

School Employees Benefits Board
Meeting Minutes

July 18, 2019
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 1:30 p.m.

Members Present

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

Member on the Phone

Alison Poulsen (Joined around 10:15 a.m.)

SEB Board Counsel

Katy Hatfield

Call to Order

Lou McDermott, Chair, called the meeting to order at 9:02 a.m. Sufficient members 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. The schedule for the 2020 SEB Board Meetings are behind Tab 1 in your Briefing Books.

January 24, 2019 Meeting Minutes

Pete Cutler moved and Katy Henry seconded a motion to approve the January 24, 2019 SEB Board Meeting minutes. Minutes approved as written by unanimous vote.

June 12, 2019 Board Meeting Follow Up

Dave Iseminger, Director, ERB Division. Slide 2. There is one follow-up question from the June meeting. The question was about current enrollment and plan design for school employees in KP Washington plans.

Slide 3 is about the PPO product line. The top blue bar graph is a group count. You can think of that as synonymous with SEBB Organizations. That is the total number of SEBB Organizations in the KP WA PPO product lines within the portfolios they're offering to school employees. The bottom green bar graph is enrollment and the X-axis is showing the various deductible levels.

The question asked was about PPO, but we have HMO data, too. Slide 4 is the same information but from the HMO product line perspective. I believe there is some overlap between these charts. Some districts offer both PPO and HMO product lines. We did not de-duplicate the information, but purely putting on the lens of each plan type, we wanted to provide the requested information about the number of districts that have these types of plans at various levels and the current number of employees enrolled in them.

Sean Corry: Dave, could you repeat what you just said about the overlap? Seattle popped into my head because they're all Kaiser.

Dave Iseminger: I was saying these two charts are not de-duplicated. I believe that Seattle Public Schools offers both products for the PPO and HMO product line. In that case, Seattle would appear on both charts, if we were to list each of the districts. They could be counted in the blue parts of the graph multiple times, but the employee enrollment would not have any duplicate counts. It's just the blue bars might have a duplicate count of a SEBB Organization's offerings.

Uniform Medical Plan (UMP) Plus

Ryan Ramsdell, UMP Plus Account Manager

Emily Transue, MD, ERB Associate Medical Director

Ryan Ramsdell: Slide 2 – UMP Plus. Dr. Transue and I are here to introduce the Uniform Medical Plan Plus Program, also known as "UMP Plus." A resolution passed in June 2018 to establish a Plus plan for the SEBB Program population. The expectation was it would carry similar services, exclusions, and networks, deductibles, out of pocket, coinsurance, etc. as the Plus plan in the PEBB Program. Like many of the UMP Plus programs, the purpose is to achieve the triple aim of looking at better health, better care, and lower costs. UMP Plus places much of the responsibility in this case on the providers. UMP Plus also works to effect change through a unique partnership with providers and the Health Care Authority (HCA). We're in constant contact with the people in the facilities on a daily and weekly basis.

Slide 3 – Value-Based Purchasing. UMP Plus is part of accountable care, which is a group of networks and providers that work together to provide care and attempt to manage costs. One of the ways we try to establish accountability through the contract is through financial and quality guarantees the networks must achieve through a combination of effective care, delivery models, health system reimbursement, and financial incentives. In terms of the PEBB Program product, and now for 2020 the SEBB Program, there will be two UMP Plus networks: Puget Sound High Value Network (PSHVN) and UW Medicine Accountable Care Network (UW Medicine (ACN)).

Slide 4 – UMP Plus Benefits. UMP Plus comes with a competitive premium. Members have the flexibility to choose a primary care provider, a hospital, and other health

providers, but it's in that network. It has the lowest deductible of the UMP plans. Primary care office visits are free. There's no prescription drug deductible. The care is coordinated, which is important, and there's no referral required for specialists.

Slide 5 – UMP Plus Network Design. This illustration we call the donut. There's the core network where the providers are contracted with Puget Sound High Value Network and UW Medicine to provide care to subscribers and members. Within that core are primary care providers, your family doctors and pediatricians. They are typically at no cost. Specialty providers are specialists, like the cardiologists, allergists, rheumatologists, etc. And finally, there are the core providers within the ancillary that are contracted with the networks. These include mental health, acupuncturists, speech, occupational, physical therapists, etc.

In order to establish a more robust network, in addition to that within the service area, any provider contracted with Regence in the ancillary network would also be accessible to the members at the same cost. There is the core network, which are contracted with the networks and the support network on the outside, which is Regence-contracted individuals within that service area.

Dave Iseminger: I want to make sure Ryan's statement is clear for everybody. The deductible for UMP Plus is the lowest among them, but it's not the lowest premium. The lowest premium is the high deductible health plan. I was reading "deductible" I think I might have heard Ryan say "premium." The lowest deductible is in Uniform Medical Plan. The premium that's lowest is actually the high deductible plan.

Pete Cutler: On that support network where it says, "Regence Ancillary Providers," is that to say that's only for the types of ancillary providers listed in the core network? The mental health, acupuncturist, etc.? Or is that a much broader --

Ryan Ramsdell: Both ancillary networks are quite broad. I didn't list them out because the list is extensive and I certainly could go through some of those items at the end if you'd like.

Pete Cutler: I mean by definition, it's not the primary care provider.

Ryan Ramsdell: Correct.

Emily Transue: I am going to talk at a high level about accountable care. Slide 6 – UMP Plus: Clinical Elements. As you look at the 30,000-foot level on accountable care, this is taking some of the things that traditionally insurers do, and shifting them to the providers. In a traditional system, the doctor orders and the insurer has its "yes" or "no" stamp. This is moving some of that so the provider has reason to think about "if I could look at this problem with a \$300 ultrasound, or I could look at it equally as well with a \$3,000 MRI." This whole movement came out of providers reaching out and saying we could do this better in some ways, some pieces of it, than insurers can, and also, having responsibility for quality. That's the philosophy of this work, building that into the contracts.

We have a number of clinical requirements in the contracts that include accountability for quality. The outcomes - are patients getting better based on the care they're given?

And also, care transformation, which is looking at the way care is delivered and making that better.

Slide 7 – Quality Improvement Score (QIS) Measures. Quality measure is the simpler side. We have 15 quality metrics in this contract for 2020 and they're pretty varied. We have measures for diabetics, depression, immunization, four around different kinds of cancer screenings plus chlamydia, C-section rates, and then four about member experience.

For member experience, we want to know if care was timely, did providers communicate well, and overall rating of a provider. There's always a concern when you look at quality measures of are you asking people to teach to the test, essentially. There's some interesting research around that. If you pick a couple measures, people really do tend to focus on those. If you make them broader across the population, that's much less of an issue. Each of these requires certain capabilities for a provider system to develop. If you're going to improve diabetes, you need to know who has a certain disease in order to reach out and track them.

Slide 8 – Care Transformation – Improving the way care is delivered. Care transformation we require in a number of ways. Part of that is participation in a number of programs and projects that are both local to Washington and national. One of those is the Bree Collaborative. If that sounds familiar, it might be because Dan Lessler, our former Chief Medical Officer, spoke to you at one of the earliest Board meetings around Bree. This is a group funded by the Legislature, but consists of independent medical experts across Washington who discuss areas where there's variation or uncertainty around care and create best practices for how people should be handling those. Our networks are required to implement those guidelines and tell us how they're doing that.

Dave Iseminger: Another reason you might remember the Bree Collaborative is those standards and guidelines created by the Bree Collaborative are the underpinnings of the Centers of Excellence Program. The total joint, hip, and knee replacement, as well as the spine care bundle. The Board authorized that Program, which is rooted in criteria established by the Bree Collaborative.

