School Employees Benefits Board
Meeting Minutes

April 30, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
1:00 p.m. – 5:00 p.m.

TVW was present and did a live stream of the meeting. The meeting will be on the TVW website in their archives folder.

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

SEB Board Counsel:
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 1:03 p.m. Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

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

Approval of November 6, 2017 SEB Board Meeting Minutes
Lou McDermott: Pete Cutler moved and Katy Henry seconded the motion to approve the November 6, 2017 SEB Board meeting minutes. Minutes approved by unanimous vote as written.

Pete Cutler: I apologize. I should have commented beforehand, but I do want to go on record saying I really appreciate the thoroughness of the minutes. I felt like I was going through the Board meeting a second time all the way through, and it was since, I think

especially the discussion from Dr. Lessler had a lot of detail. It was really helpful to have a second go.

Prior Meeting Follow-up Questions

Dave Iseminger: I have six areas, some of them are questions, some of them clarity and context to prior discussions, not in any particular order. The first one is to follow-up on a long-standing question I believe Wayne originally asked in the fall about whether school Board Members themselves would have eligibility for benefits. Under state law now, there is authority for school districts and ESDs to make coverage available to their Board Members. Nothing within House Bill 2242 or Senate Bill 6241 changed that authority, so that authority still exists for school districts and ESDs in the post-January 1, 2020 world. If the school districts elect to provide benefits to those members, they still have that ability to contract with the Health Care Authority for benefits. Nothing changed in the current world for school Board Members and district authority to offer benefits to them.

Wayne Leonard: I saw where it talked about legislative bodies being ineligible, but would that include them if they did not meet the 630 hours?

Dave Iseminger: We believe there's separate express statutory authority for school districts and ESDs that is particular to school Board Members and their ability to offer benefits to those members.

The second question came up at the last meeting during my legislative briefing. I believe it was also from Wayne. This question was about optional benefits under 6241, meaning those benefits that are outside this Board's authority, whether those optional benefits in the post-2020 world were employer paid or could be employee paid. Under the legislation, it's Section 29 of the bill, that amends RCW 28A.400.280. The language there describes school districts may provide employer contributions for optional benefits, and it goes on to define those optional benefits, again, as those that are outside this Board's authority for offering. There isn't anything that expressly prohibits or authorizes employee-only scenarios. The statute is silent as to whether it could be an employee-only piece, but it does allow for an employer contribution. That's what the statute says.

Number three follow-up was a Pete question, which was about the context of Resolution 2018-12. This resolution prompted many questions from the Board. This resolution is about the effective date of benefits. You'll see it's not here for you to take action on today. Stakeholders had a variety of different opinions and ideas for how that resolution could work. We're still working through that feedback and realized it was not ready for this Board to take action on today.

In that context, Pete asked about the Department of Retirement Systems (DRS) eligibility requirements and the framework for the Teachers' Retirement System (TRS) and the School Employees' Retirement System (SERS). I'm going to summarize and if anyone wants to correct my oversimplified explanation, please do so. In general, under DRS, if a school employee works at least 70 hours per month for five months within a

school year, and that school year is defined as September 1 through August 31, the TRS plans require the employer to anticipate the employees work for one year, while SERS plans require an employer to anticipate employees work for two years. We believe there are approximately 7,300 people in TRS and 15,700 in SERS. That's about 23,000 people between those two systems.

Fourth topic for follow-up is not a question, but some nuance that I want to make sure is clear on the record. When we talk about the 3:1 ratio, I want to clarify some nuances between what we understand exists in the current K-12 system and what the legislation requires. There's been talk about what school districts in the current K-12 system have or haven't been able to achieve on the 3:1 ratio. The agency's understanding at this point is that many of the carriers have produced premium ratios that fit within that 3:1 ratio. But the way the state allocation has been rolled out does not necessarily translate to a 3:1 employee premium contribution. What the legislation did in 6241 is mandate that the *employee* premium position be within a 3:1 ratio. I did want to clarify that our understanding is that carriers may have been submitting premiums that fit within a 3:1 ratio, but the legislation now requires that the employee contribution also be within a 3:1 ratio.

My fifth area is an update. Since we last met, 6241 was signed by the Governor, which then triggered claim submissions by both OIC and carriers. We received OIC's data the same afternoon that the bill was signed, and we had already begun communicating with carriers about the expectation for data and what needed to be submitted by the April 1 deadline, which ended up only being eight days after the legislation was signed. I am happy to report that the majority of carriers provided at least an initial data set by the end of the first business day of the month. We've gone through an iterative process over the month with carriers to improve the data and we have a robust data set. It does have some missing pieces but overall it's a pretty solid data set. I want to make sure the Board was aware that the carriers provided a substantial amount of data that will help us do enrollment and financial modeling going forward, as well as, inform procurements.

