Washington State Health Care Authority

School Employees Benefits Board
Meeting Minutes

January 24, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 p.m. – 3:00 p.m.

Members Present:
Dan Gossett
Terri House
Wayne Leonard
Pete Cutler
Katy Henry
Lou McDermott

Members via Phone
Sean Corry
Alison Poulsen

Members Absent:
Patty Estes

SEB Board Counsel:
Katy Hatfield

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

Agenda Overview
Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda. Patty, Sean, and Allison, are planning to call in around 10:00 a.m.

Approval of June 13, 2018 Meeting Minutes
Pete Cutler moved and Katy Henry seconded a motion to approve the June 13, 2018 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

December 13, 2018 Board Meeting Follow Up
Dave Iseminger, Director, ERB Division. There were questions asked at the last meeting embedded within presentations today. I'm doing a miscellaneous follow up.

Slide 2 relates to Paid Family and Medical Leave (PFML). The Employment Security Department (ESD) provided details about this new benefit. There was a question after the meeting about how local collective bargaining interacts with this benefit; and specifically, if there was a Collective Bargaining Agreement (CBA) signed that doesn't expire until after the 2020 benefit goes live under ESD, exactly when premiums are collected, and how that impacts eligibility. The general concept is the hours accumulated before a local CBA expires will retroactively count for purposes of eligibility and determination of hours and wages. Those hours aren't lost simply because there's a local CBA that leapfrogs over the PFML implementation date.

I believe Pete asked a question related to stipends and how that interacts with unemployment insurance; and thus, related to Paid Family Medical Leave. In true lawyer fashion, Pete, it depends. Employers are supposed to report moneys and hours for paid work, including stipends, depending on the purpose of the stipend. If it's for hours worked, they should be reporting it. If it's simply reimbursement, it doesn't necessarily need to be reported. It really depends on the purpose.

Pete Cutler: The key point I was curious about was whether they were collecting hours. It sounds like it depends. So, at least sometimes they are, but sometimes they're not.

Dave Iseminger: Correct.

Slide 4 is a series of links from each of the carriers because utilization management policies could take up their own briefing book. I want to highlight, because several carriers asked for this to be provided as context, that clinical policies change periodically. What you read today in these links won't necessarily be what exists tomorrow. They are highly technical and used by clinicians. Keep that in mind as you're reading through them. They're not necessarily geared for the average member to understand 100%; but ideally, they'd be able to follow the flow of it.

Slide 6 shows some of the provider search tools and links that members would ultimately be able to experience as they try to understand provider networks. The Board has not authorized the carriers at this point. This is a preview of what provider search tools could look like. We will work with carriers over the year about our expectations with regards to provider search. I did not include Regence's search tools for the Uniform Medical Plan. I can follow up with that, but we are working on a major revamp of the provider search tool that was already in the works for 2020.

Governor's Proposed Budget – 2019-2021

Kim Wallace, SEBB Finance Manager, Financial Services Division. There are four parts to this presentation. Slide 2 – SEBB Funding Rate. The funding rate is important in terms of what the districts will be paying to the Health Care Authority. It's also important in terms of the calculation of money that's coming from the state to the districts. The funding rate is important in both directions. This dollar amount is the per subscriber amount that will be invoiced to the districts for all SEBB Program benefits-eligible employees, including those who waive. The waive rate is already assumed in the projections of total expenditures covered by the funding rate.

Dave Iseminger: I want to give context because several people have asked me if the funding rate is going to be the same amount that HCA invoices for both state funded and locally funded enhanced positions. The answer is yes, the funding rate is the basis for what will be charged for all eligible school employees, regardless of the funding source of those school employees.

Kim Wallace: Slide 3 – SEBB Program Funding Rate Details - is very familiar. We will refer back to this slide in another presentation to compare and contrast the top part of this funding rate table. The point of including this is we are building up the SEBB Program funding rate. The Governor's team did their version of this based on information we provided, and our modeling that we sent to them as well. Last summer we created this slide and the numbers are changing as we speak, and the numbers will continue to change. Remember we were showing just the buildup of the monthly funding rate driven largely by the medical premium contribution of $977. The $977 is the lion's share of the $1,174. That mathematical calculation at the top of the slide, the Employer Medical Contribution (EMC), times the ratio factor, gives us that medical premium contribution on a per subscriber per month (PSPM) basis. That's the area of this table we'll refer back to because it becomes key when considering some of the policy proposals.

Slide 4 – SEBB Funding Rates. The Governor's budget does include $1,170 per employee per month for FY20 and $1,195 per employee per month for FY21. We're in a very fluid situation, but these numbers in the Governor's budget do align with our most recent suggested levels based on our modeling and includes all of the provisions from the Collective Bargaining Agreement. They also cover build-up of reserves for the self-insured plans at the same level, 7% of projected expenditures for medical, and 4% of projected expenditures for dental in the first year.

Lou McDermott: Kim, how many dollars are associated with that build-up?

Dave Iseminger: Lou, are you asking the component of the funding rate that's attributable to 7% or what the value of 7% is of project expenditures?

Lou McDermott: The value of 7%.

Kim Wallace: I will get that later because we have to estimate and project the number of people who will enroll in the self-funded plans and the costs associated with those people. Not 100% of the population will enroll in self-funded plans. It's easy to get, Lou. We did make an assumption for how many people will enroll in the self-funded plans, the total expenditures we're projecting for them, and then 7% of that. I'll confirm what that is. Essentially, we'll collect that amount and put it into a fund. It's kind of a rainy day amount of money. We don't know if that 7% will be needed in year one, year two, or year three. Now, the prudent thing is to assume that we want to build up appropriate reserves. This 7% and the 4% match the PEBB Program levels.

Lou McDermott: Isn't there a loan payback component?

Kim Wallace: Exactly. The last bullet on Slide 3 indicates these funding rates also cover repayment of the General Fund – State loans needed to start the SEBB Program. That payback will be complete, given these numbers, by the end of the next biennium.

Pete Cutler: I have a question on filling up the reserves, both for the medical and dental. Do I understand correctly the rate in fiscal year 2020 is designed to generate enough money in one year to generate that level of reserves? It wasn't spread over two years so, unlike repaying the amount spent by general fund for getting the program up and running is being repaid, but over a two-year period, versus trying to do it in one year?

Kim Wallace: Correct.

Dave Iseminger: Pete, just one refinement. Remember that calendar year 2020 is half of fiscal year 2020 and half of fiscal year 2021. It's not just the per employee funding rate of 2020. The projection is to build up the reserves in calendar year 2020. It's embedded within both of the fiscal year funding rates. It's not just attributable to the first fiscal year 2020 funding rate.

Kim Wallace: The $1,170 and the $1,195 both.

Pete Cutler: But, it could have been done over two plan years.

Dave Iseminger: Correct.

Kim Wallace: I want to clarify for the Board that after we build up that 7% amount and the 4% amount in plan year 2020, we hope we don't have to apply that same 7% and 4% the next year. After the first year, we're assuming we will be maintaining that level of reserve.

Pete Cutler: If all assumptions work out for the model, all you would be adding is the increment associated with the benefit cost increase or increased enrollment, but just on the margin. My experience from working with this budget-wise is I can only remember one or two years where the reserve was ever touched, that generally, rates have been projected and turned out to be higher than actual expenses. I would be curious if you could bring back when and how much. I know I think it was 2009 or so when there were layoffs. There was a tendency for people to get a lot of medical work done before they got laid off, or in fear of being laid off. I think that's probably the most dramatic year we've had. I would be curious how much of the reserve was needed or utilized for whatever that period was.

Kim Wallace: In the PEBB Program experience, I believe that's exactly right. It was right around the recession in 2008, 2009. We used all of it.

Pete Cutler: You used all of it. That's good to know. That actually is sufficient. The whole amount that was plugged in for the medical reserve was needed.

Kim Wallace: Not only tapped. It was used up.

Dave Iseminger: People keep asking, you look at these funding rates compared to what is in the projected budget for the funding rates for the PEBB Program and there's a several hundred dollar difference. Building up the reserves, repaying back the loan, is a significant part of that difference. But, once we get past the reserves and the loan payment, we would anticipate they would normalize to similar levels.

Lou McDermott: Dave, on the PEBB rates, are we also in a surplus position so the rates are artificially low in the budget to draw down the surplus?

Dave Iseminger: Correct. There are three main reasons that those numbers between the PEBB and SEBB Programs look different in the next biennium. Two of them are on this Slide 4, building up of reserves where the reserves are already built up in the PEBB Program; needing to pay back the admin loan, which doesn't exist in the PEBB Program; and we are in a surplus position in the PEBB Program so that funding rate gets bought down over time. That's called the "net funding rate," the true cost of the benefits versus what's actually funded on a year-by-year basis. We're in a surplus position on the PEBB Program, whereas there's nothing to dip into on the SEBB Program side. But again, after the initial launch and these hurdles are crossed, we would expect both of them to normalize to similar levels.

Kim Wallace: Slide 5 – Tentative Collective Bargaining Agreement (CBA), is a quick review of aspects of the Collective Bargaining Agreement included and funded in the Governor's budget. Of course, the EMC, that 85% contribution that's tagged to the premium of the UMP Achieve Two plan, gets multiplied by tiers. We all remember that goldenrod table with all the EMC columns. The Governor's budget covers 100% of the premiums for the other benefits. It also covers SmartHealth reduction in deductible starting in year one for school employees, and also includes the Benefit Allocation Factors that were bargained. That factor is multiplied times the FTEs to approximate the actual head count of benefits-eligible individuals.

Dave Iseminger: Although we listed the wellness incentive of $50 related to plan year 2020, it also includes the $125 that would be in plan year 2021.

Kim Wallace: Yes, this slide is just for 2020.

Pete Cutler: I feel obligated, for the record, to once again point out that the collective bargaining statute says that the sole thing that can be negotiated is the dollar contribution. It's not clear to me how wellness comes out of a statute that says the only thing you can negotiate is a dollar contribution. But it is water under the bridge so it's nothing. I don't need to be dealt with. I just want it on the record that there seems to be a discrepancy to at least one Board Member here.

Dave Iseminger: So noted, for the record, Pete.

Kim Wallace: Slide 6 – State Basic Education Health Insurance Funding, reviews the amount of money being sent from the state to the districts for basic education, health benefits. You've seen this equation before. People have pointed out there's no equals sign and so it's not really an equation. Nevertheless, it is the amount of money calculated by taking the number of prototypical model generated FTEs by district and

the classified number gets multiplied by the 1.43 and the certificated number gets multiplied by 1.02. All of that gets multiplied by the funding rate.

The Governor's proposed budget does include an increase to the number of prototype generated FTEs. Special education FTEs are considered under basic education. I believe there are others but I don't have an exhaustive description of all the changes in the prototypical model there. But there were some increases.

Dave Iseminger: That might help explain for people, we described, or you may have heard a number that said $860 million for the biennium, and then you may have read in some newspapers it's more like $900 million. Some of the differences of that are proposed FTE increases. HCA's budget projections used what was anticipated by the prototypical model. And then, additions to that happened in the Governor's budget, those staff obviously come with benefits and that's one of the reasons that helps explain the difference between what you heard before and what you heard later. How people round is another reason.

Kim Wallace: We will be updating the modeling and submitting new suggested funding rate levels to the Legislature by March 1. We're actively in the rate development process on the self-insured side and rate negotiation with the fully insured carriers. We're in the phase where we're considering all of these rate negotiations at “not-to-exceed” (NTE) levels. What we’ll be submitting to the Legislature is new suggested funding rate levels based on the not-to-exceed bid rate amount.

Dave Iseminger: If you look at the Governor's budget, you might start to sear these numbers in your mind, the $1,170 and the $1,195. When you pull up the House incentive proposed budgets that come out in March, you will naturally want to compare those numbers to these numbers. I caution you to not directly compare them because the numbers in the Governor's budget fully fund the program based on the modeling that was done at that point. There's going to be new modeling that the Legislature will take into account. The numbers in the legislative budgets could equally fully fund the program and be completely different numbers. I just wanted to give you a word of caution. It's not necessarily an apples to apples comparison because the modeling will have been updated.

Lou McDermott: For those Board Members who don't know how to find the budget or go through the thousands of pages, I'm assuming we'll be getting updates from Dave and Kim as each of the budgets come out.

Dave Iseminger: That is correct. But you may have friends and colleagues who are more familiar with the state budget telling you numbers and then you have questions. So, this is an early word of caution not to directly compare the numbers. We'll give you all the insight that we can about them.

Lou McDermott: Dave, maybe when the budgets do come out it's something you could send to the Board Members, the component of the budget and highlight that for them so they can see it without having to dig for it.

Dave Iseminger: We'll do that between the March and April Board Meetings and we'll certainly bring a presentation about the legislative proposed budgets in April.

Kim Wallace: Actually, Slide 7 speaks to the next steps in the budget process. The Legislature convened this month. In March we will see the House and Senate budget bills, but not in time for our March 7 Board Meeting. We will know more at our April Board Meeting. The regular session is due to end on April 28. The key result is that SEBB funding rates will be established mainly for the FY 2020. There will be an FY 2021 funding rate as well. That rate can be adjusted next year, one year from now in the second session.

Dave Iseminger: As a reminder, when we build the Board calendar, we assume that we will set rates in July. It's always a welcome reward if we were able to work with the Board to escalate that timeline, but we have come accustomed to assuming it will happen in July. If a funding rate is established at the end of April, we very well may be able to get some of the Board's work done a little earlier, in late June perhaps. That would expedite the ability to communicate things to school employees for the open enrollment that's coming up. But we have come to assume we will set rates and premiums with the Board in the month of July.

Legislative Update

Cade Walker, Executive Special Assistant, Employees and Retirees Benefits Division (ERB). I am facilitating the legislative process this year for the ERB Division and both the PEBB Program and the SEBB Program. We have a long session this year, 105 days. It will set the biennium budget, which Kim shared with you.

More has happened since I submitted this slide presentation, I will give you some verbal updates because the slide has outdated numbers.

Slide 2 – Number of Bills Analyzed by the ERB Division. We have actually completed 64 bill analyses, 46 of which are low priority and 18 high priority. For our analysis, the priority we establish is determined based on three factors. Is there a substantial financial impact? Is it going to impact our rules requiring rule writing to account for the legislation? Is it asking us to do something or to change the program? Things that meet any of those criteria we designate as a high priority. We follow and track these bills closely.

Dave Iseminger: Cade said that one of the criteria is substantial financial impact. I just want to put a little more insight on that. The benchmark is if it's above or below $50,000. In the context of this program, if there's a financial impact, it is higher than $50,000 for the most part.

Cade Walker: We currently have 94 bills assigned to us to review. We've got 30 more that need a completed analysis. We expect that number will continue to grow for a bit. It will then slow down as the first round of bills come in to play, as they go to hearings, and the legislative process continues. We might see another ramp up of bills before the first cutoff.