Emily Transue: Another area of participation is the Foundation for Health Care Quality, which is a Washington-based group that has the Clinical Outcome Assessment Programs (COAP). These programs collect detailed clinical data around certain areas of care and use that to drive improvement. An example of that would be one around obstetrics, and the ability to determine if a woman is given Pitocin to drive labor, at this point in labor, she's much more likely to have a C-section. If you delay a couple of hours and give it at a later stage, there are much better outcomes. That kind of thing you would never be able to see unless somebody was really looking at that detailed data across a big group. That's the kind of work COAPs do. We require them to participate in those.

Another is Primary Care Medical Home (PCMH). This is a national set of standards. I think of these as being what primary care should be. Certainly, I as a primary care doctor, do. This includes making sure the primary care office is functioning well as a team. Making sure they're coordinating all of the patients' care and making sure that

different specialists aren't contradicting each other or failing to communicate, doing outreach to people who need care but aren't coming in.

Slide 9 – Care Transformation – UMP Plus Quality Improvement. This list of projects are what we have them working on. Things like care coordination, preventing re-admissions, total knee, hip, and spinal fusion, a new project around opioids and addiction, which hadn't been part of the PEBB ACP Program, but will be going forward. Each of these has a number of components they're working with us on. The knee and hip replacement and spinal fusion will seem familiar from the Centers of Excellence (COE) Program.

The financial model in COE is different from the financial model of accountable care, but the clinical standards are the same. The care somebody would be getting would be the same within this program. Many of these projects have a requirement for shared decision making, which is a structured process for making sure somebody making a complex medical decision is getting information about all the options, all the pros and cons, and what about their values and goals would make them pick one choice versus the other?

Ryan Ramsdell: Slide 10 – Financial Arrangement. We talk a lot about accountability. In this particular arrangement, there's a combination of cost and care. UMP Plus incentivizes the networks to provide more efficient care than other plans, while being held to quality and care transformation standards, many of which Dr. Transue mentioned. It's a lot about sharing. If the networks save the program money, they share in those savings. However, if the networks overspend or underperform in care delivery, they share in some of those deficits. Quality results determine the percentage of savings and deficits shared, and this is what enables the plan to have a higher actuarial value, with the lower premium and deductible.

Slide 11 – Contracts and Negotiations Update. Negotiations wrapped up mid-June and we have two UMP Plus networks starting January 1, 2020: Puget Sound High Value Network and UW Medicine Accountable Care Network. Both networks contracted to participate through 2021, with an option to extend through 2024. Negotiations for strictly financial terms will begin late 2020 through early 2021. In terms of the contract related to operations and clinical expectations, those remain the same during that time frame, depending on outcome.

Pete Cutler: Ryan, are the networks for both identical between the SEBB and PEBB Programs?

Ryan Ramsdell: They are, in terms of the partner providers within the networks. I'll talk about the counties they serve at the end.

Dave Iseminger: It was important not to have opportunities between the two programs for people to stumble on similar, yet different, information.

Pete Cutler: Great strategy.

Lou McDermott: I want to make sure people understand. For us who work on this all the time, we understand it deeply! But when we try and explain it, we're utilizing our

third party administrator's network. We're utilizing Regence as the network, but we're subcontracting. We are making a direct contract with the networks. We're still using Regence, payments are still being made, but then we take a look at the data and the separate quality measures and separate financial terms. It's a contract on a contract. It's a bit cumbersome to explain, but we're still using Regence. There are more expectations on top of it.

Ryan Ramsdell: Slide 12 – Network Partners – PSHVN. For 2020, there is the Puget Sound High Value Network. The partners in that group are Virginia Mason; Rainier Health Network, better known by its individual parts: CHI Franciscan, City MD, Northwest Physicians Network, The Doctors Clinic, Pediatrics Northwest, and Highline Medical; the Physicians Care Alliance, better known as The Polyclinic; Seattle Children's Hospital; and Signal Health, which serves mainly in Yakima.

Slide 13 – Network Partners – UW Medicine. For the UW Medicine Accountable Care Network, there is UW Medicine, Multicare, Cascade Valley Hospitals and Clinics, Seattle Cancer Care Alliance, Seattle Children's Hospital, and Skagit Regional Health.

Slide 14 – UMP Plus – 2020 Counties Served. In terms of the actual counties served by both of these networks, there is a group of roughly five core counties in the center in yellow that serve both Puget Sound High Value Network and UW Medicine. In addition, UW Medicine will be serving Skagit County and Spokane County, and Puget Sound High Value Network will be serving Yakima County. This is a mirror of the PEBB UMP Plus.

Lou McDermott: I'd like to thank you for all the work on the contracts. It was an extremely difficult negotiation with a lot of moving parts and many unknowns, especially with the SEBB Program. Nice work.

Pete Cutler: I want to second those congratulations. As a Board member, waiting for this status report, I was getting a tad nervous, as the months went by. I'm very excited about what the HCA is doing here.

Lou McDermott: We were all getting nervous, Pete.

Dave Iseminger: This was one of the longest contract negotiations. We initiated contract negotiations for the PEBB Program extension. It was a very complicated, four-phased negotiation that lasted somewhere between 16 to 18 months. It's been a very long journey to get to this point.

Lou McDermott: We had some complexities refreshing our contract with Regence starting in January 1, 2020. That added a layer of complexity. The SEBB Program coming online added a layer of complexity. The negotiations were taking hit after hit, but they managed to get it done. So, really nice job.

Medical Plan Service Areas

Lauren Johnston, SEBB Senior Account Manager, Employees and Retirees Benefits (ERB) Division. First, I want to provide a procurement update since the last time we met. The Kaiser, Premera, and MetLife contracts are signed.

Dave Iseminger: Again, an understatement to the amount of work required for this. In total, about 24 contracts have been executive or amended since the beginning of the launch of the SEBB Program. It has been a very long journey. Lauren's lived with the medical piece from the inception of the procurement to the execution of the contracts, and she's done a fabulous job for getting choices for school employees.

Lauren Johnston: The presentation has been updated since its original release. We received a number of similar questions. When people were looking at the service areas based on the county in which a member lives, and then looking at their school district, there was confusion between seeing a bunch of plan options based on the counties in which they lived, going down to the employer level, and only seeing the three UMP plans. We have gone through and updated this presentation to eliminate some of that confusion.

Dave Iseminger: When you see “primarily based on the county in which a school employee lives,” that approximately applies to well over 95% of the population. That is the rule. The exception addresses about 5,000 school employees. A lot of people are used to looking at things from the lens of their district offering and not where they live; but we need to help people understand the rule is where you live. The additional options are based on where you work.

Lauren Johnston: Over the next 20 pages, there is a lot of information that's going to be layered on top of itself, which ultimately will lead to the end result of what plan options are available to school employees.

Slide 3 – County-Based Service Area Maps. This is in contrast to current K-12 offerings. The vast majority of the school employees’ options for SEBB medical plans are based on the county where the employee lives. When the fully insured plans file with the Office of the Insurance Commissioner, they do so based on county. There's no more granular level, not zip code, not by school district. It's based on county lines. The following maps reflect the county-based medical options.

Slide 4 – Kaiser Permanente Service Areas. This map shows service areas for all of the Kaiser Permanente plans, which includes Kaiser Northwest, Kaiser Washington, and Kaiser Washington Options. The purple is Kaiser Northwest with three plans offered in both Cowlitz and Clark Counties. The Kaiser Washington Core 1, 2, and 3 are in the green counties. Kaiser Washington 1, 2, 3, and the Kaiser Washington Options Access PPO 1, 2, and 3 are in the light blue. Kaiser Washington 1, 2, and SoundChoice, and the Kaiser Options Access PPO 1, 2, and 3 are in the dark blue. The only difference between the light blue and the dark blue is that the light blue offers the KP WA Core 3 Plan, and the dark blue is where KP WA SoundChoice is offered.