Number six is an update on the Requests for Information (RFI) that the agency did, also since the last meeting. You remember we released an RFI on vision to get information from the carrier community about what they see and what experience they have to inform an eventual RFP for a standalone group vision benefit. That RFI was due to the agency last Tuesday and we had ten responses. The carriers that provided insight, in alphabetical order, were: Ameritas; Davis Vision; EyeMed; MetLife; Northwest Administrators, Inc.; Premera; Superior Vision; United Healthcare; Unum; and VSP. It was not mandatory that a carrier respond to the RFI for vision in order to participate in a later procurement. We'll review that information and bring back to the Board insights we gained as an agency.

At the same time, we're doing the RFI for the fully insured medical. That was due last Friday, and unlike the vision RFI, a carrier had to respond to the RFI in order to be eligible to participate in the eventual procurement process later in this calendar year. We had six responses to the RFI on Friday. They were: Aetna; Kaiser Permanente

Northwest; Kaiser Permanente Options, which for those not familiar is their PPO product line; Kaiser Permanente of Washington; Premera; and United Healthcare. [Editor's Note: At the May 30, 2018 Board Meeting, the record was corrected indicating a seventh RFI, from Providence, had also been received.]

We've already had a lot of interest from stakeholders into learning about the responses that were received in the RFIs. We are working with the carriers to identify anything that they deem proprietary or confidential, and then we will post redacted versions on the Health Care Authority's website after that process is complete. Our public records office is going through that process with both the vision and medical carriers to ensure we adequately redact what the responders believe is proprietary and confidential.

[Sean Corry and Alison Poulsen arrived.]

Cafeteria Plan Overview

Tristin Sullivan-Leppa, Supervising Staff Attorney, Health Care Authority. I provide support to the PEBB Program and the SEBB Program. A Cafeteria Plan is a written plan document maintained and designed by the employer. Here under state law for Cafeteria Plan purposes, the employer is the Health Care Authority. It is maintained for employees and must meet specific requirements set forth in Section 125 of the Internal Revenue Code. A Cafeteria Plan document is the only way an employer may offer employees benefits on a pre-tax basis.

Dave Iseminger: Many people, I've learned, think a Cafeteria Plan means "like a buffet" where you get to pick and choose different benefits. The central idea of a Cafeteria Plan is the vehicle by which pre-tax payroll dollars can be used for certain types of benefits. A lot of people will throw around the phrase "Cafeteria Plan" thinking it means, "I have a choice in medical benefits," when really it's about how you're paying for those medical benefits and whether it's pre-tax or post-tax.

Tristin Sullivan-Leppa: An employee agrees to contribute a portion of their paycheck on a pre-tax basis to pay for benefits offered under the Cafeteria Plan. These salary contributions are funds not actually received by the employee; and therefore, these contributions are not considered wages for federal income tax purposes. Because it lowers taxable income for individuals, the IRS has strict rules that must be followed.

Slide 4 contains the benefits currently offered under the state's Cafeteria Plan administered by the Health Care Authority. You may recognize the slide because it's from a previous presentation done by Scott Palafox at the December 2017 Board meeting. In the Appendix to my presentation, you will find slides from the December presentation that explain each of these benefits.

The IRS has strict, narrow rules about who can participate and be covered under a Cafeteria Plan. According to Section 125, employees may participate in a Cafeteria Plan, and the regulation allows participating employees to cover their spouses and dependent children. Spouses and dependent children can only participate if the employee also participates.

Dave Iseminger: At the last meeting, there were questions around language the agency was using in presenting the resolutions. We wanted to be very clear that under IRS rules there are often strict, black and white, lines as to who counts from a legal standpoint that an employee is able to take those contributions on a pre-tax basis. There could certainly not be a Cafeteria Plan, and then school employees wouldn't be subject to the IRS rules, but then they also wouldn't get the advantages of having a lower taxable income when taxes are due.

Tristin Sullivan-Leppa: Participants can choose the type and amount of benefits offered under the plan they want to elect. There are three events that allow for someone to make elections under the plan: when a participant first meets eligibility requirements, during the annual open enrollment, or during a special open enrollment period.

The IRS provides strict rules for when elections become effective. Generally, elections are made in advance on a prospective basis as opposed to a retroactive basis, with very narrow exceptions. Two of those exceptions are: one for newly eligible employees, employers may allow retroactive enrollment for up to 30 days from the date of hire; and second, when a participant experiences a birth or adoption of a child, the participant may retroactively enroll that child onto his or her benefits. The last point on Slide 6 is that elections are generally prospective because the IRS does not want individuals to have hindsight knowledge to impact his or her taxable income.