Slide 3 – Legislative Update – ERB high lead bills. For us, not many things have progressed because it's early in the session. We use this slide to show the process of a bill starting with its introduction in the original chamber. It then moves through fiscal, rules, and the floor of the different chambers. Then it goes to the opposite chamber, and goes through their policy, fiscal, and their floor. Then it goes to the Governor for signing. If it makes it through all of those hurdles, it becomes a law.

Dave Iseminger: The important thing is that each of those white bars, as you move down this funnel, represent typical cutoffs in the legislative calendar. We haven't hit any cutoffs yet so no funneling has occurred. The Legislature is still in idea generating mode.

Pete Cutler: Is the first policy cutoff towards the end of February?

Katy Hatfield: It's February 22.

Pete Cutler: And a few days later or a week later at the most will be the fiscal committee cutoff. Thank you.

Cade Walker: Thank you, Pete. I will continue giving an updated presentation on the legislative session at upcoming Board Meetings.

Slide 4 – SEBB Program Impact Bills. We have identified one bill to date with potential SEBB Program impacts. Senate Bill 5092, introduced by Senator Fortunato, is providing flexibility to school districts by authorizing school district waivers. It is a rather broad bill that would allow school district boards to approve waivers submitted by individual schools or school districts to exempt themselves from a vast majority of the requirements under 28A. There are some exceptions to the ability to waive requirements, like teacher certification. What is able to be requested to be waived, is participation in the SEBB Program, as well as the K-12 remittance payment. It's scheduled for hearing tomorrow and we'll report back on this bill.

We may see other impact bills, but if you were watching the working session yesterday where Dave presented to the Senate Ways and Means Committee as well as Shawn Lewis from the Labor Coalition, and others, it seems there's a lot of support for the program moving forward. We have no anticipation of seeing any significant bills changing the program. We're keeping a close eye to see if any other bills come up that would impact the SEBB Program.

Pete Cutler: Which committee was that testimony?

Dave Iseminger: We'll talk about the work session now. It was yesterday during Senate Ways and Means. If you go onto TVW's archives, it was 3:30 p.m. yesterday and it started about 15 minutes into the presentation.

Lou McDermott: Can you have Connie send out a link to that?

Dave Iseminger: Yes. The work session was about an hour and the panel consisted first with me giving an update on the agency's and the Board's work on the last year on

implementation efforts and policy decisions. Second on the panel was Shawn Lewis, on behalf of the Labor Coalition that bargained with the state this summer, speaking about various aspects from their perspective and representing a member perspective. The last part of the work session was a panel of two individuals, Kate Davis, CFO of Highline School District and Tom Fleming, CFO of an ESD in the Yakima area. They were speaking from the district or ESD perspective. They were highlighting concerns, not specific to anything implementation-wise, but gaps in funding, especially the difference between state funded positions and locally funded positions.

Lou McDermott: I recommend the Board watch the hearing. Shawn's comments were very favorable towards the SEBB Program. It was very good.

Cade Walker: I would also add that I think Dave did a great job encapsulating all the work the Board has done over the last 18 months and condensed that down into a very good presentation. Dave's and Mr. Lewis' comments were well received by the committee.

Slide 5 – PEBB Program Impact Bills. House Bill 1085 concerns the reduction in the Medicare eligibility retiree participants in the PEBB Program. This bill flips the funding mechanism for the retiree subsidy.

House Bill 1220 and its companion bill, Senate Bill 5275, adds a non-voting representative from the Office of the Insurance Commissioner to the PEB Board in replacement of the K-12 non-voting member that will be leaving the Board due to the creation of the SEBB Program.

We're tracking both of those bills closely as the impacts to the PEBB Program would be significant.

Dave Iseminger: We bring you impacts to both programs because it gives you a sense of the types of things the Legislature does within these programs. Even if it doesn't directly relate to you, it's conceptually the types of things the Legislature could do to the SEBB Program.

Cade Walker: Slide 6 - Senate Bill 5335 is paying state retiree benefits until the end of the month in which the retiree beneficiary dies. This bill would do a great service to our retiree population where an individual retiree passes, the benefit is paid out to the end of the month in which they pass. It eases a workflow issue because monthly premiums are not prorated for benefits. By allowing the retiree pension payment to be made to the end of the month in which the individual passes, HCA would have fewer issues getting premiums for the last month of coverage and there would be no gap in coverage for the time of death for the individual. We support this bill.

Dave Iseminger: This bill is Department of Retirement System (DRS) request legislation.

Pete Cutler: I'm glad to hear it's a DRS request legislation. I used to be a Legal Legislative Affairs Manager. We tried to pass this in the 1990s. The actuary's office reaction was it has a very significant fiscal impact on the pension funds. We ran into a

very big brick wall very quickly in trying to get it passed. But it makes a lot of sense. It's very, very messy to do. A lot of times people don't understand their insurance has been canceled. The last month of their life, the person who died had very expensive care that everybody thought was covered by an insurance policy. It turned out their coverage was retroactively eliminated because they didn't have enough in their last pension payment to cover their medical premiums. So, I'm very glad to hear DRS is pushing it. I wish you all the best of luck going forward.

Cade Walker: We're tracking this bill as well. We do appreciate the impact it has on our members.

Slide 7 – ERB Impact Bills. These bills don't impact solely the PEBB or SEBB Programs' populations, but impact the health insurance industry more broadly.

House Bill 1065/Senate Bill 5031 protects consumers from charges for out-of-network healthcare services. House Bill 1215, a closely related bill, addresses concerns about out-of-network and balance billing. You may have heard some of this in the news about balance billing, which is where a member goes to an out-of-network provider, or often times they're in an emergency situation. They have surgery and the anesthesiologist, or the lab, or the radiology tech is actually an out-of-network provider. They get paid the out-of-network rate by the carrier. The additional moneys the provider bills for gets transferred to the member. They're expected to pay the additional costs that are incurred for the services provided. These bills attempt to address that problem.

Lou McDermott: Cade, who are they expecting to make the balance of the payment? Is it the carrier or the provider?

Cade Walker: It depends. One bill has the out-of-network provider absorbing the cost and another bill provides a mechanism for determining some solution between the carrier and the provider that provides for arbitration-style proceedings for them to negotiate the rates they would get paid.

Pete Cutler: Are either of these Office of Insurance Commissioner request bills?

Dave Iseminger: I want to correct myself that when I said SB 5335 was DRS request legislation, it's actually LEOFF Plan Two Retirement Board request legislation. So, before I change my screen and look up this one, I wanted to correct the record. As Cade goes forward, I will give you insight as to whether these are request legislation from the OIC.

Cade Walker: I believe one of them is. I believe the one that leaves the onus of the balance billing on the provider is not from OIC. But I will let Dave confirm.

Dave Iseminger: I can already confirm that. HB 1065 and SB 5031 are OIC request legislation. HB 1215 is not.

Cade Walker: House Bill 1074 and Senate Bill 5057 raise the age for purchasing tobacco products, including vapor products, from 18 years of age to 21 years of age. While we don't see this having an immediate impact on the program, we note that it is a

significant bill that has a lot of other implications that could impact our smoking cessation programs, as well as the tobacco surcharges that are assessed in the PEBB and SEBB Programs. We are keeping an eye on these. They had a hearing earlier this week and we anticipate seeing more action in the coming weeks.

Dave Iseminger: That is Attorney General's Office (AGO) and Department of Health (DOH) agency request legislation. We'll add who is requesting the legislation in the future.

Cade Walker: Slide 8 – House Bill 1099 requires providing notice about network adequacy to consumers. This comes about because of mental health issues and having accessibility to mental health providers. The bill requires carriers to list the adequacy of their networks for all carrier types, as well as listing the wait times to see those providers, to give members an idea of the provider types that are going to be a little harder to get into. The hope is to address mental health provider adequacy issues and ensure the ability to get in to see a mental health provider. Though that's not called out specifically in the bill, we understand that is one impetus of this bill.

Lou McDermott: Cade, I want to jump back real quick. When you said implications of age 21 for our smoking cessation program, if it becomes 21, does that mean someone under 21 would no longer be eligible to take our smoking cessation program because, legally, they're not supposed to be allowed to purchase the tobacco?

Cade Walker: I don't believe so, but I can get back to you on that. I think I'm confusing an aspect of the tobacco surcharge, which is for 13 years of age and above.

Lou McDermott: Okay, because I think we know that probably there would be people between the ages of 18 and 21 who might acquire cigarettes anyway, or vaping, or whatever it is.

Dave Iseminger: The other piece to keep in mind is I'm sure you all remember Policy Resolutions SEBB 2018-16, SEBB 2018-17, SEBB 2018-18, and SEBB 2018-19 that you passed. Those related to the tobacco surcharge attestation, the definition of tobacco products, and the definition of tobacco product use. The vapor products are not included within that definition at this point. We have been tracking how the state is regulating vapor products in various forms. At some point, if they are similar enough to tobacco products, there may be a day when we come back to the Board to talk about whether those should be included within the tobacco surcharge. That's another reason we are very heavily tracking vapor product bills to see how the regulatory environment changes for other parts of state government. At some point, it may be relevant for this Board to revisit that definition.

Pete Cutler: For House Bill 1099, would the new notice requirements about network adequacy apply to the carriers and the Uniform Medical Plan or self-insured, self-funded plans offered by SEBB and PEBB?

Cade Walker: I don't believe there was a carve out differentiating between fully insured and self-insured. I think it is blanket, "all carriers must post this information on network adequacy."

Pete Cutler: I'd be curious to hear how it would impact the SEBB Program. Actually, I have a family member who's had, in a different state, a very frustrating time with finding all sorts of providers who are listed by the insurance plan as in their network, a great majority of the ones she's contacted aren't taking new patients. Trying to define who's in your network, at least in some states, is a big difference between the names listed as in the network versus the names of people who actually will take a patient. It'd be interested to know whether that issue is dealt with in this bill.

Dave Iseminger: I can tell you for sure that it would address all the fully insured products. The regular question that we have to always confirm is whether it applies to the Uniform Medical Plan as a self-insured product. But it would definitively apply to fully insured products in both the PEBB and SEBB Programs.

Cade Walker: House Bill 1132 and Senate Bill 5178 affect the TRS and SERS plans. It lowers the age from 62 to 60 for early retirement options without penalty where members have accumulated 30 service years of work and still places the same restrictions.

Pharmacy 101: Part 2 PEBB Uniform Medical Plan & K-12 Experience

Molly Christie, Strategic Plan Project Manager, Benefit Strategy and Design Section, Employees and Retirees Benefits Division.

Ryan Pistoresi, Assistant Chief Pharmacy Officer, Clinical Quality and Care Transformation Division.

Molly Christie: Today's presentation is the second in the Pharmacy 101 series. I am providing background on the PEBB Program Uniform Medical Plan trends in pharmacy and talking about available K-12 data and their pharmacy experience. I previously presented on national trends in pharmacy. I discussed how population demographics are influencing prescription drug utilization, how the specialty drug trend is driving growth in prescription spending, and how drug companies are spending more money on advertising than on research and development to ensure brand loyalty over generics.

Chair McDermott, you asked a question about Slide 4 in the last presentation dealing with national utilization and the statistics from the Kaiser Family Foundation health tracking poll. There was a pretty shocking statistic that one in four Americans take four or more prescription drugs. Those statistics were not including children, just adults aged 18 and over.

Today we'll be using Uniform Medical Plan and available K-12 data to discuss pharmacy trends and drivers. I'll also be looking at basic components of commercial pharmacy benefit plans. As we saw nationally, pharmacy is a big and growing contributor to overall medical benefit spend. This holds true for PEBB Program UMP as well.

Slide 4 – Uniform Medical Plan (PEBB) Pharmacy Trends. In the upper left-hand corner, we're looking at UMP Classic non-Medicare. Between 2012 and 2017, there has been a 66% increase in pharmacy bid rates. It's growing.

The bottom left-hand corner is dramatic and represents PEBB UMP Classic Medicare bid rates from 2012 through 2019. When we received this information, it was projected. I'm bringing this to you, not because PEBB Medicare is within the SEB Board's authority, but because it has been a major topic of conversation in the past few years for the PEB Board. The graph is quite dramatic. In 2018, over 60% of the medical bid rate was attributed to pharmacy. In the next part of the series, I will be discussing policy levers to address pharmacy trend. There are a lot of interesting things being proposed for Medicare to try and address drug trend. As we go forward, please keep in mind that, when I'm talking about PEBB UMP pharmacy trends, they do include Medicare rates. It's all built in. It's the UMP Classic, Consumer Directed Health Plan (CDHP), the Affordable Care Plan (ACP) plans, as well as classic Medicare.

Slide 5 – Total Spending. Looking at total spending on pharmacy, it's become a larger component of the medical benefit cost. This slide shows total allowed spending, including what the plan pays, what the member pays, and what their cost share is or their contribution. This is for pharmacy for PEBB UMP from 2010 through 2017. Spending has steadily increased, at some points, more rapid than others. This is influenced by how many people are using drugs, how much they're using them, what kinds of drugs they're using, and how much those drugs cost. Specialty drugs have become the largest driver of prescription spending for PEBB UMP.

Slide 6 – Member Cost Share. This slide is broken down by what's paid by the plan and what's paid by the member. The green shows what the member paid. The orange trend line shows that member cost share has been decreasing as a proportion of total spending over time as the plan total spending has increased. The plan is picking up more of that cost mainly because the share that UMP members pay over time, since 2010, hasn't changed significantly. Co-pays, co-insurance, they haven't changed to offset the trend in increasing drug costs and increasing drug spending. Most of that's being borne by the plan. There is a relationship between premiums and total spending. As the total spending goes up, member cost share goes down. There is a give and take where premiums are likely to go up because that money needs to be paid by someone in some way. This is in regards to the self-insured plan.

Pete Cutler: It appears to me that, in addition to the percentage drop, which you note is driven largely just by the fact that the total pharmacy spend is going up in the amount being paid by employees or members is relatively flat. It actually looks like between 2010 and 2017, there's been a slight decrease in terms of absolute dollars because a lot of times, people will say the percentage increase is too much. But it looks like actually, in terms of actual dollars spent out of pocket by members, that's done even a little bit better than average, at least compared to 2010.

Molly Christie: It has. It's an interesting dynamic. Later we'll look at our pharmacy benefit in tiers. But there is a maximum out of pocket for each of those tiers. There is a cap for how much you'll spend per month. What we've seen is that members have been reaching that cap more quickly because drug costs have gone up. It's possible that an individual member has been paying more out of pocket because they've reached that cap, whereas before, they were paying a co-insurance, a percentage of their prescription, which was lower than that cap. But it is possible, too, that other people are paying less in total dollars.