Dave Iseminger: This map represents the full county footprint that each of these carriers serves in the individual market and their other filings.

Lauren Johnston: Slide 5 – Premera Service Area. Premera is offering three plans: a high PPO, a Peak Care EPO, and their standard PPO 33 counties across Washington, only six counties they are not in. In November 2018, you originally saw a Premera Plan 1, later named Value PPO, which was withdrawn recently during negotiations. That

plan was at a higher prescription drug deductible. It had a \$500 prescription drug deductible for a single subscriber and a \$1,250 prescription drug deductible for two or more enrollees. During the November 8, 2018 Board Meeting, you asked Premera to price this plan and another plan that met, or was lower, than the UMP Achieve 1 prescription drug deductible at \$250 for a single subscriber, and \$750 for two or more enrollees. Since that time, and after rate development, Premera has decided to remove their Value PPO at the higher prescription drug deductible and keep the Standard PPO at the lower prescription drug deductible.

Dave Iseminger: The rates ultimately were so similar that to add the extra complexity of such a nuanced difference within the portfolio did not make sense. Premera consistently asked the Board to consider the Value PPO plan. You offered to entertain that in rate negotiations, but when the rates came in, they decided it was no longer necessary to continue to request that plan.

Lou McDermott: Lauren, the counties that Premera is not in, are those related to blues rules?

Lauren Johnston: Only Clark County.

Dave Iseminger: Building on the statement I made on Slide 4, Premera filed service areas within the individual market in 38 of 39 counties. They cannot file in Clark County for blues rules, but the package they presented includes 33 counties. They are serving the individual market in the other five counties. We are hopeful that in future years there will be opportunities for expansion to encompass their entire footprint in the state.

Lauren Johnston: Slide 6 – Uniform Medical Plan (UMP) Coverage, administered by Regence and Washington Prescription Drug Services. This is their coverage map for the state of Washington. Because UMP is a self-insured plan, they do not need to file service areas with the Office of the Insurance Commissioner (OIC). Regardless of where a member lives, even if they live outside of the state, or they have dependents outside of the state, they could enroll in the Uniform Medical Plan.

Slide 7 – UMP Plus Network Coverage. We included this slide so you would have the whole portfolio of service and coverage areas for the SEBB Program.

Slide 8 – Combined Medical Plan Service Areas. This is a tile map to give you an idea of the carriers and the number of plans each carrier has in every county in Washington State. There are only three counties that are UMP only, San Juan, Douglas, and Klickitat County. The two counties with the most plans are Thurston and Pierce Counties at 14 plans. The counties after that are Kitsap, Skagit, Snohomish, King, and Spokane. They all have at least 12 or more plans.

Sean Corry: What plan is missing from King County, relative to others?

Lauren Johnston: One of the Premera plans.

Dave Iseminger: Sean, to be more specific, it's the Peak Care EPO plan. It's similar to UMP Plus, in the sense that it's a smaller partner provider network and it's an

agreement that Premera has with Multicare, so Multicare servicing Pierce, Thurston, and Spokane counties. That network is an option within those areas that Multicare specifically serves.

Lauren Johnston: Slide 9 – Plan Availability Considerations. Carriers must file their service areas based on county lines. 71 school districts cross county lines. Going through this process, we were looking at what constraints our IT system might have and what the carriers' preferences were. There were a number of different considerations, as well as the complexities that each of the considerations involved. Something to note is that well over half of those 71 school districts that crossed county lines have different plans in the two counties served. We decided the easiest way to present this to school employees who work in a school district that crosses county lines, was to give them the maximum number of options available that were in one of the counties. If you had one county that had three plans and one county that had five plans, and the school district crossed both of those counties, the employees that worked for that school district would have five plans available to them instead of just the three.

Dave Iseminger: There's always an exception to the exception. Lauren's statement is generally true. There are a couple of instances where it is not the full package of the most generous plans, if you lined up both counties. The specific example is UMP Plus as Ryan highlighted. The network contract itself requires a residency requirement. If a school district straddles into and out of the UMP Plus network, that plan would not be available based on the work location. You have to live in the county that fits the UMP Plus service area. There are a couple of nuances, but we were working with the carriers to have the most generous offering for a school district that straddled both county lines and service areas.

Lauren Johnston: Also considered, we found there were a little over 1,700 employees that would only have access to UMP. We were able to bring that number down to just under 1,500. The other consideration was there are over 1,500 school employees that live outside of Washington State.

Slide 10 – SEBB Program Medical Plan Offerings. All school employees may select from plans based on the county they live. An exception to this is additional plan options may be available if an employee works in a district that straddles county lines, or is in a county that borders Idaho or Oregon. We gained an appreciation of the plans that were going to be available to members who lived in rural communities and worked for rural school districts. We tried to prioritize to get them as many plan options as possible.

Slide 11 – Medical Plan Offerings Based on Where a School Employee Lives. All school employees, regardless of the county in which they live, may select a plan based on the county they live in. As you go down the county lines and across the columns, school employees will be able to see the options available to them.

Slides 12 – 20. These slides are the medical plan offerings based on an employee's employer. For example, if I work for Aberdeen School District, I have to select my plan based on the county in which I live. So if I live in Aberdeen, and I live in Grays Harbor County, I would have the plans available to me that are offered in Grays Harbor County. If I live in Mason County and I work for Aberdeen School District, I would have the plans available to me offered in Mason County.

Dave Iseminger: Because Aberdeen School District is wholly within Grays Harbor County, and Grays Harbor County does not touch the state of Oregon. Line-by-line, everywhere you see employer medical plans are based on the county in which they live, it's because that district does not meet one of the two exception criteria.

Lauren Johnston: Almira School District crosses county lines of Grant and Lincoln Counties. If I live in Grant or Lincoln County, I could choose one of the plans offered in those counties. It just so happens in Almira's example the plans offered in both counties are the same, two Premera plans and three UMP plans available to me.

Slide 21 – Examples Applying Exception Criteria. These are examples applying the exception criteria of crossing county lines, or border Idaho or Oregon. A school employee lives in Grays Harbor County and works in the Mary M. Knight School District, which crosses Grays Harbor and Mason Counties. The employee can select from one of the following plans: KP WA Core 1, 2, 3; KP WA Options Access PPO 1, 2, 3; Premera High PPO and Standard PPO; UMP Achieve 1, 2; and the Uniform Medical Plan High Deductible. This affects approximately 15-20 members who have additional plan options after applying this criteria.

Dave Iseminger: Lauren, can you explain why some plans are underlined on Slide 21 and others aren't?

Lauren Johnston: The underlining indicates the additional plan choices based on the Slide 8 employer criteria, crossing county lines or bordering Idaho or Oregon.

Dave Iseminger: I just realized, when we updated the slide deck, we didn't update the slide reference at the bottom. It should "Slide 10 employer criteria."

Lauren Johnston: The second example is a school employee who lives in Stevens County and works in the Nine Mile Falls School District, which crosses over Stevens and Spokane Counties. They can select from one of the following plans: KP WA Core 1, 2 and SoundChoice; KP WA Options Access PPO 1, 2, 3; Premera High PPO, Standard PPO, and Peak Care PPO; and the UMP Achieve 1, 2, and the Uniform Medical High Deductible Plan.