Dave Iseminger: The first sub-bullet on Slide 6, “Employers may allow retroactive enrollment for new hires,” is directly related to Resolution SEBB 2018-13 that's before the Board for action today. Someone may say 31 days isn't the same as 30. I always had this problem with math in school. It's fence posts versus lengths. There's actually 30 24-hour periods (i.e., fence lengths) between 1 to 31 days (i.e., fence posts). So the recommendation to the Board was to allow the maximum allowed period for the retroactive enrollment. While it may seem counterintuitive to an employee, "I just started work. How am I being retroactively enrolled?" That's how narrow the IRS rules are.

Tristin Sullivan-Leppa: Slide 7 – Can Participants Change Their Elections? Under a Cafeteria Plan, elections are generally irrevocable for a 12-month plan year. However, if a participant experiences one of the specified special open enrollment events, they may be permitted to make mid-year plan changes.

Slide 8 – Where Does the Money to Pay for These Benefits Come From? I touched on this on Slide 3. A participant pays for benefits that he or she elects by agreeing to reduce his or her salary on a pre-tax basis. Employees can elect benefits offered under the plan with pre-tax dollars. Slide 9 includes some advantages for employees: buying qualified benefits with pre-tax dollars; lowering taxable income; and specifically, for flexible spending arrangements there is an idea called "First Dollar Coverage." This essentially means that an employee can use all of the dollars they’ve elected to contribute for the plan year at the beginning of the plan year, even though the contributions are spread out over the entire plan year.

Dave Iseminger: I see puzzled looks on that one, so I'll describe that with an example. Let's say on a medical FSA I elect $1,200 for the year, roughly $100 a month, and I'm a 24 pay-period employee. That means $50 is coming out of every paycheck. On January 1 I have immediate access to all $1,200, even though a single penny hasn't come out of my first paycheck. That is what “First Dollar Coverage” means in this context.

Tristin Sullivan-Leppa: Slide 10 addresses disadvantages for employees with the Cafeteria Plan. Elections are irrevocable for the plan year, except for the narrow exceptions. Some Cafeteria Plan benefits, such as FSA and DCAP are subject to a "use or lose" rule, meaning that if an employee's eligible expenses incurred during a plan year are less than the amount they elected to contribute, they would forfeit the difference. An example would be if you elected to put $1,000 into your FSA and you only spent $500 in qualified expenses, then you would forfeit the remaining.

Dave Iseminger: Under IRS rules, the forfeiture goes to the employer, which for purposes of the Cafeteria Plan is the State.

Tristin Sullivan-Leppa: A salary reduction reduces the employee’s earnings, which may reduce his or her social security benefits. In other words, participating in a Cafeteria Plan saves you money now by reducing your social security taxes because the lower your income, the less your taxes; however, your lifetime social security benefits would be calculated using those lower salaries.

Dave Iseminger: A little more context: Under the consolidation for the SEBB Program, there's the authority for a Cafeteria Plan, but it's not under the Board's jurisdiction. It's under the Health Care Authority's jurisdiction, just as it is for the PEBB Program to administer a Cafeteria Plan. The agency is responsible for creating and maintaining the benefit structure of FSA, DCAP, and the other benefits that fall within the Cafeteria Plan.

We have been working under the assumption and building towards having a robust Cafeteria Plan, including the same benefits on the slide that Tristin presented for the SEBB population. The premium payment plan is an important one that directly impacts most people. It allows people to have all their medical premiums taken on a pre-tax basis. In order for that to be part of the Cafeteria Plan, which we've been assuming would be done for the SEBB Program, we have to present certain resolutions to you in a way that comply with the IRS regulations to be able to administer those prepayment payroll tax deductions.

Sean Corry: I think you answered my question, but just for clarification: I know from experience that Cafeteria Plans have various provisions that an employer might choose or not choose. That might not apply to us, is that what I heard you say? That variation is on how to deal with run-out money, or spending money from the last plan year, that kind of thing, that's not our purview? That would be the purview of the Health Care Authority?

Dave Iseminger: That's correct, Sean. For example, when Tristin described the "use it or lose it" rule for FSA and DCAP, there's also an alternative scheme where you have an extra grace period and you have a longer time for your plan year to incur and submit expenses, and in the Cafeteria Plan document, the employer has to pick one or the other. The authority for setting up the Cafeteria Plan structure is with the agency versus with this Board.