Ryan Pistoresi: One of the reasons that you're actually seeing some of that total dollar amount go down is because some brands become generic. When brands become generic, we often will have the generics at a lower cost share because it's more affordable to the plan and at a lower cost. Because they've been paying at that Tier 2 cap, which is $75, and the generic comes out at Tier 1, now they're paying at a max $25. As a lot of these brands are becoming generic over the years, we're actually seeing patients transition from the brand names to the generics, which certainly helps both the member and the plan.

Dave Iseminger: Are there any prominent examples from the last five to seven years of a drug that might represent one that's heavily utilized that embodies the point you're making?

Ryan Pistoresi: Yes, the Statin medication Atorvastatin, (which was brand name Lipitor) or Rosuvastatin, (which was brand name Crestor). Those were very big blockbuster, $12 billion a year drugs in the early part of this decade that have since become generic and have become very affordable for members and plans.

Pete Cutler: I was going to say, from a policy point of view, it sounds like that's a sign of success of a tiered premium structure that there are incentives for people to choose a lower price alternative and it's actually saving them money. The theory is being born out in practice, at least with those aspects.

Lou McDermott: I'd like you to speak to this. One of the issues is that, if they're using a brand name medication, sometimes they're getting coupons from the manufacturer to offset their cost share to zero. If they were to go to the generic, it actually would cost them more money to go to the generic. The insurance company, basically, is footing the bill. That's the dynamic we've been running into.

Molly Christie: Absolutely. If you look at the top drug classes, for specialty for PEBB UMP, which we're going to look at later, cholesterol medications, statins, are still in the top specialty drug classes. I think it probably plays into some of what you're talking about with co-pay coupons.

Lou McDermott: At the end of the day, even the fact that the member cost share is level; of the increase, because of the 85/15 split, I assume the member is actually bearing the increase of those pharmaceutical costs within their premium structure.

Molly Christie: Exactly.

Lou McDermott: It's hitting them less, but still hitting them, just in a different way.

Dave Iseminger: At the end of last month's presentation, there were illustrations of the manufacturer coupon phenomenon. I would just point Board Members back to the last meeting's materials if you want a refresh on additional examples.

Lou McDermott: One more point. The retirees are feeling more of the impact because they're carrying 100% of the increases within their premium structure. With active employees, 85% is borne by the state and 15% by the employees. The retirees feel the

full impact. All of these pharmacy expenses get translated into member premium for retirees, the population who needs the most relief.

Dave Iseminger: Additionally, once you're Medicare eligible, UMP Classic pays primary on pharmacy and Medicare pays secondary, whereas for medical, Medicare pays primary and UMP pays secondary. It also has a disproportionate impact because of that relationship.

Molly Christie: Slide 7 – Why is Uniform Medical Plan (PEBB) Pharmacy Spending Rising? Components of drug trend include utilization, like the number of people using prescription drugs, how much they're using them, and the drug cost. This is the actual expense incurred to pay for those drugs. Drug Mix is the types of medications being used. Are they brand, specialty, or generic? How are people switching between those? Changes to one or more of these components can impact overall drug trend and volatility. When a new expensive specialty drug reaches the market, pharmacy spending can increase. Sometimes it's dramatic, sometimes it's not. As patients switch to these new drugs, the drug mix changes. Often, specialty drugs are treating very rare conditions that impact cost. Spending can be low if that drug is treating a small number of people. However, in 2014 and 2015 when the cure for Hepatitis C came out, it had immense impacts on cost because Hepatitis C is relatively prevalent in the US. There are 2.4 million cases nationally in a single year of people living with the disease. That's a lot to pay for when a drug costs over $100,000.

Other forces within the prescription drug market can also affect the cost and price of medications. You can have price increases for existing brand drugs. You can have patent expiration so you get new generics that come on the market. There are also off-invoice discounts and rebates. The point being, it can be very difficult. Predicting trend and making decisions on that trend is difficult because all of these things work together and converge in ways that can be very surprising and causes volatility.

Utilization rates for PEBB UMP have remained relatively stable in recent years. Slide 8 shows discrete prescriptions per 1,000 members per year since 2010. It's a little misleading because the orange line at the bottom looks flat. It looks flat because there are so few prescriptions compared to brands and generics. In reality, from 2010, we had 79.9 prescriptions per 1,000 members per year, and that jumped up to 130.6 in 2017. That is a 63% increase. There is a change in the drug mix. More people are switching to specialty drugs, or using new specialty drugs, as they come on the market. That's what's driving this spend.

Consistent with national trends, PEBB UMP spending has been affected by extremely pricey specialty drugs. Slide 9 shows plan paid only spending. It doesn't include member cost share. It has per member per year on prescription drugs from 2010 through 2017 broken down by specialty, brand, and generic. Total plan spending has increased substantially, most of which is due to the specialty drugs shown in the gold area. As of 2017, specialty is the largest component, at 53.5%.

Dave Iseminger: You are hearing correctly. A very small percentage of the prescriptions are driving over half the cost. It's less than one half of one percent driving over 50% of the cost. That is, in fact, what we're saying.

Molly Christie: Slide 10 – Drug Mix, illustrates that point. These charts show that specialty medicines account for a small percentage of prescriptions, but they represent the majority of total spending. On the left of the slide is drug mix as a percentage of total prescription, looking at utilization. In 2017, 0.38% of prescriptions were specialty, but that's 53.5% of the cost to members and the plan.

Drug mix is about patients switching to specialty, so there are situations where you'll be properly controlled. You'll have a condition that's controlled on brand or generic medication A. A new specialty drug comes out, specialty drug B. You switch to that drug and that's what's driving a lot of this change. It's by no means saying that the specialty drugs are not curing disease, but it is at a cost to the system.

Slide 11 – Top 5 Therapeutic Classes in 2018. Specialty medicines are more likely to treat very complex or rare diseases. This is reflected in the top traditional versus specialty therapeutic classes by utilization for PEBB UMP. The top traditional drugs are treating higher prevalence for more chronic conditions, such as depression, high blood pressure, high cholesterol, diabetes, and pain. Specialty medications, in contrast, are often treating things like auto-immune inflammatory diseases, tumors, neurological diseases, and endocrine or hormone issues.

Slide 12 – What do we know about the K-12 pharmacy experience? I've been talking about PEBB UMP. How will the K-12 pharmacy experience and this population use its pharmacy benefits? We've been working with Milliman to gather available pharmacy data provided by some K-12 carriers. We've completed some initial analysis for plan year 2017.

The data is very limited, but it does provide a few takeaways on utilization and top drugs or drug classes. The data isn't comprehensive. We don't have information on spouses and dependents or on new people that will be eligible under the SEBB Program that are not currently on benefits. It doesn't include people currently enrolled in the PEBB Program. We've not been able to independently validate the data and some of it appears inaccurate or incomplete. For some carriers, certain analyses have excluded some carrier data and there is a lot of variation in pharmacy benefit design across plans. Even within the same carrier they'll have multiple plans, each with a different tier structure, different formulary. All of that impacts the drivers of drug trend. Unfortunately, there's no standard plan that we can use to compare it to PEBB UMP.

Pete Cutler: Am I correct that this data is purely for active employees? We're not including any of the early retirees? The PEBB data, would that include both active employees and the non-Medicare retirees that are in the pool?

Molly Christie: Correct.

Wayne Leonard: I'm looking at page 11 and maybe I'm misunderstanding this slide. The numbers on the right-hand side are prescriptions per 1,000 members. So, for every 1,000 members, there's 1,100 prescriptions for antidepressants?

Molly Christie: They're discrete prescriptions. They're unique prescriptions. Some members might have multiple.

Wayne Leonard: Multiple. Wow. Okay.

Molly Christie: Slide 13 – K-12 Pharmacy Utilization Plan Year 2017. The first takeaway from the K-12 data is we know that K-12 employees use their pharmacy benefits. It appears that a similar percentage were prescribed a medication in 2017 as folks under PEBB UMP. I've provided some different ways to look at this. You can see utilization percent. You can see average prescriptions per user. They're all pretty similar. I'd like to emphasize that PEBB UMP data has Medicare retirees included. K-12 data doesn't have spouses and dependents. It's an illustration and we see they're similar. These numbers will change as we learn more about the new SEBB population.

Slides 4 and 5 show similarities between PEBB UMP and K-12 in terms of the top traditional drug classes. Again, they're treating chronic or common conditions. We had a list of medications of drugs, but they weren't organized into drug classes. Plans, carriers, pharmacy benefit managers, they use different ways to classify drugs into different drug classes. PEBB UMP has their own way, too.

We looked at 1,000 drugs that HCA tracks for PEBB UMP and applied the drug classes that we use for PEBB UMP to the drug list that we had for K-12. There are drugs that are left off, but it gives us a good idea of what we're tracking and what the big bucket items are. Three out of five of these top traditional drug classes, antidepressants, opioid pain medications, and cholesterol medications appear on the top five traditional drug classes for PEBB UMP, also. The same goes for specialty therapeutic classes. Similar to PEBB UMP and national trends, these top classes treat rare conditions. Four out of five are identical to PEBB UMP and are treating things like autoimmune inflammatory conditions, tumors, psychotherapeutic, and neurological agents.

Slide 16 - What does this all mean for the SEB Board? HCA reviews and analyzes this type of pharmacy data to better understand and manage the UMP pharmacy benefit. If we identify a new opportunity or strategy for that benefit, such as changes to the tiering structure or to the formulary, we'll bring it to the Board for action.

Slide 17 – Pharmacy Benefit Tiers. Pharmacy benefit tiers tell the member how much they are responsible for the cost of a drug when they go to the pharmacy. Each tier represents a group of drugs classified according to cost. Lower tiers have less expensive drugs so you have a lower member cost share. There's no standardization in the tiering structure across plans. Some plans have two tiers, a generic and a brand. Some plans have five or more tiers, and not all of those tiers have the same drugs in them or the same cost share, necessarily. There's a lot of variation. Plans try to use this as a lever to get patients to use less expensive drugs or generic alternatives.

Slide 18 – Why do health plans use tiers? There was a study that looked at health consumer sensitivity to the cost share published in the New England Journal of Medicine. Researchers found the use of health services will decrease as cost sharing increases and vice versa. The more you have to pay as a patient when you receive a service or when you pick up your prescription, the less likely you are to use it. The same is true, the more likely you are to use it if it's less expensive. An example of this is a plan putting cost effective drugs in a value tier or in a zero-pay tier to encourage people to use those drugs. The Affordable Care Act did that with contraceptives and

with vaccines so people would get them. The wanted to avoid barriers so people could get the necessary preventive care.

Slide 19 – Pharmacy Benefit Tiers – Uniform Medical Plan Achieve 2. The Uniform Medical Plan (UMP) has a tiering structure consistent with these principles. The Preventive Tier includes vaccines, contraceptives, and other drugs that are required at no cost share by the Affordable Care Act. It also includes drugs recommended by the US Preventive Services Task Force. The Value Tier includes high utilization drugs that usually have generic alternatives, but treat chronic conditions like diabetes, high cholesterol, high blood pressure, depression. Tier 1 drugs are primarily low-cost generics. Tier 2 are preferred brand name drugs and high cost generics. Tier 3 are non-preferred drugs, the specialty and non-preferred brand drugs, the very high-cost drugs.

All Tiers have a maximum out-of-pocket cost. For Tier 3, there's only a maximum out-of-pocket cost for specialty drugs, not if it's a Tier 3 non-preferred brand drug. At that point, you're paying a 50% co-insurance. There's no cap on that until you reach your plan cap for your pharmacy benefit.

Slide 20 – Prescription Drug Formulary. A formulary is another major component of the pharmacy benefit structure and lists drugs covered by a health plan. There are different ways to structure a formulary. It can be Open to include all medications with some preferred that are less expensive and placed in Tiers in different ways to influence utilization. A Closed Formulary includes only drugs listed in that formulary. It's not covered by the plan if it's not on the list and the member would pay the full share. There is a Hybrid Formulary that combines both concepts.

Which drugs are included in a formulary usually depends on how well they work under controlled conditions like a clinical study and how cost effective they are in terms of risk; on cost effectiveness compared to alternatives, if there are generics available; and whether there are special discounts. Rebates are discounts for plans, not discounts for patients. Plans can negotiate special discounts for certain drugs or drug classes that are very competitive. They get money back from the manufacturer for those drugs.

Slide 21 – Uniform Medical Plan Preferred Drug List. All Uniform Medical Plans under both the PEBB Program and SEBB Program use the same Open Formulary, but we do have a Preferred Drug List (PDL) that includes certain medications at a lower cost share. Drugs are chosen for the PDL based on safety efficacy and effectiveness. We comply with recommendations made by the Washington State Pharmacy and Therapeutics Committee. We also review coverage recommendations made by the Washington Prescription Services P&T Committee. These teams are health care professionals that include physicians and pharmacists that evaluate how drugs are used. They monitor and report adverse drug events and approve guidelines for medication adherence and management. P&T Committees also manage formularies and they authorize or restrict new drugs for clinical use.

Dave Iseminger: As a reminder, the state has this P&T Committee because the Health Care Authority isn't the only entity that does state purchased health care. There is

workers compensation and several other significant programs. The state tries to align different aspects of the formulary across the state programs.

Molly Christie: Slide 22 – Pharmacy Benefit Challenges for Health Plans. Health plans do face challenges when making decisions about how to structure a pharmacy benefit, the tiers, the formulary. Three important aspects to consider are: 1) ensuring access to medically necessary medications when determining what drugs to cover on a formulary, particularly if you have a closed formulary; 2) protecting affordability, who pays when there are high cost members; and 3) adherence, do members adhere to their prescribed medication regimens, because that's the goal.

When protecting affordability, do the plans increase the individual member cost share so the person using high cost drugs ends up paying more? Do you spread risk through premiums? Do you keep the coinsurance low and then spread the risk?

We want to make sure that people that have high cost chronic medications are able to afford those and that they're not going to be rationing their drugs or that they're not going to discontinue use because they can't afford them.

Slide 23 – Key Takeaways. Three things I hope you take away today are: 1) pharmacy is a significant component of the PEBB Program UMP spending and it can impact member premiums; 2) K-12 pharmacy data is limited, but it does suggest a huge divergence from PEBB UMP trends for utilization and top drug classes; and 3) tiers and formularies are used by health plans to ensure appropriate access to medically necessary medications, to promote adherence, and to hold down costs.

Pete Cutler: This is a lot of really great information. Going back to Slide 22 where it mentions balancing the challenges of providing access, affordability, and promoting adherence, I'm curious. Frankly, when I worked in the field, it was only access and affordability on our radar screen. I think adherence is really important. It makes a lot of sense. Giving somebody a prescription, but then not having them actually follow it or take it is not working in the right direction. What is done to track how a plan design is evaluated, for determining whether it promotes good adherence?

