School Employees Benefits Board
Meeting Minutes

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

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

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

SEB Board Legal Counsel:
Katy Hatfield

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

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

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

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

Legislative Update:

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

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

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

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

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

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

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

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

Dave Iseminger: This is applicable only to fully insured.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dave Iseminger: We'll follow up on that.

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

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

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

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

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

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

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

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

Follow-up Board Questions

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

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

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

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

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

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

Medical Services Comparisons

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

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

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

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

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

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

Pete Cutler: Okay, thank you.

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

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

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

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

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

Scott Palafox: Accountable Care Network.

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

Scott Palafox: Yes.

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

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

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

BREAK

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

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

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

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

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

Dave Iseminger: Our understanding from the Legislature was that, generally speaking, the powers, roles, and responsibilities of the two Boards were intended to be very similar. When you look at this with regards to the contracting and procurement aspects of the agency, you'll see especially in Section 1, where that word oversight is changed to insight. That is functionally what has happened with the Public Employees Benefits

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

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

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

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

School Employees Benefits Enrollment Data

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

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

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

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

John Bowden: Yes.

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

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

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

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

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

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

John Bowden: Yes.

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

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

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

Patty Estes: Okay. Thank you.

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

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

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

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

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

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

Wayne Leonard: I have a comment on Slide 3. I have written comments on slides coming up in the next section. I think it's important to point out as we go forward that

one of the reasons why there has been so much discussion about the cost of things, or who is going to pay for what, is that currently the way most school districts fund their benefit pools is on an FTE basis. Under these plans, we're moving closer to a headcount basis, so when we see a difference of 24,000 employees, between the headcount and the FTE, essentially what we're talking about is the locally funded insurance, or locally funded employees, going from 15,000 up to 39,000 people.

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

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

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

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

Dave Iseminger: I was thinking more about the family columns across the slide, there is another indicator pointing to the relationship of the 3:1 tier ratio. If you look at the right family columns, you see more people are enrolling dependents in the two far right

columns compared to other situations. Remember a 2.75:1 ratio exists for the far two right sets of bars, but the ratio is higher than 3:1 on the other family columns. This is another piece that ties to the proposal you'll see this afternoon when Barb does her presentation about a tiered rate structure.

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

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

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

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

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

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

John Bowden: There's a difference of opinion within school districts about whether they can contribute to an employee's HSA, which goes with the CDHP. Some school districts believed they could not put money into an HSA for an employee. Other districts believed they could. This is around whether an employee can take the contribution for the HSA with them when they move to a different job. Difference of opinion contributed to some districts either going with CDHPs or not.

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

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

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

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

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

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

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

Dave Iseminger: This slide and the prior slide helps give insight on future proposed resolutions. The tier structures in orange/yellow and red are those extra tiers that can exist within a four-tier rate structure. What I wanted to highlight is both on this slide and on Slide 6. You'll see that when school employees, regardless of their full- or part-time

status, regardless of whether they're east or west, and regardless of which school district they're in or in PEBB, there are more enrollments of children on a plan than there are of just a spouse or state-registered domestic partner. That factor influenced the agency's recommendation in the proposed resolution about the tiered rate structure. We saw more information suggesting school employees tend to add more children as dependents rather than spouses. We're seeing more of that in the tier structure in all of these slides.

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

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

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

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

Patty Estes: Okay.

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

Slide 16 – Statewide School Employee Enrollment Non-Medical by Eligibility Threshold. We were able to separate this information between the employees that work less than 630 hours and the employees that work 630 or more hours. This information is from the 2016-17 school year, but we recently collected it, so in terms of vision, 11% of employees under 630 hours had enrolled in vision benefits; 79% of those above 630 hours or more had enrolled in vision. For dental, 11% of employees under 630 hours, 85% had enrolled in the dental if they worked 630 hours or more. Dental and vision are often considered mandatory, so waiving or not being covered would get you down to less than 100% in these two categories. The 11% and 79% get you to 90%. The 11% and 85% for dental get you to 96%.