The final example is a school employee who lives in Portland, Oregon and works in the Washougal School District, which crosses over Clark and Skamania Counties. They can select from one of the following plans: KP Northwest 1, 2, 3; Premera High PPO or Standard PPO; UMP Achieve 1, 2, and the Uniform Medical High Deductible Plan.

Dave Iseminger: I'm going to describe a couple of other high-level numbers. Lauren described the first example on Slide 21 would impact about 15-20 school employees. The second example would impact about 120 employees. The third example would impact approximately 15-20 employees. As you add up the individual scenarios across the state, it ends up being about five thousand school employees.

I want to highlight a couple of large examples. For example, about 780 school employees work in a school district in Clark County, but live in Portland, Oregon. All of those individuals, without the exception criteria, would only be able to elect Uniform

Medical Plan options. They have additional options because of the exception criteria. In Southeast Washington, about 90 individuals who work in the Pomeroy School District would have additional plan options because of the exception criteria. In Clarkston, which straddles Asotin, Whitman, and Garfield Counties, about 300 school employees who have additional plan options because of the exception criteria. An additional 120 who commute from Idaho would have additional plan options.

About 200 people commute to Spokane and Mead Public Schools and some of the sister school districts in Spokane that have additional options. About 90 people that work in either White Salmon Valley or Bickleton in Klickitat County will have additional plan choices because of the exception criteria. About 200 people who live in Island County but work in the Standwood Camano School District will have additional plan options. Approximately 1,300 school employees who work in the Northshore School District will have additional plan options because of the Premera option that exists in King County, which is not in Snohomish County.

There are lots of examples of the exception criteria, giving real additional options to about 5,000 school employees in the state. Our ultimate goal is to work with carriers in future iterations to see if we can continue to expand and push the envelope on work options and have a full live or work ability for plan selection. We wanted to make strides on out of state and rural access choices to be able to present as much of a robust offering and opportunities for school employees for this program launch.

Lauren Johnston: The Appendix has a high-level look at available benefits. There are a couple changes since the last time you saw this.

Dave Iseminger: There are two items in the Appendix. The first one is a six-page document. The second document, Board Members have a blown up version in the pocket of your binders.

Lauren Johnston: The first change I want to note is that Premera had previously presented, in their rate development for the Standard PPO, the lower deductible at the Achieve 1. They also wanted to lower the deductible for their high PPO and their Peak Care PPO. They essentially cut the prescription drug deductible in half, so now it's \$125 and \$312.

Dave Iseminger: We presented that and had it as a footnote in this chart in several of the iterations we've been bringing back to the Board since January or March. We're embodying that in the final chart here. Your interest was in having no drug deductible if possible, but certainly not a drug deductible higher than Uniform Medical Plan Achieve 1 when Premera came forward several months ago. We added this as a footnote to the chart. When you ultimately vote on resolutions, it would be ratifying that change from the November benefits that you authorized into the rate development process.

Lauren Johnston: The next change is in the Uniform Medical Plan. The prescription drug out-of-pocket maximum limit used to say " \$2,000 per member" for the UMP Achieve 1, UMP Achieve 2, and UMP Plus. It now says, "\$2,000 per member; \$4,000 family maximum."

On the Dental Benefits slide, the change is under the high-level overview for the dental benefits. Originally, there was a mixture of what the member would pay and what the plan would pay. It now shows only the member's cost share. For example, the routine emergency exams used to say "100%" because the plan covered at 100%. It now says, "\$0" to indicate the member will pay \$0. Another change under the dental benefit is under fillings. It used to say under the Uniform Dental Plan, "80%," which is what the plan covers. It now says, "20%," which is the member share.

Dave Iseminger: In the Uniform Dental Plan if you go back to prior iterations, there was one line for fillings and crowns, when actually the coinsurance is different for those. We broke out those two lines.

Lauren Johnston: There were a couple changes to the larger chart, too, the SEBB Program Medical Benefits Comparison Chart. Under Kaiser Washington Options Access PPO Plan 1, the diagnostic tests, labs, and x-rays row, it used to say "20%" and now it says "20% over \$500." The plan pays the first \$500 and the member share is 20% over that amount. It matches the column for the Access PPO 2 Plan.

Looking at the back side of the chart, for Premera's High PPO and Peak Care PPO plans, the prescription drug deductible is now \$125 for a single subscriber and \$312 for two or more enrollees.

The Uniform Medical Plan out-of-pocket limit for prescription drugs changed from "\$2,000 per member" to "\$2,000 per member; \$4,000 family maximum" for UMP Achieve 1, UMP Achieve 2, and Uniform Medical Plus.

Dave Iseminger: The vast majority of these changes are clarifications of how it was supposed to be written. They're not fundamental changes, with the exception of the prescription drug deductible being cut in half for Premera's High PPO and Peak Care PPO, which was highlighted as a footnote on these charts, and verbally whenever we were presenting them in the past couple of Board Meetings.

Terri House: I'd like to say thank you to Lauren, because over the last year I know we, as Board Members, have come to her on different things to ask the insurance companies on our behalf. She's followed through every single time with everything we've asked her to do so I really, really appreciate that. Thank you.

Lauren Johnston: You're welcome.

2020 Rates Overview

Megan Atkinson, Chief Financial Officer, Financial Services Division. Today we are getting to a culminating point of our journey. We are at the last stage of rate development. We can see the results of your hard work in setting up the program, the partnerships we established with our managed care partners, and our own rate development for the self-insured plans. You've had the slides for a few days and many of you had an opportunity to talk with Dave in advance of the meeting. Similar to what Lauren experienced, after these slides were posted, we received questions that led us to the conclusion that it's not clear to a lot of people exactly how the tier ratios work. I'm going to spend time on these slides. I know the Board gets it, but others might be listening that need clarification on understanding how the tier ratios work.

Dave Iseminger: We're also taking that feedback and refining our final member communications. The Board is one audience and the record for what you built. That is a different audience than the individual school employees. We expect the school employees in districts are paying attention. We were fast to incorporate feedback on Lauren's presentation in the last 48 hours. We will take that feedback and work on ways to minimize the chance for confusion, especially when it comes to the tier ratio. For example, in the final member communications, we won't show the multiplier. We'll just do the multiplication.

Megan Atkinson: Slide 4 - Determining Employee Premiums – Sample Illustration. We have a bid rate and premium mechanism in the SEBB Program where we hinge off what our Employer Medical Contribution (EMC) is. In this illustration, we receive plan bid rates, Plan A is a bid rate of \$700 per member per month (PMPM). In Plan B it's \$650 and Plan C it's \$600. The Employer Medical Contribution (EMC) calculation is based on the bid rate of our self-insured Achieve 2 Plan, which is our self-insured plan with an 88% actuarial value (AV). When you do the math you get the employee contribution. Plan bid rates – EMC = Employee contribution.

Staying with the green bar, sample Plan A had a bid rate of \$700. The EMC is \$500. You subtract and end up with an employee contribution of \$200. That's how the math works in all of the examples.

Slide 5 – Determining Employee Premiums by Tier – Sample Illustration shows how the tier ratios work. This is where the multipliers come into account, and where we're getting feedback that it's confusing to folks. Tier 1 is our single subscriber tier because there is only one subscriber in that tier. As you move down the tiers is where the subscribers can add their dependents to coverage. Tier 2 is two adults, the subscriber plus his or her spouse or partner.

Then we get into iterations of the family tiers. Tier 3 is a single adult and a child or children. The tier ratio is 1.75. Here's where I want to pause because this is where some of the confusion come in. Tier 3 is one adult, and it's always one adult, but it can be any number of children. It can be a single dependent child, it can be two, it can be twelve, however many. The tier ratio remains the same at 1.75.