Ryan Pistoresi: Adherence is a newer phenomenon in health care management because the plan is starting to step into patient care and monitor how the patients are using their drugs. Are there side effects? Are they having issues using the medication or understanding it? It's a service specialty pharmacies are starting to do because when a plan is paying for a drug that costs $10,000 or $50,000 a month, they want to make sure that drug is achieving the outcome they're paying for. If they're paying for a medication and not getting the desired effect, it's not cost effective or valuable to the plans. The specialty pharmacies will call the member and work with them. They'll coordinate between their provider and the pharmacy, or their provider and other services, if they're getting infusions at certain other sites. They take a proactive approach to make sure the medications are working.

In the traditional side, they also do analyses to see if patients are filling the medications on time. If not, are there opportunities for them to reach out and learn why they're not taking it? An example could be they have more at home and don't necessarily need to

fill it, or they're having other challenges or side effects. It's helping to determine if these are the best medications for those members.

Pete Cutler: From what you've said, it sounds like the primary focus and initial focus was with specialty drugs. We have a very high cost and if something is not being used or it's not having the desired result, you don't want to continue paying for it for multiple months if it's not really having the desired intervention and impact. But it sounds like now there's also some expanding into looking at whether, for non-specialty drugs, there are signs that can be traced in terms of whether refills are being done on what would be the expected pattern.

Ryan Pistoresi: Yes, that is correct.

Dave Iseminger: As an anecdote on the non-payer side of things, my partner is a pharmacist at one of the local major hospital systems. There's regular conversation we talk about at dinner sometimes, not in a HIPAA issue way, but in an "I can't believe I had to have this conversation again," highlighting the role of pharmacists in helping a patient manage care. A doctor doesn't necessarily know the general insurance plans that the patients have. He'll often get some prescription to fill or review, and he'll call the doctor to discuss options. Is she aware that the drug prescribed generally has a $500-$600 out-of-pocket cost share for most insurance plans? He provides information on a drug with the same mechanism of action to achieve the same results that would be more in the $10 to $15 per month range. Ultimately, that's what gets prescribed. That's just another anecdote of how some providers may be helping with the affordability/adherence side of the equation.

Policy Resolutions

Barb Scott, ERB Division Policy, Rules, and Compliance Section Manager. Today we are asking you to take action on two policy resolutions, SEBB 2018-57 - Maximum number of months that self-pay coverage is allowed and SEBB 2018-58 - Continuation coverage for dependents not eligible under SEBB.
Policy Resolution SEBB 2018-57 will allow an employee to continue enrollment in SEBB Program benefits on a self-paid basis for a maximum of 29 months while on an approved leave of absence. The 29 months would include the number of months allowed under COBRA. We did send this out to stakeholders and the stakeholder comments we received back supported the resolution as it is written.

Lou McDermott: **Policy Resolution SEBB-2018-57 – Maximum number of months that self-pay coverage is allowed.**

Resolved that, the maximum number of months that a school employee may continue SEBB benefits during an approved leave of absence, by self-paying the premium and applicable premium surcharges, will be 29 months.

The 29 months a school employee may self-pay for coverage under this provision includes the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA).

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-57 passes.

Barb Scott: Proposed Policy Resolution SEBB 2018-58 will allow those domestic partners who are not state-registered domestic partners and their children to enroll in SEBB Program coverage on a self-pay basis for a maximum of 36 months as school employees transition from school district coverage to SEBB Program coverage. The policy is being brought to the Board because COBRA defines qualified beneficiary as the covered employee, a federally recognized spouse of a covered employee, or the federally recognized dependent child of a covered employee. Federal law does not recognize domestic partners.

Two stakeholders supported the resolution as presented. Another stakeholder supported it with concerns related to the anticipated cost of the coverage. The resolution in front of you today includes corrections made from the December Board Meeting. The resolution presented to you on December 13 is in the Appendix.

Dave Iseminger: We realized when we presented it in December that the opening clause needed to refer to the phrase "dependent" rather than specified to spouse or state-registered domestic partner. We highlighted it at the meeting so the final version before you on Slide 5 is reflective of what we said on December 13. You had questions about cost and Kim's here to try to answer that question.

Kim Wallace: Pete Cutler asked a question at the last meeting about how the costs associated with the COBRA covered individuals under the PEBB Program compare to the costs of active employees. We did some analysis and I have data points I will share for 2015, 2016, and 2017. There is a relationship that's pretty steady. In 2016 and 2017, essentially we saw two times the paid per member per month (PMPM) cost for COBRA covered individuals compared to their active counterparts. In a paid PMPM dollar figure, in 2017, we are talking about $408 paid PMPM versus $929. Those numbers are actually across UMP and the fully insured carriers. The pattern we see, the two times in 2016 and 2017, is consistent whether we looked at UMP or at the fully insured carriers. Interestingly, in 2015, there was a three times relationship. Again, that was a consistent pattern regardless of which carrier was enrolling the members.

When we think about the two times and the three times relationship, it's important to remember the COBRA population is a very small number of people, both in terms of what kind of cost that generates, but also volatility that is present. Without going into detail, we did see a fair amount of volatility, especially when you looked by age band. My understanding is that, based on this policy, individuals potentially enrolling under continuation coverage are potentially all ages.

Barb Scott: Yes, because it includes the domestic partner who would lose eligibility, as well as their children.

Kim Wallace: The data I am sharing with you includes all ages as well.

Dave Iseminger: As additional context for the Board, when Kim says it's a relatively small population, on the PEBB Program side, there's about 385,000 covered lives. The self-paid population for COBRA and leave without pay is between 1,000 and 1,100. It is a very small percentage of the entire population in the PEBB Program.

Pete Cutler: That was very helpful. The point is, it is definitely a benefit. Nobody should misconstrue that the COBRA premium is covering the costs. It's not like a self-pay where they 100% cover, on average, 100% of the cost. It's definitely subsidized by the larger pool. But, on the other hand, given the small number of individuals who elect the coverage, and I'm sure that has to do with its cost, it's not a significant impact in terms of the overall rate. I am curious. David, you just mentioned that domestic partners who are no longer eligible. Under SEBB Program rules, they would be able to continue coverage. Would that be under 2018-58 because 2018-58 seems to be very clear about it only applies to dependents.

Barb Scott: This policy is mainly capturing a population that includes domestic partners who are not state-registered domestic partners currently covered under district plans, as well as their children. The majority of these are domestic partners losing coverage based on the Board's earlier decision on dependent eligibility for the SEBB Program being limited to state-registered domestic partners.

The original slide was accidentally edited to include state-registered domestic partners. This population is not going to be your state-registered domestic partners because they're eligible under the SEBB Program. You'll start to see this idea in additional resolutions that Rob Parkman will be introducing to you later. We're starting to shift to dealing with some of the policy decisions that are needed to address the transition from district plans and to the SEBB Program, specifically dealing with the population not eligible under federal law. The only way they're going to be eligible is through the Board passing a policy resolution and extending that eligibility to them, which is within your authority to decide.

Terri House: Do you know how many families, roughly, this will affect?

Barb Scott: No. We received no SEBB data as far as how many domestic partners are enrolled within district plans today.

Wayne Leonard: If I recall, it may have been the first thing we took action on, the state-registered domestic partner issue. During that discussion, our current plans were more lenient in the definition. There was quite a bit of discussion on why we couldn't just keep the more lenient definition. What we were told, if I recall correctly, is because it had to meet the definition of state law and the state law was very specific on the definition of a state-registered domestic partner.

Barb Scott: When the Board made a decision on that particular policy resolution, we talked about the recommendation we brought forward that dependent include legal spouse and state-registered domestic partner. That's consistent with what the PEB Board has done. Pension system extends survivorship pension benefits to state-registered domestic partners, not to other domestic partners. State law has a process, as well as other states, for registering domestic partners. That was easier to look at,

administer against, and consistent with what we're seeing in other places. We also said, though, that the Board could come back and relook at dependent eligibility and maybe change it in the future if that was something you were interested in.

Dave Iseminger: Wayne, that was Policy Resolution SEBB 2018-01. We were making a recommendation for what the ongoing permanent rules should be. You can think of this as a transition relief rule. There are always risks with every decision. Having a permanent standard that aligns with state law is desirable, acknowledging at the same time, this is an opportunity for transition relief that balances some risks.

Wayne Leonard: Okay, I guess that's what I'm trying to clarify in my mind. This policy will allow us to not follow the law for three years? Or as we transition to a new program?

Barb Scott: It's not that there was a law in place that necessarily prohibited the Board from establishing eligibility that was more generous than state-registered domestic partnerships. We did not recommend that because there were so many different eligibilities that existed within the school districts. It would have been administratively difficult. We knew the state-registered domestic partnership eligibility that passed fit into alignment with other things a little better.

Dave Iseminger: Don't forget about the financial question. Under the permanent rule, Policy Resolution SEBB 2018-01, the funding structure is taken into account in the tiering structure of what's subsidized with employer funds. This is a complete self-pay basis. There are those financial implications. You'll remember that on Policy Resolution SEBB 2018-01, we talked about the underlying assumptions that are built into financial modeling, the parity with the PEBB Program, and that opening the door to a wider eligibility was not something that had been envisioned in the legislative process. This is a way that, on a self-pay basis, individuals could have eligibility for a short while. That's another big difference.

Wayne Leonard: For the self-pay, there would be no impact to the state or the SEBB plan?

Dave Iseminger: I think that goes back to Pete's question that there are implications here; but given the size of the population and what's charged in COBRA, there is some implication, but not significant.

Lou McDermott: They're benefitting from the risk pool. It isn't going to be calculated based on the thousand. It'll be calculated based on the total pool population.

Wayne Leonard: And the 36-month time period, is that to get those people from 62 to 65 that might not have been? Where did the 36-month time period come from?

Barb Scott: The 36-month time period actually comes from the COBRA regulation itself. If a federally recognized dependent loses coverage under a covered employee, that loss of coverage is triggered by the event of a divorce or the event of a child reaching the age limit under the plan, age 26, then that dependent is eligible under federal law for 36 months of COBRA coverage. The 36 months you're seeing here

aligns to that. These domestic partners and their children will lose eligibility as of December 31, 2019 and this will give them the equal number of months they would get if they lost eligibility based on a dissolution, a divorce, or a child aging out on that same date.

Dave Iseminger: It's aligned to COBRA and it will help with the administration of it. It's basically treating these individuals as if COBRA recognized them.

Wayne Leonard: Okay, thanks for that.

Barb Scott: The other thing it will do is allow them to have access to coverage as they figure out what to do after the 36 months.

Lou McDermott: **Policy Resolution SEBB 2018-58 - Continuation coverage for dependents not eligible under the SEBB Program**

Resolved that, a dependent of a SEBB eligible school employee who is enrolled in medical, dental, or vision under a school employee's account on December 31, 2019 who loses eligibility because they are not an eligible dependent under the SEBB Program may enroll in medical, dental, and vision for a maximum of 36 months on a self-pay basis.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-58 passes.

Wellness Program

Justin Hahn, Washington Wellness Program Manager, Benefits Strategy and Design Section, Employees and Retirees Benefits Division. At the December 2018 SEB Board Meeting, I presented detailed information about the SmartHealth health and wellness portal, an implementation plan, and two draft resolutions. One resolution was the incentive deadline. The second resolution was whether a spouse or state-registered domestic partner would have access to the SmartHealth portal. In December, the Board had questions for follow up that I'll be addressing before you are asked to vote on the wellness resolutions.

Slide 3 – December 2018 SEB Board Wellness Questions. What is the return on investment for spouse participation in SmartHealth? In general, it is expressed as a comparison of dollars spent on a wellness program, for example, administrative costs, incentives, promotion, vendor costs compared against dollars saved as a result of the wellness program, such as reduced claims costs, reduced absenteeism, reduced health related productivity losses, et cetera. Showing causal return on investment is difficult. It can be expensive to determine and can take years to prove. This is a perennial question that a lot of people struggle with in the wellness universe. That being said, we do have information on the health behavior connection between employees and spouses.

The quote on Slide 3 is from the HERO Employee Health Management Best Practice Scorecard in collaboration with Mercer Annual Report 2012. HERO is a national nonprofit dedicated to identifying and sharing best practices in the field of workplace health and wellbeing. "Health behavior research has found that other individuals and groups can have a profound impact on an individual's behavior, with spouses being key influences. Social support is a predictor not only of initial engagement, but also of long-term success."

Slide 4. In a 2014 Journal of the American Medical Association (JAMA) published study, it says men and women are more likely to make a positive health behavior change if their partner does too, and with stronger effect than if a partner has been consistently healthy in that domain. Involving partners in behavior change interventions may help improve outcomes. Some of the high-level takeaways from this study found that when a spouse or partner participated, nearly half the participants in the study quit smoking, two-thirds became more physically active, and approximately a quarter lost weight.

Slide 5 – SmartHealth Value. I wanted to provide information about the value of SmartHealth and the work we've done with regards to what value it is bringing individuals, employers, and the state of Washington.

We performed a SmartHealth cohort analysis in the PEBB Program. As part of SmartHealth, there's an annual well-being assessment (WBA) that participants in the program take. It is a 200-question survey, takes about 15 to 20 minutes, and covers four life areas. It includes physical, emotional, financial, and work life balance. It's across 34 different dimensions. There are specific areas under those four life areas, such as, exercise and fitness, sleep, managing stress and anxiety, resilience, job satisfaction, and work meaning.

We followed de-identified SmartHealth users who completed the yearly well-being assessment from 2015 through June 2018. To be included, you had to complete the WBA every year. We compared aggregate self-reported scores on the well-being assessment year over year. When we analyze at risk SmartHealth users, they are defined as users who originally rated themselves at risk, which means scoring themselves 3.5 or lower on a five-point scale. When looking at these high-risk SmartHealth users from the beginning, we see an increase in well-being assessment scores from 2015 baseline for all 34 SmartHealth dimensions across well-being, productivity, and health, so across those four life areas with 31 of the 34 dimensions increasing by double digits. This is a broad overview that shows the value SmartHealth brings. This analysis, specifically, shows an increase in self-reported well-being scores from SmartHealth users who have consistently used SmartHealth since 2015.

Pete Cutler: On that last point, my guess is what you're saying is, as a group, all of that entire group of individuals who had scored 3.5 or lower as an average, the average score for all the 34 dimensions went up but not for each individual.

Justin Hahn: That is correct. It's an average, not every individual.

Pete Cutler: Getting more to the core point, I admit I wish that the handouts included your opening comments because I think that's really important for a policy making Board in the health care area to keep in mind is that it's very, very difficult to track or measure a return on investment in health promotion activities. It's just not an easy thing to do. I think that's really the core question.

From my prior career background, my reaction to the information from these various studies is that none of them get to the question of does including spouses as eligible to sign up on SmartHealth, does that cause greater engagement of those spouses. I can say, from my personal experience, my engagement with SmartHealth triggered me doing more activities, my wife got interested, and we did do it together. But she's not taken me up on any offer to go on the SmartHealth website herself. She's happy and motivates me and then we do stuff together.