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

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

SEBB Financial Considerations and Fully Insured Medical Benefits Procurement

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

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

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

Slide 2, again thinking globally, is helpful when we start talking about funding mechanisms and funding amounts for a large program, which SEBB is. We ground ourselves in a basic construct - we have finite resources. It's easy to lose sight of that. We'll be having a 12-month conversation talking about per member amounts, per employee amounts, per subscriber amounts, per adult unit, per FTE. You've already started having those conversations today around headcount versus FTE. There will be

times we bring you those amounts and it will be $200 or $800 or even $5.67 for the xyz benefit on a per member, per month basis.

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

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

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

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

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

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

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

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

While that decision of funding per FTE versus per headcount for the state recognized staff has been made, the amount of money implicit in that decision is in the hundreds of millions of dollars on the state side. We have a statewide headcount and statewide FTE count. John walked you through a state funded FTE count of about 94,000 employees. If you assume state funded, statewide headcount, and statewide FTE, that ratio between the 109,000 and the 133,000, if you assume that same ratio exists for the state

funded FTE to headcount, and again we don't know state funded headcount, we know state funded FTE is about 94,000. Using that ratio, doing the calculation, you have an additional push on the state funding side of around $200 million.

Dave Iseminger: Per year, right Megan?

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

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

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

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

Megan Atkinson: It was the $780.

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

Megan Atkinson: Then, yes, it would be significantly more. You are correct. Let me walk you through how I did this. I didn't know all the items I had to know to do the calculation. I knew statewide headcount and statewide FTE count and that ratio, the 109,000 to the 133,000. I knew that state funded FTE is 94,000. From those then I could calculate the number of state funded headcount. The difference between the two was around 20,000. Essentially, I added an additional 20,000 people times the $780 times 12 months. I set it up using different amounts to see how much it had to increase to get me over roughly $200 million. That's why roughly $200 million for the $780 per month. I also calculated at $900 per month, which is currently the funding for PEBB. I think $900 brought the calculation to around $300 million. Again, talking big numbers,

$200-$300 million per year, to make this change from FTE to headcount on the state side. Then there's also the locally funded staff.

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

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

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

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

Sean Corry: In our last conversation about the multiplier, the $780 versus the funding for the current PEBB enrollees being a significant difference of roughly $100 million,

rounding as you did. Knowing that it is up in the air, I'm wondering about the chicken and egg question as we develop our models for benefits that we might want to consider for offering to SEBB employees and the costs associated with providing money for these things. Dave, maybe you can help me understand, when are we going to have to make benefit decisions, or the range of benefit choices that we'll be making later, relative to knowing what kind of money is available to districts for benefits?

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

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

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

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

Dave Iseminger: Rates procurement, right?

Megan Atkinson: Rates. Thank you. We don't do the procurement for the rates until next winter, early spring. That's when we would know, based on the benefit plan design, enrollment, and demographic assumptions how the carriers are bidding back our population, and are we or are we not within the amount that was collectively

bargained? Either one of those outcomes has a different impact, a different next step. Next session, the Legislature has to fund a certain amount.

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

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

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

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

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

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

Megan Atkinson: Every time I talk about this, and try to peel the onion, there is no one experience for districts. There's too much variability across the districts in terms of how they currently have benefits procured, funded, and offered. There is no one scenario for the districts and that adds to everyone feeling a little bit at sea. If you think in terms of

the most significant places where we're changing the experience, one of the most significant is the funding change. The eligibility change being on the employee basis and the minimum of 630 hours. That alone drives a significantly different eligibility calculation. Thus, that drives a significantly different funding situation. That's what I've been trying to talk about here. The tiering could be the next biggest significant difference or the standardization of the benefits. Dave, what would you say is the next biggest place that drives differences?