It's a similar construct on Tier 4, which is sometimes referred to as the Full Family Tier. It's the subscriber plus an additional adult (their partner or spouse) and any number of children in their family unit. It can be two adults and one child, two adults two children, two adults 25 children. That tier ratio of three remains the same, regardless of how many are on that subscriber's account.

The math for the tiers is Employee Contribution x Tier = Employee Premium. Staying with the green bar:

- Plan A – \$200 x 1 (Tier 1) = \$200 per month for the single subscriber
- Plan A – \$200 x 2 (Tier 2) = \$400 per month for two adults.
- Plan A – \$200 x 1.75 (Tier 3) = \$350 per month for one adult and child(ren).

This is where confusion is happening. It is just \$350 per subscriber's account per month. It is not \$350 times the tier ratio. It is \$200 times the 1.75 tier ratio. That is what gets to the \$350. No additional multiplication needed.

- Plan A - \$200 x 3 (Tier 4) = \$600 per month for two adults and child(ren).

Slides 6-7 – Employee / Employer Premium Contributions. Because we have a large number of carrier and plan offerings, this table is split across two slides. These slides show the results of procurement, our final rates, and showing you for each carrier and plan offering how the total composite rate, the employer medical contribution, and the single subscriber employee contributions, come out mathematically. I have additional slides that will show you how the employee contributions across the tiers work out mathematically.

Slides 6-7. These two slides show the entirety of the offerings. The table is read from right to left. On the far right are the proposed 2020 total composite rates. The middle column is the employer medical contribution (EMC). That number is the same for every plan because we pivot off the 85% of UMP Achieve 2. Based on our final bid for Achieve 2, the final rate build for Achieve 2 is \$555. For every subscriber in the SEBB Program, the employer contribution is calculated for purposes of calculating employee premiums at \$555.

The green column is the math. Composite Rate – EMC = Employee Contribution. For Kaiser Permanente NW 1, the total composite rate (rounded to the nearest dollar) was \$583. Subtract \$555 and you get \$28, the single subscriber employee contribution. That's how the table on Slide 6 works and it continues on Slide 7.

Sean Corry: On the first example, I was figuring out the percentages that employees pay, percentage of the total premium, and the percentages themselves vary widely. On top, if the employee contribution for Kaiser Permanente NW 1 is \$28 over \$583, it's 4.8%. I've come up with 2% at another place, 13% at another place, 17% of the premium that the employee pays? Could you explain why there is that percentage variation? Why employees pay a bigger share, or a lesser share of a premium?

Megan Atkinson: The Collective Bargaining Agreement dictates how we set employee contributions for the SEBB Program. In terms of the Collective Bargaining Agreement on the SEBB Program, we're benchmarking off of the UMP Achieve 2 self-insured plan. The Collective Bargaining Agreement says the employer contribution shall be 85% of the state self-insured 88% AV plan. That's our Achieve 2 Plan. If you look at that row on Slide 7, third from the bottom, the UMP Achieve 2 Plan is \$555 is 85% of the \$653, and the \$98 is 15% of the \$653. As employees make their plan choice, their percentage will vary. You're correct, the percentage of the total they are paying will vary because that \$555 is locked in as a raw number, a nominal number, and doesn't float as a percentage. Does that answer your question?

Sean Corry: It does, although I raise the thought that it changes the selection process. In terms of the rating of a plan, there's an expectation that a certain number of people will come in either of the vendors, it doesn't really matter. The point is that there's an expectation for a plan, certain type of people coming in, family sizes, all of that, and if

the premium sharing arrangement is set up based on a fixed contract number that skews the selection process. How did the carriers take that in?

Megan Atkinson: I think it definitely changes the dynamics. I don't want to speak for the carriers. I would imagine it would change the dynamics by which they think about selection, because you are correct. Again, depending on each individual's selection and the utility they're trying to drive from their plan selection. We had an interesting conversation at our HCA Coordination Team meeting yesterday talking about what drives people's selection. For me, and I'm decently good at numbers and decently understand health care selection, I am going to select the plan where I can get to my pediatrician. It doesn't matter, anything else. If my pediatrician changes networks, I'm changing plans. When I was single, I had a very different utility equation. I selected on very different criteria.

To your point, Sean, the amount of the premium, the financial consideration, will most likely play into the decision-making. If people are making decisions based on minimizing their employee premium, then yes that can skew the way they select. I don't know exactly how each carrier took that into consideration. What we did, from managing the portfolio from our perspective, we made certain the carriers understood the way the SEBB Program employee and employer premiums were calculated. That was a topic of conversation in many of our carrier meetings. In addition, we made sure they knew how the UMP bid rates were coming out as we were developing those, and gave them an opportunity to adjust their bid rates, based on the UMP bids. and then based on the final EMC, \$555. That allowed them to position themselves competitively in the market based on what the carriers and the plans are trying to maximize for themselves, either in terms of positioning or maximizing revenue. There's a variety of things I would imagine they take into consideration, just like we do.

That's how we address that. I understand the point you're making. It is a different dynamic in the SEBB Program than what we have for the PEBB Program. It's one of the things we've worked on trying to communicate, especially with Kaiser Permanente, because they partner with us already in the PEBB Program. Premera, it's a little bit different. We are starting from ground zero with them on explaining how it works. Does that help at all?

Sean Corry: It did, thank you.

Pete Cutler: Megan, part of the context for this, if nothing else, is I want to get confirmation as I understand the change was made with the most recent Collective Bargaining Agreement. My understanding is that prior to this Collective Bargaining Agreement, all the prior ones had the employer commitment to be funding an average of 85% of the overall average premium cost. On average, regardless of which plan people picked, the rates were calculated to come up with, for the total premium costs, 85% would be employer money, 15% would be employee contributions.

Megan Atkinson: I want to clarify, Pete. We are in a situation where the PEBB Program health care benefits are calculated per that methodology. The PEBB Program Collective Bargaining Agreement, of course, is separate from the SEBB Program Collective Bargaining Agreement. The way the employer and the employee premiums are split are different in the two programs.

Pete Cutler: That's very helpful because I actually had not tracked that the two Collective Bargaining Agreements for the two different groups this year had varied in terms of that point. With the SEBB Program, instead of the commitment from the state being for the employer to contribute 85% of the overall average, we have a commitment of a funding level for 85% of the Achieve 2, which is more expensive than the average, I believe. But the bottom line is it appears to drive much lower percentage employee contributions, as a total, than would be the case in a PEBB Program. I haven't done all the numbers, but from just going through all the examples, it seems to me that's a major win for school employees compared to state employees. Am I reading that correctly?

Megan Atkinson: I haven't done the math on if we used the PEBB Program methodology on the SEBB Program rates, how it would pan out. One of the things we faced working with our labor relations partners and supporting collective bargaining last summer, is the PEBB Program methodology uses what you were describing, a weighted average methodology. But with the SEBB Program, we don't have any enrollment yet. There's no way for us to do a weighted average methodology. When we were working through collective bargaining last summer, one of the things from the HCA perspective was we went through collective bargaining after the Board voted to have the self-insured products. There were so many unknowns when working through collective bargaining. That was something we could use as a known. We are familiar with the UMP product, obviously. We know our TPA. The Board supported having that as one of the offerings, and it gave us something we could benchmark off and model.

Lou McDermott: Pete, I did play with the numbers a bit. The answer is, it depends. It is possible, theoretically, for members to sign up and depending on the tier they sign up for, it could be at 15%. But that's not going to happen. It's going to be over/under depending on what plans they select and doing the PEBB Program weighted average calculation, we'll know at the end what the actual number is.