What I still don't have is any sense that paying to make it possible for several hundred thousand spouses to be part of SmartHealth will make any difference in that engagement, in that spousal support. I don't know that you have any way of measuring that, but that's a concern in terms of is it a good investment. I admit, a part of our dynamic is we're retired. Some of the SmartHealth questions and suggestions are geared towards current employees, in fact, a large amount. But my wife never went on at all so I'm sure that was not what was discouraging her. She just did not feel like she needed that additional motivation. That's a comment rather than a question.

Terri House: Can I answer Pete's question maybe? Currently, we have a wellness portal through our insurance that my husband and I both have to go on to get the discount. We've done that and it has encouraged us to exercise more and diet more together, things like that. We've done it together. So, maybe there is a little something there.

Dave Iseminger: I wanted to add a little bit about the 34 dimensions. Although it's not on the individual basis, it's on an aggregate basis, we do understand from Limeade that we are uniquely, positively special in this regard. They don't have many clients where their aggregate self-reported scores improve on all dimensions.

Justin Hahn: This is looking at a population that was at risk. A population that didn't have high wellness scores to begin with so that, arguably, you could think they would have more room to make up. They did make up that room, which is pretty interesting.

Slide 6 continues with SmartHealth legislative reports. There have been six SmartHealth legislative reports submitted to the Legislature since 2015, the most recent submitted in October 2018. The reports focused on topics such as SmartHealth participation, the SmartHealth cohort analysis, and the positive impact of well-being leadership support. All six legislative reports are at the link on the slide (https://www.hca.wa.gov/about-hca/legislative-reports). It provides a lot more information for instance on the cohort analysis.

Slide 7 responds to another question from the December 2018 SEB Board Meeting. Can the SmartHealth Well-being Assessment and medical provider health assessment be combined? The two assessments have different goals. The WBA, as part of

SmartHealth, is used to assess and address comprehensive well-being strengths, weaknesses, and interests using an online portal. Employers have access to aggregate and de-identified SmartHealth data for their organization. The employer does have, not specific to the individual, but at aggregate level, information about what their employees are doing with SmartHealth, and in regards to the well-being assessment.

A provider health assessment is focused more on preventing and addressing disease with clinical resources. It's also important to note that, if employers were to have access to aggregate data, meaning if these things were combined, if employers can see with SmartHealth, it could negatively affect employee disclosure of health information to the provider and participation in medical care. Sharing a combined assessment between SmartHealth vendor and multiple medical providers would require PEBB Program member releases, as well as data sharing agreements. A combined assessment would be logistically challenging and not supported by the SmartHealth vendor.

Lou McDermott: So, no.

Justin Hahn: Yes, in a nutshell, no.

Pete Cutler: I'll confess, I'm pretty sure I was the one who asked and thank you for the information. That's what I was looking for.

Justin Hahn: Slide 8 - Policy Resolution SEBB 2018-55 – Eligibility for Participation in the SEBB Wellness Program. This policy resolution is for the inclusion of spouse or state-registered domestic partners with regards to accessing SmartHealth as portal only and no financial incentives. We did some stakeholdering and there were general comments of support. There was a comment of concern about funding and a question about how much. There was a response about how much that would be that I talked about at the December 2018 meeting. That was the extent of the stakeholder's feedback.

Dave Iseminger: I want to highlight there's one slight wording change compared to the resolution you saw in December. At the very end, it used to say, "receive an incentive payment." We got some concerns that technically reducing a deductible isn't really a payment. We flipped it around to say a "financial incentive." Substantively the same thing.

Lou McDermott: **Policy Resolution SEBB 2018-55 - Eligibility for Participation in the SEBB Wellness Program**

Resolved that, the spouse or state-registered domestic partner of an eligible school employee may participate in the SEBB Wellness Program activities, but is not eligible to receive a financial incentive.

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

Sean Corry: I intend to vote for the resolution but I'm a little bothered by the response to Pete's question today and in the past. We never really did get to talk about the marginal cost of having this benefit. It comes at a cost to add the dependents, the

spouses, in the program. That comes to a certain dollar amount, PMPM, or however you want to measure it. The savings is what we don't know and I think it's probably a portion, maybe to the good, maybe it's not, but it's probably not a very big number so that's causing me to choose to vote for it this time. But, Pete's question never was answered and I really would like us to consider looking at it in say, a year's time to see what the take up really is and begin measuring what might be some sort of bend in the curve of people who are enrolled. Because it's just a wish, I think, until we get that type of data and are able to make that kind of informed decision. So, that's my request for future work and that's it. Thanks.

Lou McDermott: Thank you, Sean, that's been noted. I do believe, on the PEBB side of the House, there have been many discussions about uptake rates and progress. Some of the legislative reports are trying to get to what are some of the benefits we're seeing. We would expect the same on the SEBB side.

Justin Hahn: Yes, that's correct.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-55 passes.

Justin Hahn: Slide 9 – Policy Resolution SEBB 2018-56 addresses eligibility deadlines. There was one general comment of support from stakeholder feedback. One point of clarity I wanted to make is, though not explicitly written in the first bullet, continuing subscribers will also have a November 30 incentive deadline.

Dave Iseminger: The way to think about this is when an individual elects a benefit during the annual open enrollment in the fall, they are enrolling effective January 1. That ongoing enrollment, or that new plan selection that happens every year, that subscriber is enrolling effective January 1 of the next year. That's how you should understand the first bullet. It's both new subscribers as well as continuing subscribers whose newly elected or continuing benefits have January 1 effective dates.

Lou McDermott: **Policy Resolution SEBB 2018-56 – Deadline for completing wellness activities**

Resolved that, effective January 1, 2020, to receive a School Employees Benefits Board (SEBB) Wellness Incentive in the following plan year, eligible subscribers must complete SEBB Wellness Incentive Program requirements by the following deadline:

- For subscribers enrolling in SEBB medical with an effective date in January through September, the deadline is November 30.

- For subscribers enrolling in SEBB medical with an effective date in October through December, the deadline is December 31.

Terri House moved and Katy Henry seconded a motion to adopt

Pete Cutler: I just want to congratulate HCA and Limeade, or whomever, for being able to get those dates pushed back farther than they have been historically for the PEBB Program.

Voting to Approve: 7*
Voting No: 0

*Sean Corry no longer on the phone. Did not vote.

Lou McDermott: Policy Resolution SEBB-2018-56 passes.

Eligibility and Enrollment Policy Development

Rob Parkman, Policy and Rules Coordinator, Policy, Rules, and Compliance Section, Employees and Retirees Benefits Division, and **Kim Wallace**, Financial Services Division. Today I am introducing seven policy resolutions. The first five deal with a new subsection within RCW 41.05.740. This will be the first time you'll see these kinds of ideas. And then, the last two deal with continuation coverage as we transition to go live.

Slide 3 is language from RCW 41.05.740, which is included to support you connecting the policy decisions we're going to look at to the Board's authority. Most of the eligibility resolutions introduced over the past year deal with satisfying requirements within RCW 41.05.740(6)(d). Today, we'll start to introduce resolutions that will establish terms and conditions, eligibility criteria, and authorized benefits to satisfy the requirements within RCW 41.05.740(6)(e).

Dave Iseminger: I want to highlight the origin of this part of the statute. This topic wasn't in the original legislation passed by the Legislature in 2017 in House Bill 2242. It was added during the legislative process last year in Senate Bill 6241. This subsection was generated to accommodate the ability for local bargaining for employees who do not meet the SEBB Program's eligibility. I want to highlight a nuance - you might think of (6)(d) as "above 630 hours and (6)(e) as below 630 hours." It's not really as simple as that because as this Board refines and expands a little bit of eligibility on the framework of (6)(d), you can't just call them "630-hour employees." At HCA, we're trying to refer to the different populations as (6)(d) and (6)(e). Just like in the PEBB Program, there are "A through F employees." We talk about which part of the framework they have eligibility under.

As a school district official, when you go through the eligibility requirements, you have to check each prong of the statutory requirements to see if they meet the requirements for (6)(d), and then they have to check their (6)(e) eligibility. It's the same way that state agencies and higher education have to start with A, then move to C, then move on to D, and then go down the line of letters. Now we're bringing you some of the foundational elements that we believe are within your authority to set as guardrails within the 6(e) framework.

Rob Parkman: Slide 4 shows why the words with blue font are important for today's presentation. The language from RCW 41.05.740(6)(e) is further broken down to show the relationship of the (6)(e) RCW with the resolutions that will be presented today. It shows terms and conditions, eligibility criteria, and SEBB authorized benefits.

The first green box shows two resolutions will establish terms and conditions, which will include what the employer's share is and what tier categories and ratios will be used. We may present more resolutions in future Board Meetings as we develop this area within your responsibility.

The second green box shows two resolutions will be presented today on what are the eligibility criteria that can be negotiated at the local level. This includes what groups can participate and the range of anticipated work hours that can be negotiated within.

The third green box shows one resolution being presented today on what are the approved benefits for this population. I would also let you know that the SEBB Program must create multiple new processes and procedures to administer this part of your authority. There is no similar requirement within the PEBB Program that we could borrow from.

Dave Iseminger: We spent a year working on several dozen resolutions for (6)(d). Although there are likely things that would come up over time that might also fall under the (6)(e) authority, we're not envisioning month after month of resolutions this year about this. We're thinking that these five really represent the foundational pieces that are necessary for launch, important for the Board to put in place, and then get into rule making by the end of the year.

Rob Parkman: Slide 5 – Proposed Policy Resolution SEBB 2019-01 – Requirement to Negotiate by group under RCW 41.05.740(6)(e).

A SEBB Organization that elects to locally negotiate eligibility for school employees under RCW 41.05.740(6)(e) may only negotiate by group as described below:

- The entire SEBB Organization; or
- An entire collective bargaining unit; and/or
- A group containing all non-represented school employees.

We believe this is similar to how SEBB Organizations have bargained in the past. For background, for SEBB Organizations that choose to opt into this locally bargain SEBB benefit program, they have the option to provide benefits for their entire organization, entire collective bargaining units, and/or all their non-represented as a single group. Some policy considerations and why we're developing this is because we must ensure that similarly situated school employees are treated the same when providing benefits. The determination of who would qualify for these benefits will be the responsibility of the SEBB Organization.

Wayne Leonard: In terms of the way this first sentence reads, "A SEBB Organization that elects to locally negotiate eligibility." In terms of bargaining at the local level, health insurance or health benefits is typically a mandatory subject of bargaining. Under this, would it be a permissive subject, what if a school district did not elect to negotiate and the association wanted to, could we not bargain eligibility requirements?

Rob Parkman: We are looking at an opt-in requirement. From an organizational point of view, do you want to partake in this, if so, there will probably be a form developed

that will have to be signed and submitted indicating you would like to access SEBB benefits for 6(e) employees.

Dave Iseminger: This language doesn't change any other obligations on state law with regards to what must or must not be part of negotiation processes. The phrase "elects locally negotiated" is really drawing off the language, if you go back to Slide 4 and look at the statutory provision that sets up the framework for this, it describes a SEBB Organization that elects to use a lower threshold of hours for benefits. We're drawing upon that statutory language. It's not meant to say that something is or isn't required, but even if something, as I'm sure you're aware, is subject to mandatory bargaining, that doesn't mean you have to come to an agreement on that particular area. It just means you have to bargain in good faith about that topic. This is setting up guardrails if an Organization is bargaining and wants to go down this route of offering benefits under this framework.

Wayne Leonard: Okay, but I thought that was kind of the purpose of SEBB, so we weren't bargaining benefits anymore.

Dave Iseminger: During the legislative process on ESSB 6241, there was some debate on the floor of the House of Representatives about the addition of this particular provision. But the Legislature ultimately agreed to include this as an opportunity for school districts to offer benefits. They did tie them to being the same SEBB benefits if authorized by this Board for this population.

Wayne Leonard: I think we've had some other discussions that we could be more generous if we wanted to in terms of eligibility. I guess my question is, is it the employer's choice?

Dave Iseminger: Yes, but you're setting up guardrails for what the bargaining process would look like for populations that don't meet the SEBB Program eligibility requirements.

Pete Cutler: As I read Section 740(6)(e), where it says the SEB Board can set the terms and conditions for an Organization to have the ability to negotiate eligibility criteria. To me, that would seem to imply that it is in authority of this Board to say whether it will be treated as a mandatory versus permissive topic of negotiation. But, as soon as I say that, I also have to add, from prior experience, I know there's a whole framework of common law and statutory framework that defines historically what is considered mandatory and what is considered permissive. Before I, as a Board Member, were locked in, if I was asked to support a motion to clarify that, whether it was permissive or optional, it's a topic of bargaining, I'd want legal advice from our counsel about that question if it comes up in the future.

Dave Iseminger: We will take that as a Board question and will bring answers back. If any of them are legal issues that need to be talked about in Executive Session, we'll plan that accordingly as well. This is the normal stakeholdering process. We're presenting you an initial piece. We'll go out for stakeholdering knowing that's a question you want answered by the next meeting.

Pete Cutler: I suspect at least one of the stakeholder groups will have an opinion on that question. Thank you.

Rob Parkman: Slide 6 – Proposed Policy Resolution SEBB 2019-02 – Anticipated work hours eligibility range under RCW 41.05.740(6)(e).

A SEBB Organization that elects to locally negotiate eligibility for school employees under RCW 41.05.740(6)(e) shall negotiate within the range of anticipated to work hours described below:

- No less than 180 hours per school year; and

- No more than the threshold to meet the SEB Board's eligibility established pursuant to RCW 41.05.740(6)(d).

From a policy point of view, how did we develop 180 hours? That is one hour a day for the required number of school days within one year. One hour a day shows some employment relationship, given that these are employer-sponsored health benefits. The ceiling for this rate of anticipated work hours is really the floor of the SEBB eligibility as approved over the last year through the many eligibility resolutions that Barb Scott has presented and the Board has approved. That eligibility was established under the authority of RCW 41.05.740(6)(d).

Slide 7 - Proposed Policy Resolution SEBB 2019-03 – SEBB benefits authorized under RCW 41.05.740(6)(e).

A SEBB Organization that elects to locally negotiate eligibility for school employees under RCW 41.05.740(6)(e) must offer all of, and only, the following SEBB benefits to school employees and their dependents:

- Medical;
- Dental
- Vision; and
- Basic Life and Basic AD&D.

Currently for SEBB Organizations, this is similar to some of the benefits offered today. We did some stakeholdering before today, and the general stakeholder feedback showed that dental and vision are desired benefits for this population.

Dave Iseminger: I will also add that we are in conversations with MetLife about whether there's an optional life and optional AD&D benefit that could be on the table. In those negotiations, we've gotten through rates and benefit designs, but we have to check some of the operational impacts because it would not be the same benefit structure that you approved in November for the (6)(d) employees. We have to make sure that we understand how operationally it would work if people are bouncing in and out of (6)(d) and (6)(e), and whether they will have guarantee issue and election rights, etc. We didn't want to include that this time, but we are working with MetLife to see if there's an optional benefit we can bring to you.

