution SEBB 2018-07. This proposed resolution is the self-insured dental plan. For the sake of time, everything I said about the Uniform Medical Plan on the medical side is the same reasons for the Uniform Dental Plan on the dental side. If the Board wants to offer a self-insured dental plan and the state decides to take on the risk, we would need to leverage the contractual relationship with Delta and the general benefit design within the Uniform Dental Plan. It's essentially the same reasons. There is no current dental TPA procurement in anticipation of Pete's question.

Slide 6: Proposed Resolution SEBB 2018-08. This proposed resolution addresses long-term disability insurance. In December 2017 we looked at comparator data, and in almost all instances, the employer-paid benefit were richer than the PEBB Program benefit. Even though the PEBB Program administered benefit for employee-paid optional supplemental coverage was closer, the school districts have a slightly richer benefit. HCA doesn't anticipate the Board asking us to leverage the PEBB Program LTD benefit. This suggests we should be testing the market and looking for a different product. This resolution acknowledges that direction to proceed with a procurement for the potential of both an employer paid and employee optional coverage. We would figure out later, once we have more of the funding insight whether both of those would be offered. We would at least pursue potential employer- and employee-paid coverage lines for long-term disability.

Slide 7: Proposed Resolution SEBB 2018-09. This slide addresses short-term disability insurance. I don't believe there were any entities that had an employer sponsored short-term disability benefit and HCA does not have a contract with a vendor for this benefit. We are assuming the Board wants us to pursue the potential for a short-term disability option. And given that generally school district employees are accessing this benefit as an employee-optional supplemental buy up, that we would not be looking for an employer-sponsored coverage line in this product.

Slide 8: Proposed Resolution SEBB 2018-10. This proposed resolution addresses life and accidental death and dismemberment insurance. The employer-paid benefit that the Health Care Authority has with its current vendor is competitive with the vast majority of the school district offerings. There is some variation but it was competitive or exceeded in many instances. The accidental death and dismemberment lines were higher in the school districts than in the PEBB Program benefit. There's a slightly mixed bag, but it was very competitive on the basic life insurance. It's just the AD&D was a little lower than what school districts are experiencing now. On the employee-paid side, HCA's coverage offerings were higher than the school districts. We believe in this instance that we'll be able to negotiate with our vendor a successful benefit that is similar to, or on par with, the PEBB Program. Having just done a procurement in the market a year and a half ago, our recommendation is that the market won't be substantially different from when we did that procurement and we'll be able to leverage the existing contract with the existing vendor for a similar benefit for life and accidental death and dismemberment for SEBB Program employees.

Slide 9: Proposed Resolution SEBB 2018-11. 2018-11 addresses vision. HCA does not have an existing contract for a standalone vision benefit. In order to have a standalone vision benefit, we'll need to do a procurement. We are expecting that given the vast majority of school district employees have a standalone vision, the Board will want HCA to perform that procurement.

If you look at these proposed resolutions, the package indicates that the Health Care Authority would proceed with roughly four procurements: a fully insured medical procurement, a long-term disability procurement, a short-term disability procurement, and a standalone vision. We would work with our existing contracts to proceed with more granular benefit design once funding numbers come in for life insurance, AD&D, and fully insured dental. Once the state determines whether or not to accept the financial risks for the self-insured plans, the Uniform Medical Plan and Uniform Dental Plan, or something similar, would be on the table.

Lou McDermott: Dave, when does this come up for a vote?

Dave Iseminger: March 15, 2018, the next SEB Board meeting. We want to give you time to vet these with your constituencies.

Lou McDermott: I know that's a lot to digest. If Board Members want to reach out to you directly or send you questions or concerns, they can do that.

Dave Iseminger: Yes. Just email Connie or me and Connie will set up a phone call.

Public Comment

Fred Yancey: My name is Fred Yancey. I represent the Washington Association of School Administrators, Association of Washington School Principals, and the Washington State School Retirees Association. All three groups have a definite stake in this sort of situation. There are four basic things that occurred to me throughout the meeting. First of all, a question that was asked very early is what are you hearing from SEBB members? And the bottom line is most people in the profession don't know what's going on. I think you got that very clearly from the survey. And I'd be interested to see the final report. I would suggest that one of the problems is that your website, the Health Care Authority website, you have to dig down into it to find the SEBB materials. It is very hard to comment on that site. It's generic comment to HCA versus comment to SEBB issues specifically. You have a frequently asked question section and I think it should also invite questions from the audience. I know that you had mentioned that at a previous meeting. And those are just some of the ideas to at least help get word out on it.