Pete Cutler: Thanks. I understand that's theoretically possible. And I sure hope that the Health Care Authority will, when we get through with open enrollment sometime in January, provide us with what the actual average employee contribution is, as a percent, because I think inquiring minds would be very interested in knowing how that has evolved. Thank you.

Megan Atkinson: I want to say absolutely we'll provide you with any statistic you would like to have. I would encourage us to not go too far down the path of "what if the SEBB modeling were on the PEBB population, what if the PEBB modeling were on the SEBB population." They are different programs with different carrier offerings. We'll see how much the populations mirror/don't mirror each other. There's geographical distribution differences. It'll be interesting to see as the SEBB Program matures.

Pete Cutler: This Board won't have any decisions in front of it or adjustments that will be needed that we expect to make between now and the next plan year cycle. I think it's more a matter of going into the rate setting for 2021. It probably will not affect there because we have the Collective Bargaining Agreement just down the road. Just being aware, are there differences? Is it shaking out differently between the two populations? I think a question for a lot of us will be, "Is that result what policy makers want?"

Megan Atkinson: Definitely.

Sean Corry: Maybe in summary, if one were able to toggle back and forth to compare like plans between SEBB and PEBB and look at the premium sharing arrangements for those plans. They would see differences that may be remarkable differences in employee share of the premium for a plan similar in the other population because the premium share for employees differs between the two programs. Finding an HMO from Kaiser Permanente, for example, premium shares for employees would be different in the SEBB Program and in the PEBB Program, and sometimes, rather large differences, I would guess, for employee share of the premium because of the differing methodologies.

Megan Atkinson: I have not done a comparison of the two to see where they are similar or identical other than when working with Milliman on developing our own self-insured bids and building those. For our own self-insured products, we utilized a lot of similar assumptions that we know about the PEBB Program population as we built out the SEBB Program rates. Again, I can't speak to the other carriers and what we did. There are general similarities and I believe our UMP High Deductible, at \$25 on the single subscriber tier for the SEBB Program is similar if not exactly the same as the PEBB Program?

Dave Iseminger: I can't speak to the bid rate, whether it's the same, but the employee premium contribution is identical.

Megan Atkinson: I think the Achieve 2 at \$98 is about the same.

Dave Iseminger: The PEBB Program single subscriber UMP Classic rate for 2020 is \$104. So it's \$6 less, but I can't speak to the relativity of the bid rates.

Megan Atkinson: I think to your point, Sean, if they are not exactly the same, for those families that may have dual eligibility, it plays into some of their decision making. I think what you'll see as we move forward into year two and three, is how the demographics, the riskiness, the health status, and the utilization of the populations is able to come in and inform subsequent rates and subsequent bid rates.

Dave Iseminger: Another piece to think about is the part-time eligibility rules between the PEBB and SEBB Programs are very different, which led to us bringing to this Board the possibility, and you ultimately approved it, of including the UMP Achieve 1 Plan, which is an actuarial value of 82%. That entire plan, within the self-insured portfolio, does not exist in the PEBB Program. That's another dynamic. The underlying eligibility framework does have some key differences between the two programs that could be playing into the demographics as Megan's referencing.

Megan Atkinson: To tie up Slides 6 and 7, they are showing the same information for different plans, sorted by carrier, by plan. Slide 6 are the KP offerings. Slide 7 shows the Premera and the UMP offerings. I want to point out at the single subscriber tier, the lowest single subscriber contribution is \$13 with Kaiser Permanente WA Core 1. On Slide 6, that's the fourth row down. The most expensive is also on Slide 6, last row, Kaiser Permanente WA Options Access PPO 3 at \$116 single subscriber employee contribution. In our communication materials, we will help educate members look at both the premium contributions and the benefit offerings of each plan. Everybody's

decision-making is unique. There are network considerations, deductible considerations, all of those things people will take into consideration as they make their selection.

On Slide 7 for the Uniform Medical Plan, I want to highlight the last four rows. The UMP single subscriber contributions vary from a low of \$25 on the high deductible, which includes a health savings account (HSA) identified in the second bullet below the chart. The HSA contribution on Tier 1 is \$375 per year. For Tiers 2, 3, and 4, it's \$750.

Dave Iseminger: Up until now, the only "not to exceed" rate numbers you've seen from the portfolio are the Achieve 1, Achieve 2, and High Deductible rows. If you were remembering something cost over \$100, you're correct. In the "not to exceed" rates from a couple of months ago, UMP Achieve 2 was looking like it was hitting a target of \$101. In these final rates, all three of these plans came in under \$100 at the single subscriber level. I believe High Deductible did not change. The not to exceed rate was \$25 before. The Achieve 1 not to exceed was \$34, so that ended up being a dollar lower. UMP Achieve 2 dropped from the \$101 not to exceed to a \$98.

Lou McDermott: Dave, what's the most expensive plan for two adults and 25 kids?

Dave Iseminger: That was a great transition, Chair McDermott, because Megan was about to go to Slide 8.

Megan Atkinson: Slides 8 and 9 can be used together because it's showing all of the plan offerings sorted by carrier and plan. They show how the employee contribution varies by tier. If you refer back to the Lego person slide from the beginning of the conversation, these tiering factors are shown at the top in the grey bar, and it's one of the things we're going to remove when we share materials. We think it's leading to confusion where people are thinking they're supposed to take the number in the column and multiply it by that tier ratio, not understanding the multiplication has already been done.

Looking at these slides from left to right is the single subscriber tier, the subscriber and spouse or partner tier, the subscriber and child or any number of children tier, and the last tier, subscriber, spouse or partner, and child or children tier. The last tier has the highest tier ratio, and ultimately, we would expect it to have the highest average number of people per account.

I will walk through a couple examples. If you go down about midway, let's look at Kaiser Permanente WA SoundChoice that has a single subscriber employee contribution of \$49 per month. Moving to the right, if the subscriber and spouse or partner enroll, they pay \$98 per month. The subscriber and child(ren) pay \$86 per month, a little lower because the tier factor is 1.75. The previous tier factor for two adults is 2.0. And finally, moving to the far right, subscriber, spouse or partner, and child(ren) is \$147 per month.

Our most expensive plan for 2020 is the Kaiser Permanente WA Options Access PPO 3, towards the bottom of the page above the second gray line. If you look at the tier furthest right, they pay \$348 per month. There is no maximum to the number of dependents the subscriber may enroll. The tobacco and the spousal surcharges can come into play for additional charges on the subscriber's account.

Slide 9 is the rest of our offerings, the Premera products and the self-insured offerings. The math works the same.

Dave Iseminger: I alluded at the very beginning we're describing and presenting this, showing those tier ratios at the top. That's proven to be a very confusing point for school employees in districts, understandably from the existing world they're coming from. When we sent out our June newsletter, we had a mockup describing the tier ratios and we used a \$300 example, because at the time, with UMP Achieve 2 had a not to exceed \$100, we wanted a round number for the purposes of examples. What we found after that newsletter went out, and after these slides went out on Monday, is we started getting phone calls saying, "I pay \$2,200 a month now for my family coverage. When I look at this, I see \$300. I have four people I'm covering, I must have to take \$300 times four. I'm going to pay \$1,200. Thank you, you're saving me \$1,000! Am I reading that right?" Staff responded that, "No, you'll pay \$300. You're going to save \$1,900 a month."

This gets back to something Patty said a couple months ago. When the Eatonville School District transitioned to PEBB Program benefits, everyone kept saying the math is so simple, what am I missing? As we go forward, we're not going to describe the tier ratios, we're not going to call it Tier 1, Tier 2, Tier 3, Tier 4, because if you call it Tier 4 people think they have to take that 4 and do something with it. We're going to say subscriber, subscriber and spouse/state-registered domestic partner, this is what you pay. We'll do some illustrative examples like Dave is a school employee and is going to enroll himself and his two children. Next year Dave has three kids. The next year Dave has four kids and Dave still pays \$300 a month. We want to help drive home that point.