I want to highlight that disability, unfortunately, can't be on this list because the reality is, as you get to a smaller and smaller hour work requirement, there's a lack of incentive to return to work at some point because of the amount of benefit you would get for the hours. There isn't a way to include a group LTD benefit in this without revisiting the entire rate structure.

Rob Parkman: Slide 8 - Proposed Policy Resolution SEBB 2019-04 – SEBB tier categories and premium tier ratios authorized under RCW 41.05.740(6)(e).

A SEBB Organization that elects to locally negotiate eligibility for school employees under RCW 41.05.740(6)(e) must offer the same tier categories and premium tier ratios as adopted in SEBB 2018-14.

SEBB 2018-14 is included in your appendix. This policy is making the tier categories and premium tier structures the same for both the (6)(d) eligibility and the (6)(e) eligibility.

Dave Iseminger: One of the things that would be advantageous about this particular resolution is, as people bounce in and out of eligibility, they wouldn't see wild shifts within the premiums and ability to cover different folks. Aligning those would really help the user experience as they are on the edge of different eligibility thresholds.

Rob Parkman: Slide 9 - Proposed Policy Resolution SEBB 2019-05 – Employer share requirement under RCW 41.05.740(6)(e).

A SEBB Organization must contribute:

- The same employer medical contribution (EMC), for all tiers, as if the school employee were eligible under RCW 41.05.740(6)(d);
- 100% of the monthly premium, for all tiers, for the dental and vision plans as selected by the school employee
- 100% of the monthly premium for the basic life and basic AD&D benefits
- 100% of the monthly administration fee as charged by the HCA; and
- 100% of the monthly K-12 remittance fee.

The intent is to have similar school employees in similar SEBB Organizations as the (6)(d) structure as much as possible.

Dave Iseminger: Again, for the reasons that I just described on the prior resolution, people bounce in and out of eligibility. If a school district opts to go down this road for offering benefits to somebody who would qualify under (6)(e), it would stabilize and smooth that process. They wouldn't fall out of (6)(d), lose the strong employer contribution that exists there, and see their premiums jump up if they suddenly got a much lesser employee premium or employee medical contribution.

Remember, there are over 950 bargaining units right now. If 6(e) were left without any guardrails, there would be some challenges with being able to administer and monitor exactly what the contribution is on a bargaining unit by bargaining unit basis. That's another reason that having a uniform experience here to drive administrative simplification and smooth out that member experience. And, effectively, this would be something that could be factored into the thought process during the summer collective bargaining processes because it would essentially hook the employer medical contribution that's agreed to for (6)(d) employees to (6)(e).

I want Kim to give some insight. I know we have questions about how this would be operationalized, especially that first bullet, and what it could mean for any differences in premiums that employees might expect if they were a (6)(e) employee versus a (6)(d) employee.

Kim Wallace: With regard to the first bullet, you'll notice that there is the word "same" and there's a phrase "as if the school employee were eligible under (6)(d)." I want to speak to that so the Board is very clear about what is the same and what is essentially the same. There is a difference that we're introducing here under (6)(d) versus (6)(e) and it has to do with how the employer medical contribution (EMC) is applied and the effect on what the SEBB Organization is actually paying. I did mention a little earlier that the $1,174 funding rate table was going to come back into play and that we were going to reference it. I will be referencing that in my comments.

What the first bullet is saying is that the employer will actually pay the EMC amount for a Tier 1 enrolled employee under (6)(e) toward medical. The $616 we had been showing in the table is going to change, but that EMC is actually the dollar amount the SEBB Organization will contribute for a single tier employee. Times two will actually be the amount of money that the SEBB Organization is contributing for medical coverage for a (6)(d) employee who enrolls their spouse. The EMC table Megan walked through before that has golden colors, and when you went from left to right, it was showing how you multiply by tier and how the EMC and the employee contribution to premium monthly were both being multiplied by the tier ratios. That EMC chart is actually telling the SEBB Organization what they will be paying and what the individual employee will be paying by tier for their medical coverage.

I'm emphasizing that because that's not exactly the same for employees under (6)(d). Under (6)(d), we know that the EMC is driving the employer's contribution to medical, the employer medical contribution by its name. On Megan’s chart, the EMC of $616 appears at the top of the chart. When we go to build up how much the employer-paid share to is sent to HCA to cover costs they're responsible for, you remember the EMC gets multiplied by that factor to derive a medical premium contribution for the employer on a per subscriber per month (PSPM) basis. That's the $977 you see on the chart.

So, under (6)(d), the regular SEBB Program, what the funding rate is doing is taking the EMC and the employer medical contribution is driving what the employer is obligated to contribute for medical. But, because it's a consolidated statewide purchasing program, the SEBB Program is one big statewide purchasing act, we are essentially averaging. We're saying the employer medical contribution has to be contributed by the employer

by tier. We're not actually saying each and every district is going to be invoiced for exactly the tiers their employees enroll in.

That's the contrast. In terms of what the employer is contributing to medical, if any school district who is considering doing (6)(e), they're not paying the funding rate for 6(e) employees. They're going to pay by tier the contribution based on what that employee enrolls in. That's how the proposal was written, because the (6)(e) benefits program is not a big statewide consolidated benefits purchasing program. It is a more discrete option. From our view, if the employer is charged the tier that the employee actually enrolls in under (6)(e), then the employer is paying for the exact employees that they negotiated to cover.

I don't want to make a big deal of this. When we say, "the same" and "as if they were eligible under (6)(d)," that's essentially a true statement. But there is this nuance. Perhaps over the coming weeks, we might get feedback about how to better state the top bullet so we can deal with this difference between the statewide EMC driven PSPM versus the pay exactly by tier. We welcome your comments and your ideas.

Pete Cutler: Actually, this was helpful because, on initial reading, I had assumed, even though it said EMC, I was thinking what's referred to as the medical premium contribution based on per subscriber rate from Page 3 under Section 5. I understand the essence of the difference is the rate that employers for (6)(d) covered people statewide, you have an estimate of what that ratio of adult units are to subscribers and you're going to apply that to everybody. You're not going to go district by district asking how many dependents they have. You're going to average statewide so we'll collect the right amount of money statewide if we use this average.

By contrast, you're saying this policy takes the position as well. But, when you're dealing with collective bargaining groups, there'll be a wide variation, so a statewide average would not be appropriate. You actually will use the EMC, which is based on how many adult units. I understand children/dependents count as some proportion of an adult unit, so if you have a bargaining unit come in for whatever reason, and there a lot of dependents in that group, the amount the employer will have to pay will reflect that. And if there are very few dependents, that would also be reflected because it would be driven off the EMC, which looks at how many adult units you have. I had missed that originally, so I appreciate you bringing it up. Now I understand it.

Dave Iseminger: I want to add another layer to it. I want to include what the implications are for what the employee will pay. Under (6)(d), there is a statewide average. When you take off that average and go on a district-by-district basis, the employee will not pay the average because there's no average in the (6)(e) world. That means we're applying tiered rates instead of a composite rate in this (6)(e) world, which means some employees may pay a little more than if they were a (6)(d) employee, or a little less, not exactly the same amount, because it will be on a tiered basis.

The legislation says the (6)(e) world has to be an enhancement, not part of basic education dollars. We have to ensure that there's not inappropriate cross-subsidization. It is as similar as it could be, but we could not ensure that an employee will pay exactly

the same as if they were a (6)(d) employee. By anchoring it to the same EMC that's in (6)(d), it makes it close. Some will pay a little more, some will pay a little less.

Kim Wallace: I will think through some of the detailed scenarios and tables that we have plan by plan and bring back potential impacts on employees.

While we're on the topic, the 1.586 factor in that table, is essentially saying, if we knew that every single (6)(d) employee across the state was going to enroll as a single employee, the factor would be one. If we knew that every single employee was going to enroll as a full family, the factor would be three. But we're saying it's somewhere in between and that, on average, the tier that employees are going to enroll in is not one, it's not two, it's not 1.75, it's not three. It's 1.586. We are refining that number as well. You'll see a slightly updated factor there.

Pete Cutler: As a Board Member, I definitely would like to see examples, hypothetically, obviously; but it would be nice if you had specific districts, even hypotheticals, of the kind of mix of people in the unit that was brought in, how it might look to the employer and to the employees. I feel uncomfortable dealing with it in the abstract. I prefer to see some examples. Thank you.

Dave Iseminger: I'm sure stakeholders would also ask for examples.

Rob Parkman: We did a little stakeholdering on the (6)(e) issue and received feedback from a couple of stakeholders. One stakeholder, basically, their whole desire is to make (6)(d) and (6)(e) as close as possible. The other stakeholder wanted actually the widest range of options as possible for future negotiations.

Dave Iseminger: That was stakeholder feedback on a prior iteration. We don't usually pre-stakeholder resolutions, but we knew this was going to be a long journey on this particular topic. We'll see what the stakeholder feedback is for the newest iteration.

Rob Parkman: I'll now share transition-type resolutions for go live. We're done with the (6)(e) discussion for now. The next proposed resolution is: Proposed Policy Resolution SEBB 2019-06 – SEBB continuation coverage eligibility for school employees not eligible for benefits under the SEBB Program. If a school employee enrolled in medical, dental, or vision under a group plan offered by a SEBB Organization on December 31, 2019, and they lose eligibility because they are not eligible under the SEBB Program, they may elect to enroll in one or more of the SEBB benefits: medical, dental, or vision coverage. These benefits will be provided for a maximum of 18 months on a self-paid basis. This is more generous eligibility than required by statute and will provide eligibility to school employees who will not meet the SEB Board eligibility criteria as of January 1, 2020.

Proposed Policy Resolution SEBB 2019-07 – SEBB continuation coverage eligibility for dependents already on a SEBB Organization's continuation coverage is another transition resolution. If a dependent of a school employee who is continuing medical, dental, or vision coverage through a SEBB Organization on December 31, 2019, they may elect to finish the remaining months, up to the maximum number of months authorized by COBRA for a similar event, by enrolling in a medical, dental, or vision

plan offered through the SEBB Program on a self-paid basis. This is more generous eligibility than required by statute and it provides eligibility to a dependent of a school employee who is already on continuation coverage as of December 31, 2019.

Lou McDermott: I want to understand this. We have resolution 2018-58 where we're saying if a dependent is no longer covered, we're giving them 36 months. But, if the subscriber is no longer covered --

Rob Parkman: We're basically tying it to COBRA so there's different COBRA requirements depending on the employee versus the dependent.

Lou McDermott: And what I want to understand is the linkage. If you have a subscriber with dependents who are both no longer eligible, does the dependent get to go 36 months and the subscriber is a different timeframe?

Barb Scott: No. Let me describe the populations that fall within these.

I'll describe SEBB 2019-06 first. Under this population, you have school employees who, as of December 31, will lose coverage because they will not be eligible under the SEBB Program. They're losing coverage, but it's not based on a COBRA recognized event, specifically a reduction in the number of hours, or termination. This policy extends COBRA benefits to them for the number of months that an employee who loses eligibility based on a reduction in hours would receive, 18 months. This would include their dependents who lose coverage. They would also be eligible for 18 months.

When you look at 2019-07, we've said a dependent of a school employee who's continuing coverage. They've already had an event occur so they are already self-paying for their coverage under the district program. For example, a domestic partner where the domestic partnership is dissolved and they lose eligibility under the district plan this summer, most districts probably already have a provision within their group health plan contracts that says to treat that person like they had a divorce and give them equal coverage. (e.g., a dissolution of domestic partnership occurs July 2019, and under the district group health plan they're allowed to continue coverage for 36 months, they would get no more under SEBB than the remaining number of months, an additional 30 based on already having used six months.

We're trying to identify people who would not be eligible to continue coverage under COBRA and we're bringing you policy resolutions to address the eligibility for the ones that aren't covered by federal regulation. I hope that helps with these two policies.

Dave Iseminger: Lou, I think the main point is, under COBRA, different triggering events have different lengths. What the team is doing is looking at what is the most analogous event as if COBRA were applying to them. Sometimes it's 18 months and sometimes it's 36 months. It's trying to align to the event scenarios.

Barb Scott: And we're hoping it captured that by saying it's for a similar event.

Rob Parkman: We will send these out to our stakeholdering group and start that stakeholdering process. We will bring these resolutions back for action at the March meeting.

Pete Cutler: How critical is it that the Board take action on these in March? I'm thinking that some of us are going to want to see some of those examples on the ones dealing with subsection (6)(e), and perhaps there'll be others who have questions about the last two resolutions.

Dave Iseminger: We are starting to, in the March/April area, come up against the rule making timeline to be able to get things codified in the Washington Administrative Code and the second rule making activity.

Barb Scott: The other factor, especially on these continuation coverage proposals, is that we're preparing communications for SEBB Organization membership. Since some domestic partners will be losing coverage, we would like to communicate what the Board has decided, if there is a continuation coverage option for them. It will be the same for employees who are currently eligible and will lose eligibility this coming December. We want to be able to provide the districts and others with information about what's available to school employees for those that may become eligible under (6)(e), as well as communicating what the Board has decided if there is a continuation coverage option for them. We're trying to get our forms and documents in place, but mainly communication, being able to make sure we provide a clear picture of what's in front of them.

Dave Iseminger: Pete, I believe it's important but I will have the team confirm the rule making timeline does, in fact, require action in March. If there is any discretion or flexibility to push into April, we'll clarify that in March. The strong preference is, we are getting very close to the cutoff piece.

Pete Cutler: Well, I appreciate that. That's all I could ask as a Board Member. But I would hope that you could communicate to us before the Board Meeting because, if we have to cram in some kind of looking hard at what are the implications because it's really important to have a vote on March 7, then I'd like at least a week's advanced notice that's what we're facing.

Barb Scott: Is that for the examples, Pete?

Pete Cutler: Primarily, it's dealing with that. That's the area I personally have the most concern. I'm not quite sure that all the key questions have been answered or that I understand the implications. That would be the package, those five resolutions, the question of do they have to get locked in by March. Can they wait until April just to make sure we have enough time to make an informed vote.

Procurement and Rates Updates

Cade Walker, ERB Executive Special Assistant and **Kim Wallace**, SEBB Finance Manager. There was a significant amount of work and Board action taken in the last year regarding procurement activities and benefits. I'm here to provide a brief overview of where we're at with procurement and then Kim will give an update on rate setting.

Slide 2 – Medical. I'll start with the fully insured medical plans. We have six apparently successful bidders that we are in the process of contract negotiations. Those six apparently successful bidders are Aetna, Kaiser Northwest, Kaiser of Washington, Kaiser of Washington Options, Premera, and Providence.

The implementation plan is a very different set of actions we take when we are no longer in negotiations. How do we get the plans established and ready for administering the contracts? While contracting implementation planning is ongoing, that will not constrain the Board's ability to continue to refine the plan design and the final benefit offering decisions as rate setting continues. None of this will limit your ability to continue adjusting plans as needed in the coming months. Additionally, under the Uniform Medical Plan (UMP) Plus plans, those are being negotiated with the Puget Sound High Value Network and the UW Medicine Accountable Care Network (ACN). Those contracts are also ongoing.