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

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

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

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

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

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

Megan Atkinson: In terms of the calendar for the next 12 months, we need to get information from the carrier community around how they're seeing the cost of this population. That is significant because the carriers are the ones with the inside information. They are the ones providing the benefits now. We're setting up a procurement calendar that includes a Request for Information (RFI). We definitely want to structure that for the fully insured medical plans and there are certain reasons and certain philosophies why we want to do that through an RFI. We want to structure it in a way that gets us the best information the quickest. We can then continue informing the

discussion here with you and use it to inform the modeling that we need collective bargaining work this summer. Kim's going to talk about that.

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

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

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

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

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

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

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

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

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

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

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

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

The guide we're using now for covered services and exclusions in the sample plans is the Uniform Medical Plan Classic in the PEBB Program. We're using this plan because

it has a wide array of covered services and a pretty standard set of exclusions. We feel it's an appropriate level of breadth of covered services to initially ask for.

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

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

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

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

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

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

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

Patty Estes: It seems pretty standard.

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

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

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

BREAK

Dave Iseminger: Amy Blondin, our Chief Communications Officer, will walk us through the website. At the last meeting there were public comments and questions about where content really is on the website. Amy will share where we are, why we are where we are, and where we're going.

Web Content Discussion

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

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

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

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

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

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

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

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

For the other programs and initiatives that we run, those have their own bucket and SEBB Program content lives there for now because it really is information just about Board Meetings, Board votes, and Board materials, not so much about benefits and coverage information for actual members. We have general information about the Board and then we have links to the Board Meeting Materials, a way to sign up for

SEBB rule making notices, a list of FAQs that our Employees and Retirees Benefits Division team have created, and a list of the SEB Board Members. That's where we're putting information related to the SEBB Program for now. If you click on News on the left-hand side, now we just have one announcement related to letting folks know that the bill passed this session. As we have new announcements and news, they will be posted here and also sent to those who signed up for the SEBB Program news alerts through our system.

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

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

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

Amy Blondin: Obviously the website is an important tool for communication, but it's not the only tool. We're working with Michelle George, the Employees and Retirees Benefits Division Communications Manager and her team, to build a robust communication plan for SEBB Program outreach in the coming months and years. I

would imagine at some point we will be bringing more details to the Board about that work for your input.

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

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

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

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

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

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

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

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

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

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

Amy Blondin: Yes.

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

Amy Blondin: We will not inundate you with messages.

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

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

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

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

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

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

SEBB Policy Resolutions: Eligibility

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

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

Each time we'll bring draft resolutions to the Board in order to have a discussion about them, get your insight, and your guidance. Bullet 1 is where we were at the January meeting, and for those we'll walk through and vote on today. After we talk about draft resolutions, like in January we incorporate your insight into those resolutions and send them out to a set of stakeholders in order to get their insight and feedback as well. There's a lot that we don't know. We are learning from the stakeholders and we want to make sure we understand the issues as we move forward. We are committed to

releasing proposals within a couple of business days of a Board Meeting. The turnaround time for the information we're getting back from them is fairly quick. That's necessary in order for us to continue to make progress forward through the decisions needing to be made. Once we receive insight and information back from the stakeholders, we develop a final agency recommended policy. The set you'll see shortly is from January with feedback incorporated. That is the agency's final recommendation.

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

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

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

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

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

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

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

Wayne Leonard: You said the bill currently mandates –

Barb Scott: At a minimum.

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

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

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

Barb Scott: It is looser.

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

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

In this state, in the late '90s, there was a Defense of Marriage Act passed by the Legislature and signed by the Governor that prohibited legal statewide recognition of same-sex couples' relationships. In the PEBB Program population there were members of the public that brought to the PEBB Board a concern about equity and wanting to recognize same-sex relationships. The PEB Board at that time, against many wishes in parts of government, put forth a domestic partnership declaration-based system somewhat similar in criteria to what the WEA Select has now. It was limited to just same-sex couples. The PEBB Board did that in the idea of generosity of benefits, generosity of eligibility. They did that partly out of a sense of equity, to be able to

recognize just those same-sex relationships, but the PEB Board did not open the eligibility so wide (by including opposite-sex couples) that suddenly there was a very big broadening of the eligibility created significant pressure on the fiscal side.