I write a piece, I know that the school directors person writes a piece, and the School of Business official person writes a piece for our membership newsletters on the SEBB. But it's still hard to get through. When you do a survey during Christmas vacation, it's pretty hard to get feedback from the field as well, and that's when the survey was taken, when it's hard to get information out.

So, Mr. Cutler asked a great question and I want to hear that answer. Can districts prorate benefits or is it all or none? You know, Mr. Cutler suggested that in Oregon, that you can allow proration. It's suggested here that this legislation

says you cannot. I need a decision to tell the school districts. That's a significant, substantial financial sort of cost to school districts depending on the answer to that question. I'm an ex-superintendent. I get money from the state for benefits, okay? I took that money and if you were a certified teacher, you were an FTE based on 1,440 hours. And so if you were a 1.0 FTE and I had 10 FTEs, as an example, I divided ten into the benefit pool and that's how much FTE got. Anything that was left then they split among themselves.

There's 2,080 hours for classified employees. Same thing. I got an allocation from the state for benefits. I divided them. I counted up the FTEs I had, divided it into the benefit pool, and said this is how much you get and anything left.

The new system is based on the prototypical model and it will generate benefit money. But it still begs the question: can you prorate. So that's a significant question and I'm glad Mr. Cutler asked that because districts need to know that.

85/15? Is that in statute or is it implied? Meaning the premium cost. An employer will pay 85% and an employee will pay no more than 15. Everybody talks about the state rate. The question is, is that the ratio that these benefit costs are going to be irrespective of what they are and what the costs are going to be?

Lou McDermott: That one I actually know the answer to. Yes, the 85/15 is referencing the collective bargaining agreement with Labor on the PEBB Program side.

Fred Yancey: From the state.

Lou McDermott: From the state. The state has picked up 85% of the cost. Employees pick up 15% of the cost.

Fred Yancey: So according to the legislation, when I begin to bargain with the Governor, that has yet to be determined then what --

Lou McDermott: That is my understanding.

Fred Yancey: Okay. Because they would have to bargain with the Governor for that. And the last piece is, and I may be misreading this, but the policy that you just went through, or the rule that you just went through on dependent child eligibility age 26, but I think if you have a stepchild, if that stepchild's mother dies and he's under age 26, then you can't cover him as the husband of the person.

Barb Scott: Stepchild eligibility would end at the death unless that child were adopted.

Lou McDermott: Okay. Barb's response is, if the relationship to the stepchild ends and the stepfather, stepmother has not adopted the child, then that legal relationship has ended; and therefore, that PEBB Program eligibility would end on the PEBB Program side.

Fred Yancey: I would disagree with that policy but I hear what you're saying. I believe that's all I have. Thank you all for the work. It's a long meeting you've put in. My backside is numb.

Doug Nelson: Good evening, Chair McDermott and members of the committee. Doug Nelson representing Public School Employees of Washington. We have 31,000 classified employees we represent in Washington State. And let me tell you I have represented classified employees at the bargaining table and here in Olympia for 35 years. And I appreciate your focus on classified employees because if there is anything consistent with classified employees is there is no consistency. So what you all were wrestling about when you were talking about, well, what about this and what about that, well, quite frankly, my experience has been, you know, good luck trying to come up with a consistent standard. But there are some things that we will work with you on as far as eligibility, etc. But on the fundamental issue about funding with the Legislature for classified employees, I think that I'm going to offer up my assistance to your staff on understanding the history because, actually, it goes back to 1984 when the Legislature put in the insurance benefit factor of 1.152 to reduce the buy down from 2,080 to 1,440. All they have to do is buy down the FTE from 1,440 to 630. That's going to change the ratio to 1.316 or some number close to that. And quite frankly, it is going to be something we're going to be negotiating with the Governor's Office starting July 1. So anyway, it would not be prorated. I'll have to tell you that. Thank you.

Lou McDermott: Thank you. The next meeting is scheduled for March 15.

Overview of March 15 Meeting

Dave Iseminger: I know the Board appreciates having a preview. Things we know that will be on the agenda are: eligibility rules and stakeholdering that's been done on the three resolutions that Barb Scott presented today; teeing up the next pieces of eligibility; revisit one of Wayne's original questions about school district, people on school Boards, and their eligibility for benefits; and I'll provide a legislative update on what has or hasn't passed.

I've heard quite a few questions overlaying enrollment data on top of the data presented today. And it sounds like the Board is ready for a funding discussion with the information we have at this point. That was quite a bit of engagement from the Board and we'll prepare a presentation. We'll bring something to the Board to talk more about those questions brought forward today.

Lou McDermott: I'd like to thank the staff from HCA, all the work that went into the presentations. I understand what that takes. I'd like to thank the Board for all the engagement today. It was really helpful.

Meeting adjourned.