Slide 3 – Dental and Vision. There are three different plans on the dental and vision procurements. There is the self-insured Delta Dental Plan. They have agreed on the plan design and the not-to-exceed rate. On the fully insured side, there is another Delta Dental Plan and the Willamette Plan. They have also agreed on plan design, not-to-exceed rates, and the multi-year rate guarantee.

Dave Iseminger: What I would say about dental is it seems like we have an agreement in principle, just getting it into writing.

Cade Walker: For the vision benefit, there are three carriers. There are agreements on the not-to-exceed rates and contract negotiations are ongoing. All carriers are engaged in network expansion, meaning they're continuing to contract with additional providers throughout the state.

Slide 4 – Life/AD&D, LTD, FSA/DCAP, Wellness. For life and AD&D, the contract negotiations are at the tail end and preparation for implementation planning, and the kickoff for those activities has begun.

We are at the tail end of the long-term disability contract negotiations. Implementation on LTD has begun.

The contract amendment to cover the SEBB Program for the work related to the Flexible Spending Arrangement (FSA) and Dependent Care Assistance Program (DCAP), has been executed. The rate negotiation is ongoing.

The wellness program, SmartHealth, contract amendment has been executed to include the SEBB Program population.

Slide 5 – Other Benefits and Services. We have completed a Request for Information (RIF) regarding home and auto insurance. We've received three responses and they are currently being reviewed.

For dependent verification support, the proposals were released and responses were received. We are now in the protest period and expect to be able to announce the apparently successful bidder once that protest period has lapsed.

Pete Cutler: Do I take it from this that the Health Care Authority's plan is to hire a vendor specifically to handle the dependent verification with the SEBB Organizations' population when the program is implemented as opposed to that being Health Care Authority staff? Is that what this implies?

Cade Walker: That's correct, to assist all the school districts with the dependent verification. Dependent verification is typically done by the employer who facilitates member enrollment. This procurement is to provide assistance to the school districts in performing the dependent verification for the first open enrollment. Moving forward, after the initial open enrollment, it will be the responsibility of the school districts to perform that function.

Dave Iseminger: It is to help with the bubble that's expected this fall when upwards of 100,000 people will need dependent verification at the same time. You will see in the demonstration a little bit later how we are going to provide an easy way forward for members to provide dependent verification documents and districts to be able to review them electronically. That will also help facilitate the future expectation of districts doing dependent verification.

Pete Cutler: My recollection is last year, when at one or more of the meetings, there was some discussion that it would make sense or be helpful to have a longer period of time for employees to get their dependent information in with this transition being new. Will we get a report on what the plan is at some point?

Dave Iseminger: After we are able to talk with and begin negotiations with the apparently successful bidder, we'll be able to talk about some of the implementation plans and if there's opportunities to start dependent verification earlier or what different opportunities there might be to either streamline that process or expand the timeframe. I know there have been some ideas of pre-verifying people before October 1. That's certainly something that will be under negotiations with the carrier to see if there's a way to have that started before October 1.

Pete Cutler: Then the Board will get a briefing on that?

Dave Iseminger: Yes.

Cade Walker: We submitted a Request for Information for open enrollment support and an online decision support tool. We received seven different responses on different aspects of that request for information. We are currently evaluating next steps.

Pete Cutler: This is probably going too much in the weeds, but I'm curious, are you at a point where you can give the names of who these seven organizations are?

Cade Walker: I'm not familiar on procurement rules with an RFI, given that the procurement is anticipated to continue with some other aspect.

Pete Cutler: Well, March will be fine, then. I would be curious if I recognize any when the time comes. Thank you.

Kim Wallace: Slide 6 – Rates Timeline. January 2019 – Medical. We have received the initial not-to-exceed bid rates from the medical carriers. We have also completed an initial not-to-exceed bid rate development for the Uniform Medical Plans. We are reviewing the rate development for UMP internally and making sure we discuss with Milliman any aspects of assumptions, various percentages, and trend that they assumed. At this point, it's still at the not-to-exceed level just like we were asking of the fully insured medical carriers. By the end of next week, we will be deriving the initial employer medical contribution because that's 85% of the UMP Achieve 2 bid rate. We will be sharing that value with the fully insured carriers because they're very interested in knowing how much will be left to the employee who chooses their plan or their plans.

In February, we will negotiate the final not-to-exceed (NTE) bid rates with the medical carriers. We will also be finalizing the UMP plan NTE rates. We will update the financial modeling with all the negotiated final NTE rates. That will change the numbers that we have been talking about in terms of the HCA suggested values for the funding rate for FY 2020 and the funding rate for FY 2021. We've been thinking in terms of $1,174 and then the governor's budget, $1,170 and $1,195. But we are going to be having it updated and we will be submitting that update to the Legislature through the Office of Financial Management (OFM) by March 1.

Later in March, we will continue to respond to legislative inquiries and requests. That's already started. We will work with carriers to lower their not-to-exceed levels.

In April, we will continue to respond to legislative inquiries until we end up with the final budget at the end of the legislative session. We anticipate in July that we will propose employee premiums for all of the 2020 medical plans for your vote. Of course, we will amend all the contracts to incorporate the final bid rates at that time as well.

August gets exciting because we will be finalizing all member communication materials and sending all matter of information out getting folks ready for open enrollment. And, October 1, is the start of the initial open enrollment.

Dave Iseminger: Also the March Board Meeting is six days after we're expected to deliver the updated financial model information to OFM and the Legislature. At that meeting, we will discuss the updated modeling that we will have provided to others.

Pete Cutler: Am I right that, at some point, it may come back to the Board that there's a need to tweak, modify, the benefits in order to deal with a funding target, or to reduce funding, or to reduce costs to fit within the funding of what's expected? Are those discussion or briefings likely? Do you have a sense of when they would likely happen on the calendar if they do become necessary?

Dave Iseminger: I would anticipate they would be when we have a better sense as to what the legislative funding will be, which could be as early as April, or later, between when the funding rate is decided and July. Obviously, if the Legislature finishes on April 28 and there's a funding rate, then those conversations can begin in May/June.

Otherwise, they'll have to be simultaneous with the proposed employee premiums if we indeed have a robust July in the works. You're alluding to the analogy that I've said for many months that the Board did 90% of its homework up through November and there's 10% refinement to hit the final financial target. Unfortunately, we won't be able to do that exercise until we have the final approved funding rate.

Kim Wallace: There are two very important, different perspectives on how is this funding going to shake out. From the state budget perspective, it's the EMC that is defining that medical contribution and expense. The EMC being lower has a significant impact on the funding rate, which is relief to the state from a budget standpoint.

The other perspective that's important and comes squarely in your purview is the employee premium levels. Because the difference between a plan's bid rate and the EMC is what's left to the employee. We are teaming well with the carriers but we know that there's going to come a time when we are going to be looking at the math and seeing exactly where the employee premiums are falling. That's not a state budget issue. It is a matter of great importance, however. Is the portfolio of offerings a reasonable array? Is it affordable for people? Do they truly have a choice? We're watching those employee premiums carefully.

Retired and Disabled School Employees Risk Pool Analysis Report to the Legislature

Kim Wallace: This presentation is a follow on to an important conversation we had last fall about the legislative report that HCA prepared. We were charged with analyzing the most appropriate risk pool for the retired and disabled school employees. Slide 2 – Background. The four sub-bullets are the things that we were required to include in the report. I will provide a high-level status of the report, the key takeaways, our recommendations and the actions, the next steps, and what's happening with the report.

Slide 3 – Status. We consulted with this Board and the PEB Board on September 17 in a joint meeting. We did complete a draft report. There were many levels of review and approval. It was submitted to the Legislature on January 17. I do acknowledge that it was due in December but we learned of a couple changes with our discussions with OFM that were appropriate to make. I believe it's available now in its totality at the link noted on Slide 3.

Slide 4 – Recommendations. We set forth that there are two appropriate risk pool structures for school retirees, in addition to the Medicare pool. We're focusing on what happens with the non-Medicare retirees. There is a desired future state based on Board comments and other stakeholder feedback that led to a strong support for creating a non-Medicare risk pool for SEBB like the one that exists for PEBB. Having those early retirees stay in the same risk pool they were in when they were active, having the same plan choices was a compelling scenario for many people, including both Boards. That was established as the desired future state. There is little to no cost impact on the retirees and employees.

The real key point is that it would minimize disruption for people. There is disruption when people enroll in Medicare. I think that makes more sense to people. At that time, they know that's a significant change in their health coverage. We did say in the report

that an implementation date of this new non-Medicare risk pool in SEBB of January 1, 2022 was appropriate. That would be the earliest.

We pulled a group of people together and walked through the many different requirements, constraints, all that would need to be put in place to be changed, including statute, etc., in order to be ready to truly implement in a high quality way. We did say we would need at least these two years. We also said that until the constraints are addressed and resolved, assuming they are, we recommend continuing the current risk pool structure where the SEBB pool is active only.

Even in the desired future state, there would be a single Medicare pool in the PEBB Program, so school retirees who are Medicare eligible would be as they are today, together with PEBB state retirees. It shouldn't be shocking to anyone. We heard your comments, many of which were included almost verbatim in the Appendix. Names were not included, but we thought it was a strong statement of support for this recommendation.

Dave Iseminger: We delivered the report this month. The Legislature could choose to take action in this legislative session. It seems there are plenty of things to talk about that don't relate to this. Given our timeline recommendation, it could be debated in a future legislative session rather than the one just convened. I wouldn't be surprised if there wasn't significant discussion on it this legislative session. It's not necessary for the Legislature to talk about it this year if they don't want to.

Pete Cutler: Having worked in that environment, they don't like to make decisions that involve money and might involve political pain until they absolutely have to.

Kim Wallace: I do have a bit of follow-up information in response to your earlier question, Lou. You were asking about how much of those funding rate amounts are for the buildup of the PSR?

Lou McDermott: Correct. The buildup of the Premium Stabilization Reserves (PSR) and the repayment of the loan.

Kim Wallace: I have the first one. There is about $60 Per Subscriber Per Month (PSPM) in the $1,174 and $1,170 in the Governor's budget for the buildup of the PSR.

Lou McDermott: The loan's fairly small?

Kim Wallace: In FY 2021, it gets cut in half to $30, because it's only half of FY 2021 that's building up the funding rate in calendar year 2020. The one point that's important to consider about potentially slowing the rate of build up to the PSR is that there are important dynamics and impacts that go beyond just spending a little less and spreading out the cost because this buildup of the PSR is in the UMP bid rate development. If we lower the amount of the reserve requirement in that bid rate development, that will not only lower the bid rate of the UMP plans, including Achieve 2, it will lower the EMC. What we do to the UMP bid rate on Achieve 2 does have implications that flow through the funding schema and would have an impact on the carriers and their bid rates.

We are hearing that there are decision makers thinking about slowing the buildup of the PSR, slowing the repayment of the loan. The repayment of the loan is different because it's not in the bid rate development. We're carefully following those thoughts and that thinking process wanting to make sure the full story is considered.

Lou McDermott: Inherently, we all know that sort of the hip bone is connected to the leg bone. We know that in the rate setting process, everything impacts everything. It's all connected. As we go through the legislative process and we see the Senate's budget and we see the House's budget, they'll be making some of those tweaks and making sure the Board is aware of the tweak and how it's rippling through the rates. It's causing this to go up, or because of this, it's causing this to go down. Those inner plays just take a while to learn.

Dave Iseminger: As we describe the budgets at future meetings, we'll make sure to describe levers and the relationship between them. We'll answer any other questions that people have in the follow-up portion of the next meeting.

Pete Cutler: Thank you, Lou, for bringing up the point. I was going to say that I'm sure budget staff are being instructed to look for every possible tweak they can. I'm sure there will be ongoing discussions between this agency, OFM, and those folks. It really has no relevance to decisions we're making but I'm curious if you look at the rates right now, there's $1,170 and then $1,195, which would seem if you knew nothing else, you'd think the inflation trend is really low, if you didn't know about these things that are one-time parts of the cost in the first fiscal year. My simple question is can we get a sense at the next meeting of what the ballpark estimate for medical inflation trend for 2021 and going from there?

Lou McDermott: Medical including pharmacy and split out?

Pete Cutler: Yes.

SEBB My Account

John Bowden, John Bowden, Manager, School Employees Benefits Section. I'm going to discuss SEBB My Account today. That's the online portal that's going to be used by both employees for making benefit selections, and by benefit administrators, the personnel/payroll staff, to upload and manage eligibility files and dependent verification. **Jerry Britcher**, Chief Information Officer, is going to provide you with a demonstration of what's been developed to date.

Slide 2 – What happens after . . .? This Board has been doing a lot of work around establishing eligibility and enrollment criteria, making decisions about offerings, and you'll be approving plan rates in the not too distant future. Shortly, the employees are going to choose plans and supplemental benefit options. HCA will send enrollment information to the carriers to make sure employees are enrolled. We'll send invoices to school districts, ESDs, and the charter schools. We'll make the payments to the carriers. SEBB My Account is how the employees make decisions and select their benefits.

We're about halfway through developing the online open enrollment systems. We're involving stakeholders in the development process as we go. We've had several meetings and there were a few sneak previews of the demonstration you're going to see that we shared with representatives from the ESDs, school districts, and some PSE and WEA folks. There will be testing along the way. We'll bring people in from the outside to assist with the testing. We want to make sure the system doesn't crash when with the initial enrollment. We will have as many as 150,000 people trying to get on at one time. We'll provide lots of training and assistance to the SEBB Organization personnel and payroll staff on how to use it. We'll be putting together how-to videos and other resources that employees will be able to use as they make their benefit selections.

Dave Iseminger: When we say training SEBB Organization personnel and payroll staff, we're also going to be training many of our union partners who want to participate and understand this enrollment system. If there are questions that their members are asking, they'll be able to help them navigate the system. When you see things that say personnel and payroll staff, put as a parenthetical after that "and union partners" because we are going to be collaborating with the Super Coalition to have them helping people navigate the system as well.

John Bowden: In March, we'll have a training session at WASWUG, which is the Washington School Information Processing Cooperative (WSIPC) User Group. In May, we'll have several training sessions at the Washington Association of School Business Officials (WASBO) Conference. Health Care Authority staff are going to ESDs to provide what might be two-day trainings, one portion being on enrollment and eligibility and the other being entirely on SEBB My Account, how to use it and how to assist employees in using it.

Dave Iseminger: I know a fair amount of school employees are used to getting a screen shot manual of how to do things. We are aware that is a practice that some of the school districts have offered. We have something in the works in that development as well to see if there's a way that we can provide a resource like many school employees are used to receiving. We are trying to think about this holistically.