Those are the calls we're getting. That's the point we're driving home and we wanted to assure you as we move forward with member communications, we're going to do everything we can to help people understand there's no extra multiplication. We'll have as few numbers on the page that might lead someone to believe they have to do multiplication, to avoid some of that confusion. The people who have called and asked these questions have been quite shocked at the final numbers. Especially for the family coverage because it's very different. It's one of those pieces, when the legislation set in the maximum tier ratio of three to one, we knew this was coming. But here we are today with the numbers, and people are digging into them and realizing what's about to happen.

Patty Estes: Looking at this, I'm getting emotional because this is what we've been building and this is what classified school employees have been working towards, because that \$2,200 a month is an employee I know. She had to write a check to the district at the end of every month above and beyond her paycheck to pay for her insurance. And now she won't have to do that anymore. So thank you, guys, this is great.

Dave Iseminger: Patty, it's -- now you're making me tear up! We've been working on the program for two years. And we're here two years after the legislation was signed. To realize the number of people who will, for the first time, have take home pay. That's a profound difference. It's what this whole thing is about.

Patty Estes: And to point out, that's the maximum they're going to pay. That's like the Cadillac version, not everybody's going to pick that one. But that's the maximum they could have to pay, and that's amazing.

Dave Iseminger: We should have brought tissues.

[laughter]

Megan Atkinson: I will say I have been pleased with how the procurement has come in. I was optimistic all along, but I've been really excited and really happy to see how the procurement is coming.

Slides 10-17 have the additional suite of benefits that are 100% employer paid. This presentation is a bit different because I don't need to break it out between employee and employer.

Slide 11 – Dental Premiums. These are the per subscriber rates for the three dental offerings. Again, the premiums are 100% paid by the employer. The rates vary from \$41.43 up to \$49.90. We do have tier ratios on dental, but I didn't show it because it's 100% employer paid.

Slide 12 – Vision Premiums. There are three vision care offerings. A difference between the PEBB Program and the SEBB Program is the PEBB Program vision coverage is part of the medical offering and is subject to employee and employer contributions. In the SEBB Program, we have vision carved out as a stand-alone vision benefit, 100% paid by the employer. The monthly premiums range from \$4.36 to \$6.66 per month.

Slide 13 – Basic Life / AD&D and Basic Long-Term Disability (LTD). These are employer paid. The rates are \$3.96 per month for Life and AD&D and \$2.10 per month for LTD.

Slide 14 – Supplemental Benefits, which are optional benefits that an employee may choose to enroll in. They are employee paid should they choose to enroll. We do leverage our contracts, however.

Slide 15 – Supplemental Life. Rates are based on age bands at the rate per \$1,000 of coverage the individual selects. There's a sample formula on the right of the slide.

Slide 16 - Supplemental AD&D. The rate is not age-banded, but a rate times the amount of coverage selected gets you the monthly premium. An example is shown on the slide.

Dave Iseminger: The last bullet says "Based on age as of December 31 prior year." That was a vestige from the prior slide with a copy and paste. As Megan just said, there's no age banding. You can't underwrite for an accident. It doesn't matter how young or old you are.

Megan Atkinson: Slide 17 – Supplemental Long-Term Disability. These rates are age banded. The formula is there and it's a simple rate times the insured monthly earnings equals the employee's monthly premium.

Slides 18-23 are proposed resolutions.

Dave Iseminger: As we look at the proposed resolutions, I'll give you context as to why you see resolutions the way you do and why you don't see other resolutions. I'll identify changes. We renumbered the resolutions in the updated Board packet. We had skipped a few numbers by accident. These resolutions are by carrier, a resolution that says the Board endorses the employee premiums for said carrier. There's one for each carrier.

You're not voting plan by plan. As we go through the rate development process, it's a bundle of sticks of those plans. That bundle, by passing the employee premium, is the ratification of the underlying benefit design, as well as the service area. Since they're all intricately linked, we just tee up premiums for you to vote on. In future years, we would tee up for you employee premium changes. We would educate you and bring you along the journey, during Executive Session, about what different benefit impacts are. We'd work through Executive Session and get insight for us to go back during the procurement negotiations cycle. Ultimately, the action that you take as a Board is setting the employee premiums and that's also how your authority is described in statute. It is specific to employee premiums. And that's why you only have medical premiums in front of you. There's no employee premium to set when it comes to dental, basic life, and basic AD&D.

When it comes to supplemental benefits, there are no resolutions for supplemental life and supplemental LTD. You already ratified and passed a specific complex benefit design resolution on life insurance and LTD. At that point, it's plug that benefit design into the actuarial formula. Specific numbers come out with very little manipulation. So by passing the benefit design on the supplemental life and LTD, that was the precursor to setting of the rates. On life insurance and basic LTD, you passed the benefit design, which comes with rates. Here you pass the rates, which comes with benefits designs. That's why you see the resolutions the way you do, each one successive.

We do things in alphabetical order:

SEBB 2019-12 – KP Northwest

SEBB 2019-13 – KP Washington

SEBB 2019-14 – KP Washington Options, Inc.

SEBB 2019-15 – Premera

SEBB 2019-16 – Uniform Medical Plan

Those are the resolutions.

[break]

Lou McDermott: Alison, did you join us on the phone?

Dave Iseminger: She might be on mute. She was texting me a while ago. She knew we were breaking. I have proof she was on the call!

Lou McDermott: We'll let it go at that.

SEBB Program Default Plans

Marcia Peterson, Manager, Benefit Strategy and Design Section, ERB Division. I am going to present the intended plan default selections for the SEBB Program for 2020 and why they were selected.

Slides 2-3 – Background. In December the Board passed the resolution establishing a default plan selection for school employees who don't make a plan selection. I'm going to bring forward the intended HCA default plans and to get your feedback. We said during the final rate setting, HCA would identify default plans with the final rate information in July for discussion. We would formalize those plans once the Board endorses rates.

Slide 4 – Default Considerations. First we said we'd look at the monthly employee premium, or in the case where the plan is 100% employer paid, we'd look at the overall plan rates. We would take into consideration the actuarial value of the plan. Second, we said we would look at the extent of the service area of each of the plans. And finally, we said we'd take into consideration the provider network availability and access.

Slide 5 – Intended Default Plans. Listed are the intended default plans for dental, vision, basic life and AD&D, and basic LTD. As you can see, all of these plans are 100% employer paid. If the member doesn't sign up, they still have the benefit and are not penalized for not signing up. In both dental and vision, these were selected because they have the most robust provider network covering the most counties.

Dave Iseminger: For dental, in the SEBB Program, the benefits are a carbon copy of the PEBB Program. Both carriers were very familiar with the process and the rate assumptions, and from the beginning assumed that the Uniform Dental Plan would be the default dental plan, which was accounted for in the entire rate development. For dental we had a lot of understanding from the carrier perspective.

Marcia Peterson: Slide 6 – Default Plan Considerations – Medical. There were more choices and considerations for medical. The first criteria considered was the default plan must be available statewide in order to facilitate administration and limit member confusion. The UMP plans, with the exception of UMP Plus being only offered in certain counties, but the UMP plans in general are the only ones fully offered statewide to all SEBB Program members, regardless of where they live or work.

We then considered the richness of the benefit. What percentage of plan costs would the employee be responsible for? The premiums and deductible rates for the two UMP Achieve Plans are on Slide 6. Achieve 2 has a higher actuarial value than Achieve 1.