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

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

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

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

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

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

Lou McDermott: I think that's why the communication plan with members will give them an opportunity to react and not discover on open enrollment day that they can't enroll their partner. Communication will be important with each iteration of the rules when established as we move forward with plan selection and design. Members need to understand that ahead of time so they can make choices appropriate for them.

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

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

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

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

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

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

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

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

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

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

Barb Scott: The eligibility that's being proposed?

Pete Cutler: Yes.

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

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

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

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

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

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

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

Lou McDermott:

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

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

- Legal spouse
- State-registered domestic partner

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

Lou McDermott: Any comments from the audience?

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

Lou McDermott: What is the total value approximately?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Patty Estes: Okay. Thank you.

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

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

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

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

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

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

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

Barb Scott: Yes.

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

Voting to Approve: 7
Voting No: 2

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

Lou McDermott: Policy Resolution SEBB 2018-01 passes.

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

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

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

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

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

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

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

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

Lou McDermott: Thank you, Barb.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Alison Poulsen: That's helpful. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-02 passes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Patty Estes: That's only the state funded?

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

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

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

Patty Estes: School employees system. Okay.

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

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

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

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

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

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

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

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

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

Patty Estes: And that was the 109,000?

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

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

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

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

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

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

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

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

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

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

Patty Estes: Okay.

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

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

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

Policy Resolution SEBB 2018-03 passes.

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

Eligibility and Enrollment Policy Development

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

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

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

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

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

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

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

Dave Iseminger: The first of the next month.

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

Patty Estes: So, the first of February?

Barb Scott: Yes, the first of February.

Patty Estes: Okay.

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

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

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

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

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

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

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

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

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

Patty Estes: Okay, because currently it does.

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

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

Patty Estes: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Katy Hatfield: Except the spouse is $10 more.

Dave Iseminger: You're right.

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

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

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

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

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

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

Pete Cutler: Right.

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

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

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

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

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

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

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

Dave Iseminger: For premium.

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

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

Wayne Leonard: Is the 3:1 ratio?

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

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

BREAK

SEBB Policy Resolutions: Benefits

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

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

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

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

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

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-04 passes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-05 passes.

BREAK

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

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

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

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

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

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

Alison Poulsen moved and Wayne Leonard seconded a motion to adopt

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

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

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

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

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

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

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

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

Pete Cutler: Significant change?

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

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

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

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

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

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

Dave Iseminger: Correct.

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

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

Patty Estes: Okay.

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

Nick Abraham: Correct.

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

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

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

Nick Abraham: Yes. Clark and Cowlitz County.

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

Nick Abraham: That's correct.

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

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

Sean Corry: Okay, great. Thank you.

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

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

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

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

Voting to Approve: 9
Voting No: 0

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

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

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

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

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

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

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

Dave Iseminger: Correct, yes.

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-06 passes in its entirety.

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

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

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

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

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

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-07 passes in its entirety.

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

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

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

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

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

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

Dave Iseminger: Yes, you were.

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-08 passes in its entirety.

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

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

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

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

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-09 passes in its entirety.

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

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

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

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

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

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

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

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

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

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

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

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

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

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-10 passes in its entirety.

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

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

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

Voting to Approve: 9
Voting No: 0

Benefits Resolution SEBB 2018-11 passes in its entirety.

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

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

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

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

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

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

Patty Estes: No. It does with classified.

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

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

Lou McDermott: That is not in this law.

Fred Yancey: It's the state law.

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

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

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

Dave Iseminger: Correct.

Lou McDermott: That is correct.

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

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

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

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

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

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

Overview of April 30, 2018 SEB Board Meeting

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

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

Lou McDermott: Meeting adjourned.

Meeting adjourned at 4:10 p.m.