I do want to make sure it's clear that, although we are focused on this online enrollment experience, we also know there will be paper enrollments. Not all school employees have access to computers on a regular basis. There will be a paper-based option that supplements this online enrollment.

We aren't building SEBB My Account in a complete black box. The agency does have experience. We have a PEBB My Account feature now. It's limited in its capabilities in that you have to already be enrolled in benefits and then you're allowed to make plan changes within PEBB My Account. It did not have an initial enrollment experience. That is an upgrade for SEBB My Account versus PEBB My Account. We are taking our experience from the PEBB IT system, reinvigorating it, and adding much more functionality.

John Bowden: I was asked yesterday in a SEBB My Account demonstration as to whether a paper option would be available and if there is an option in foreign languages. We're not able to do SEBB My Account in foreign languages, but we will have paper

enrollment forms. We can look at making translations on those forms. We'll be able to image any paper forms coming in and have that information automatically entered under SEBB My Account. An important piece behind SEBB My Account is that we want to make sure the personnel/payroll staff in the districts, ESDs, and charter schools do not have to do massive amounts of keying. The employees will be able to do a lot on their own. We'll also be able to front load a bunch of information about employees so it will already be there when they go online to sign up.

Jerry Britcher, HCA CIO. Hi. I'm Jerry Britcher. A little background about how we're going about doing this. We are developing this front end in two-week increments. The video you're going to see basically is the first six iterations for six two-week increments. We continue to add functionality. Basically, every two weeks there is additional operational functionality added to the system. At our current rate, we're about four weeks ahead of schedule. There's also backend development occurring so the old PAY1 system that supports the PEBB solution is also the backend for SEBB. It's a different development effort, but the functionality you see at this point in time is not tied to that backend functionality that occurs later in the process. So, what you're seeing is really both what the employee will experience, as well as the pers/pay staff or anyone doing administrative-type functions within the system.

Dave Iseminger: When we say front end and back end system, front end is what the member or the business official at the district would experience. That's the visible part of the system that would capture the enrollment selections. The back end is where the golden record is kept and is the system used to send carrier and payroll integration files. That's not something members would necessarily have insight into.

Jerry Britcher: The current plan has always been we will wrap up development by April, which is when we begin the testing. Testing includes both in-House testing to ensure the functionality is working correctly and with SEBB Organization staff so they can see what the system is like and does this actually make sense from their perspective, not just our perspective.

Video demonstration started.

Lou McDermott: Jerry, during the presentation, it said your statement of insurance will be available when you start receiving benefits. Can you downloaded it earlier? Do you have to wait until January 1, 2020?

Jerry Britcher: You won't be able to download it until January 1, 2020.

Dave Iseminger: The statement of insurance feature will reflect the existing state of enrolled benefits as of January 1, 2020. Members won't have the ability to print a statement of insurance for benefits that exist in the current system that are effective prior to January 1, 2020. Once the program is up and running, at any point after January 1, 2020, you'll be able to get a statement of insurance to show your enrollment and have one document that verifies enrollment for you and all of your enrolled dependents.

Pete Cutler: In my vague recollection, a statement of insurance actually has a definition within the insurance industry; and by definition, it can only be for what insurance is in place as of the date it's generated. Will there be a functionality that will allow a person to print what they signed up for, effective January 2020?

Dave Iseminger: Let's say I'm an eager school employee and I go in on October 1 and I make all my plan changes, and come November, I can't remember what I signed up for 30 days ago. Is there something that people will be able to access between their election and January 1? Is that what you're asking?

Jerry Britcher: At this point, we haven't included that, but we certainly can. The purpose of doing a demo is to get feedback. If that's a desired functionality, we can certainly add that.

Terri House: Like an election of benefits?

Lou McDermott: Yes. Different parts of the site will show all the pieces, but it would be nice if it all came together. That's why I was asking about a statement of insurance. It comes together nicely there. If it could come together in some other way for them so they can print and know it's set, that's great, too.

Pete Cutler: Some of us have spouses who were a little skeptical of our ability to follow through on internet functions. It's nice to have a physical print out.

Dave Iseminger: In editing the demo, one sentence ended up on the editing room floor. An expected feature is the ability for a school employee to upload dependent verification documents. You could take a screenshot of your birth certificate from your smart phone and upload it. Or you could take a file from your computer hard drive and upload it into the system. Then the district official would be able to view that document. You saw the drop down used to identify the uploaded document. That would be the verification. There would also be an auto purge feature of the documents. The intent is not to maintain longstanding records of the dependent verification documents. If there were a dependent verification project in the future, people would have to resupply that documentation. We believe people are more comfortable if they know it's purged rather than maintained.

If someone doesn't want to put their document in the system, they could physically show the district business official their birth certificate. That business official would log into the account and indicate they saw a birth certificate and check done.

Lou McDermott: Jerry, that brings up a good point. This is mobile friendly, correct?

Jerry Britcher: Yes. As it's designed, it will automatically reformat to the device you're using. It's not a mobile app per se. What it is, is your browser. SEBB My Account will auto format to smart phone, tablet, or PC.

Pete Cutler: I would imagine, especially your business folks at the school districts, would want to go into more depth, especially as you get more of the functionality built.

Jerry Britcher: We've already started meeting both virtually and live with some school districts and actually demonstrating the system live as opposed to a recorded video so they can ask more detailed questions. Those have gone well so far.

Lou McDermott: You have done a great job on that, Jerry.

Pete Cutler: Are there plans to do some kind of stress test to see what happens if 40,000 employees want to access the system on the same day?

Jerry Britcher: That's actually part of the testing design. On our end, we call that load balancing. This whole environment is within the Amazon Web Cloud Services environment, designed by default to expand and contract based on usage. But, yes, that is part of the plan.

Dave Iseminger: Perhaps that might be something the Board's interested in hearing the results of that stress testing to make you feel more comfortable about this enrollment opportunity. We can certainly share that when we're at that point.

Pete Cutler: Towards the very end of my career, I was around when the Washington Benefit Exchange went up and ran into some of those kind of problems. I have to admit personally, I would like to hear how that goes.

Lou McDermott: I know not all benefits will be selected on that tool. MetLife will be a separate site. I know there were issues with original sign up with MetLife. We buried the system. Have those issues been corrected or will they be addressed for the next round?

Dave Iseminger: Lou is right. It's called "My Benefits," MetLife's portal for online life insurance enrollment. We will have appropriate linkages from SEBB My Account to that platform for that benefit election. Lou is referring to when we did the reboot of the life insurance benefit in November 2016 for PEBB. We told MetLife to expect that there would be significant interest. They said their load testing and stress testing said they had it! We have members in the PEBB Program who are used to doing things in the last 48 hours. We crashed their system. It turned out that, in the end, MetLife said the enrollment that the PEBB Program population went through was among the top three that they'd had in their company's history, which if you know anything about MetLife, it's a very long history. We ended up extending open enrollment for a little while.

Public Comment
Julie Salvi, Washington Education Association.
Doug Nelson, Public School Employees.

Julie Salvi: I wasn't here for the legislative background, but, as representatives of the Coalition, we wanted to come up and share with the Board a little bit of what has been going on with the Coalition. As you probably heard, all of the organizations in the Coalition have ratified the agreement. And now, we are all working together to implement the funding of the SEBB Program. There were presentations recently, a letter is being circulated among legislative members, and we are starting as a Coalition

to work together, meet with legislative members as a group, and have discussions about the School Employees Benefits Board funding and implementation.

Doug Nelson: And I'll just speak for the rest of the members on the Coalition. It's been really exciting and I think the teamsters representative said it best, “It was great to see the K-12 labor community working together so well; whether it's the Principal's Association, the AFT, the operating engineers, teamsters, PSE, NWA, it's been an unprecedented experience and very positive for the groups.” I have to tell you, the legislators we've been meeting with really appreciate how united we are. We look forward to the next three months and a successful conclusion in April when the Legislature approves, and the governor signs, the budget.

Lou McDermott: April, did you say? I like that.

Julie Salvi: We're optimistic. Thank you.

Dave Iseminger: We have a copy of the letter that Julie and Doug were referencing and when we send you the link for yesterday's Senate Ways and Means work session, we'll include a copy of the letter that was distributed to legislators in the last few days.

Fred Yancey: Mr. Chair, members of the Committee. Again, thank you for all the hard work you do. I wrote down some notes as the meeting went on so we have to start at the beginning and then I'll work to the end. As always, I apologize for any ignorance that I show. But, we have natural states and that's one of them for me.

You started the meeting with a brief presentation that the Ways and Means had a hearing yesterday on the status of SEBB. And it was a good brief presentation on the whole process. There was certainly a feeling in the room, for myself as well, that all employees are entitled to health insurance, health, vision, dental, that it's the humane, it's the right thing to do. That was not in dispute by any of the parties at all. What was in dispute was at least two members are still very concerned because the members are lacking information on the fiscal cost impact that this is going to have on school districts. And that's the difference between funding on a prototypical school model and the fact that a school district has to provide a headcount sort of benefit. I've heard from many legislators, and staff said as much as well, and I anticipate in today's hearing that they have at 3:30 on the House side they'll say the same thing, is they don't have information on that impact. And I believe it's in the millions of dollars. And so, legislators need to know that.

The issue of the (6)(e) people, whether it's a permissive topic to negotiate really is an issue that needs to be defined because that's going to open up a whole new round of negotiations for school districts and have potential impact. Along those lines, and this is the first time I've heard this phrase, and schools have been called political subdivisions, they've been called local educational units. I think you're calling school districts now a SEBB Organization. First time I've heard that term. And, when you say a SEBB Organization that elects to locally negotiate, I think you're saying a school district or, potentially, if the waiver bill goes through, an individual school. If so, I think you need to define that.

Dave Iseminger: Fred, sorry to interrupt you. But that is a defined term. We've described it to the Board before, but it also was done in the rule making activity. "SEBB Organization" means school district, educational service district, and charter school. We didn't want to say district over and over because the entities that are part of the SEBB Program are more than just school districts. It is a defined term in WAC. If anyone wants to look at the WACs that are codified by the Code Reviser, they're in 182-30, 182-31, and 182-32. There is also a definition of SEBB Organization.

Fred Yancey: I don't dispute that fact at all. What I'm saying is if I read that as a lay person, you are the SEBB Organization in my mind. That's what comes to my mind when you hear that phrase "a SEBB Organization." I read this and I'm thinking that means you get to come into my district and negotiate. I'm just reading it as a lay person. I understand that, technically that's why schools can be called political subdivisions or local education units. They're referenced in the law and in all sorts of various abbreviations. But I'm just sharing my perception. When you use the term "SEBB Organization," I think it will cause confusion.

It has been said, and I just want to reinforce, on those resolutions in the (6)(e) section, examples are needed. I think, in fact, every resolution that's come before you, it helps to have an example. The resolution on dependents, this goes back, and then there was one in the appendix and I think you changed it. Do you know what I'm referring to, David? It dealt with dependents.

Dave Iseminger: I think you're referring to Resolution SEBB 2018-57 or SEBB 2018-58.

Fred Yancey: But you took out a definition of domestic partners, children, and so forth, for verification, and just said dependents. I forget the phrase.

Dave Iseminger: It's Resolution SEBB 2018-58. This is where we realized last month, whenever we presented it, that it actually carved out the very people that we were trying to include. When we said it originally, that a spouse or state-registered domestic partner of a SEBB Program eligible school employee who will no longer be eligible, those are the very people who *will* be eligible because of the decision. We made it "dependent" for purposes of the resolution. As we go forward, we'll make sure it's clear in the communications.

Fred Yancey: Clarity on what a dependent is, because that was confusing to me. The retiree report was part of what you were charged with to determine, analyze the need for, and the amount of an ongoing retiree subsidy allocation from the active school employees. There is a small reference made to that in the report. And it just wasn't highlighted during the presentation here. I think what it said is that, if you move to option one, it looks like the subsidy could be reduced by something like $12 or $13. It sticks in my mind something along those lines. But that's a cost to school districts. That's the important thing for them to look at because they pay that.

The SEBB My Account, I'm real impressed. I really like that, other than I think it would scare me as a user just to give you some feedback, that whole concept of uploading a document. I don't have any idea. What I'm going to do is take my birth certificate to the

business office and say here it is. Of course, that's going to add a workload issue to the business office, unless it's real clear that you can photograph it and send the photograph in using your phone, but I think people aren't proficient in the concept of uploading their own documents. We can download anything. It's the other direction that we have a problem.

The statement was made early in the meeting that there's a small loan that needs to be paid. If my memory serves me correctly, I think it's $26-plus million that you're talking about being paid. I don't know where you come from, but that's not a small loan. And it was stated in the hearing the other day that the state gave money. I like to pay attention to words. The state funded this program. Well, they really didn't fund this program. They loaned this program money. We, as school districts, are funding the program. That's an important distinction I haven't lost sight of, and certainly, it relates to what I don't consider as a small loan that schools have to pay back. It's just an additional cost and thank goodness it will go away.

Dave Iseminger: One thing for the record, the administrative loan for the current biennium was $28 million. That included the ability to do the IT build, which is also the retrofitting of Pay1. There's also a second loan needed to bridge from July 1, 2019 to December 31, 2019 before the funding rate would kick in and have the administrative aspects to the program. That's the nature of the loans being described.

Lou McDermott: And, to your point, I don't think anyone thinks $28 million is small. But, when we were talking about it in the totality of the funding rate, what portion of it was associated with the loan versus what portion is associated with the reserves, it's relatively small. Agreed, $28 million is a lot of cash.

Preview of March 7, 2019 SEB Board Meeting

Dave Iseminger: We will bring the Board more information about the seven resolutions Rob presented today and we hope to take action on them. In addition, we'll tee up resolutions for the next month – more transition rules for things that could help during the initial transition of benefits from the current system to the SEBB system. The concept of error correction which is, inevitably, when you have this large of a system, people are going to make mistakes and what are some of the rules and guidance that will address those mistakes. There's another concept that relates to cancelation of coverage for dependents.

We'll have a finance discussion because we will have just delivered the financial modeling Kim referred to the Legislature. We won't have legislative budgets to talk about but we will talk about the updated model.

There should be some benefits updates. For example, the new and updated vision provider networks. Molly and Ryan will be here for part three of pharmacy 101. They'll be bringing and describing policy levers for managing costs within pharmacy.

We have another section building from today's SEBB My Account with other operational readiness updates. Things the agency is doing from the administrative perspective, about how we're going to support districts, both in IT as well as training.

There were some references today about a work session today at 3:30 p.m. in the House Appropriations Committee. It's a staff presentation, not a panel like yesterdays in the Senate. If you were to watch one versus the other, I encourage you to watch the House panel link we're going to send you because it has different stakeholder perspectives and is not just a legislative staff presentation.

Next Meeting

March 7, 2019
9:00 a.m. to 5:00 p.m.

Meeting adjourned at 2:48 p.m.