Slide 7. The other plan considered for the default was UMP High Deductible. It fits the criteria of offering statewide coverage and it has the lowest monthly premium cost. By definition, it has the highest deductible. There were a couple concerns with this option. If a member is defaulted into UMP High Deductible and they don't sign up for an Health Savings Account (HSA), they'd be paying for a more expensive plan by the end of the year because they'll be paying for the high deductible directly out of their pocket. We

also worried about a member signing up for the HSA but then don't sign up for a SEBB Program plan because they think they are going to be covered, or perhaps they are going to get coverage through their spouse or their state-registered domestic partner. There could be tax consequences for that member because you cannot contribute to an HSA if you have any other health insurance other than a high deductible plan. We didn't want to put our members in that situation.

Slide 8 – Intended Default Plan – Medical. The Health Care Authority believes UMP Achieve 1 would be the best option to put forward as the default plan for SEBB Program members. Mainly because we heard from stakeholders that affordability is a real concern for SEBB Program members, especially those members who are part time. We are concerned that committing those members to a higher monthly cost could cause them financial harm. About half of K-12 employees make less than \$50,000 annually and about one third make less than \$31,000 annually. Affordability is a real issue when you start talking about a default plan, something that someone didn't know they were going to end up paying for.

We know people will often choose a plan with a lower monthly premium. The annual Achieve 1 premium would be \$396. It does have a higher deductible cost. They often choose a lower monthly premium even though there's a higher deductible. Particularly if they think they don't use health care all that much. The annual premium for Achieve 2 is \$1,176. So \$396 versus \$1,176 is a significant difference. Even if you run the risk of having to pay out that higher deductible of \$750, before your deductible kicks in, for people who haven't placed a value on medical insurance, the certainty of that lower cost premium they have to pay monthly beats out the potential for a future cost savings.

We were also concerned about the impact on appeals, which is something we look at on the PEBB Program side. Appeals for people who didn't know they were being defaulted into a plan. We want people defaulted into a lower cost plan, in that event. We felt there would be fewer appeals.

We also heard from Washington Association of School Business Officials (WASBO) representatives. They thought there would be less risk to the SEBB Organizations if the default were the lower cost plan. If an employee loses employment without paying their contribution, or the amount of pay the employee earned prior to their departure wasn't sufficient to cover the contribution, the SEBB Organizations would rather be on the hook for the lower premium.

Dave Iseminger: At the same time, you might have thought why not the high deductible health plan? We also heard a strong commitment from WASBO officials who provided feedback that the Achieve 1 would be a good, appropriate balance of all of those interests. They want their employees to have a high quality plan and they felt Achieve 1 balanced those pieces. It wasn't just a cost analysis from that stakeholder.

Marcia Peterson: To summarize, we selected the UMP Achieve 1 Plan for the intended default plan for SEBB Program members. It is available statewide; provides full coverage for members who fail to enroll, but commits them to a lower out of pocket cost; may avoid appeals; and has a lower financial risk to SEBB Organizations if the employee were to leave service.

Slide 9 – Communications Plan. We will communicate the default plans in the fall enrollment guide and throughout our member communications.

We would love to hear your feedback.

Pete Cutler: I would defer to the employee and school folks on the appropriateness, but to me it sounds like a good decision based on good logic. The one question I have is I don't see a resolution or motion. Is it the belief of the Health Care Authority that it's a decision that doesn't require Board action?

Dave Iseminger: I think when we first started talking about the default plans, even with the original resolution about defaulting into or out of coverage, we believed it is part of the administrative aspects of being able to manage this part of the portfolio. The administrative function is with the Health Care Authority. But I did make the commitment that we would bring to you and get your insights as we move forward on this decision. You're not seeing a resolution, because we believe it's in the agency's purview, but we certainly know that it's a key piece that school employees and the Board are heavily interested in. We wanted to make sure we shared it with the Board before a final decision was made.

Pete Cutler: I appreciate that. Thank you very much. I will note that interpretation is something upon which reasonable people can have different outcomes, but I'm happy with moving ahead. Thank you.

Wayne Leonard: I think these look like logical default plans. Last month we talked about the smoker surcharge being a default, right? I'm appreciating your communication plan. It's an incentive to save money because to positively affirm to go in and enroll so people say, "these were the plans I'm going to choose anyway, I just won't enroll and I'll be defaulted in." They will be paying the smoker surcharge.

Dave Iseminger: Thank you for raising that, Wayne. I believe even in some of the FAQs right now we describe you would be defaulted into medical at a subscriber only level, into dental, and it highlights the tobacco surcharge piece. We'll make sure we communicate that, along with the other parts of what happens if you don't engage in the system.

Another piece I'll highlight for the Board is once open enrollment starts on October 1, we're going to be heavily watching the uptake in utilization of SEBB My Account. If we are seeing low enrollment in the first week or two, we'll ramp up additional communications. We all want the default rate to be as low as possible. We want people to engage, make affirmative choices. There will always be individuals who just let the default happen. We're talking about 150,000 people. We'll have some people, just like in the PEBB Program, who just don't like to give the state of Washington anything with their signature on it.

There are many reasons someone might not engage in the system. As we go through the first couple of weeks of open enrollment, if we see the chance for a high default rate, we may send a postcard to everybody who hasn't done something in the first two weeks to let them know there are four weeks left. If you don't, you will be enrolled in medical

insurance, your paycheck will be deducted \$33 per month, plus \$25 for a smoker surcharge. We have an interest just as you in school employees keeping that default rate as low as possible.

Lou McDermott: I always find it interesting when an item's brought before the Board and I know the background on how much time and effort the agency has spent. This topic has been many meetings. Many differing opinions. Pete, to your point, reasonable people can come to different conclusions. This issue's no different. There were varied opinions within the agency. I think Dave and his staff did a good job of trying to collate that. There is no right answer. There is just answers that have different pros and cons and I think they landed on a good ground, despite all the various input they received from everyone who had an opinion, which is just about everyone in the agency, and people outside the agency. So, Dave, good job. That was a tough call.

Next on the agenda is Executive Session. We are early. Are we going to start early?

Dave Iseminger: Chair McDermott, I can bring you up to date. We can certainly start Executive Session early. We don't anticipate Executive Session will take the full time allotted. We are likely to start early and end early. Katy Hatfield is nodding her head all of those things are okay.

Public Comment

Fred Yancey, Washington Association of School Administrators. Like many, thank you all and the Health Care Authority staff for the tremendously hard work to get to this point. It's nice to see fruition. The only remark I would make, I've sent a few emails on some follow-up questions, but the only remark I would make is I was very impressed with the UMP Plus presentation. I would hope the Health Care Authority and the SEB and PEB Boards work to increase the number of counties that provide that level, let's call it coordinated outcome-based care which saddens me if I think that my care currently doesn't fit that definition. [laughter] But that's really all I have to say. I would really like to see that model expand across the state. Any effort you and/or the PEB Board and Health Care Authority to advance that would be appreciated. Thank you very much.

Katy Hatfield: We're going to break for Executive Session. The meeting will adjourn after Executive Session, but there won't be a public portion of the meeting after Executive Session.

Next Meeting

July 25, 2019
9:00 a.m. – 12:00 p.m.

Preview of July 25, 2019 SEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the July 25, 2019 Board Meeting.

Lou McDermott: The Board will meet in Executive Session during lunch period, pursuant to RCW 42.30.110(1)(l) to consider proprietary or confidential nonpublished

information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session will conclude no later than 1:30 p.m. The public portion of the meeting will resume right after the Executive Session concludes, and then the public meeting will immediately adjourn.

Meeting adjourned at 12:28 p.m.