SEBB Financial Considerations and State Budget Calendar

Megan Atkinson: I'm going to do a quick run through revisiting information that we talked about last time.

At the last Board meeting there were questions and we wanted to revisit a few concepts and then introduce new material, largely around the state budget calendar and the timing of rate procurement, legislative action, collective bargaining, to get that calendar in your mind. Then Pete had a question about the tiering ratios. We did a calculation to illustrate if we looked at changes or comparisons to the PEBB Program tiering ratios.

Slide 3. One of the things we wanted to level set for everyone was a reaffirmation of the current way K-12 health benefits are funded, and then the way they would be funded under the SEBB Program. Currently in the K-12 world, we have a state allocation provided in the budget bill each year. The state funding is currently on a per-FTE basis. We'll talk more about that, but that was a foundational difference between the current K-12 world and the SEBB world FTE versus headcount. The third bullet, all of those can vary by district. You do have some variability by districts across the state. In addition, your bargaining agreements can vary by district. Finally, some districts do allocate the employer contribution proportionally equal to the percent FTE. Essentially, if you are a half-time employee, some districts allocate half of the benefit allocation and the employee makes up the rest.

Slide 4 – SEBB Health Benefits Funding Structure. In the SEBB construct, because of the consistency in the statewide approach, there's some significant differences. The first one is still the same: the state allocations provided in the budget bill each year. We already know there's statute guidance that the amount allocated for state funded staff in the 2019-21 budget will be no less than the per employee PEBB funding.

Pete Cutler: When it talks about the amount allocated for state funded K-12 staff, it's to be no less than the per employee PEBB funding. For PEBB, as you mentioned, the budget structure has agencies determine how many PEBB eligible employees they have and they get a full $800, $900 a month, whatever, allocation for each of those PEBB eligible positions. For state funded K-12 staff, is this language intended to mean the same thing, that if a school district has positions that are going to be eligible for SEBB coverage under the 630-hour rule that they would receive the full amount of however much? Or is it intended to continue the funding by FTE, at the FTE level, and then have some breakdown of that afterwards? Is that clear?

Megan Atkinson: That is very clear. Trust Pete to dig in right on the crucial question right out of the gate. The issue of per-FTE funding in the current world and the need for

per headcount funding in the SEBB world, is the crux of the issue in moving from the current funding model to the SEBB funding model since the Legislature has not taken action to fund the SEBB Program, and they wouldn't. It's not time for that yet. That decision will be in front of the Legislature in the upcoming 2019 legislative session. I can't say what they're going to do. We talked about this last time, and what I said I think got misunderstood by some people. The minimum eligibility criteria of anticipated to work 630 hours, and the statutory reference to the per-employee funding, signals a headcount funding model, but the Legislature hasn't funded it yet. That is the crucial thing we'll be watching and discussing next legislative session: exactly how much does it take to go from a per-FTE funding to a per-employee funding? How much of that is on the State? How much of that will be left the responsibility of the districts? Those are all crucial questions that we just don't know yet what the Legislature is going to do.

Lou McDermott: Megan, do you think that will partially be addressed with collective bargaining?

Megan Atkinson: I think it could be. Again, I can't speak to what ultimately ends up in the collective bargaining agreement, but I think the stakeholders both on the executive side and the district side, the employee side, everyone is aware of this crucial issue.

Lou McDermott: I would imagine that they would want to at least have a framework for their collective bargaining to say, "We think the world's going to look like this; and therefore, we're going to bargain this," and understanding that seems like it would be pretty critical.

Megan Atkinson: It is a significant question.

Dave Iseminger: For the record, the second bullet on Slide 4 is designed to mirror the language of Section 34 in Senate Bill 6241. If for any reason there's any variance, it's unintentional and not meant to signal to anyone something different.

Sean Corry: I think I might be stepping on Pete's toes a little bit, but I still want to make sure that I understand what "no less than" means in this bullet. Does this mean that whatever the dollar amount per head allocated to PEBB employees, whatever that number is, the SEBB dollar amount per head for SEBB employees needs to be no less than that? Is that how "no less than" applies in this? What does that "no less than" mean?

Megan Atkinson: I believe that is a clear, plain English read of it. I'm not legislative budget council. I don't want to get outside my professional swim lane, but I think the words "no less than" have a plain English read interpretation.

Sean Corry: On an individual employee basis as opposed to an aggregate basis, different numbers of employees, of course, in each pool.

Megan Atkinson: The language in the bill does say "per employee PEBB funding." That is in the bill.

Sean Corry: I'd like to note before pushing the button here that the population that will be going into the SEBB Program is, of course, a different population than what's in the PEBB Program. Different demographics, different location, maybe in the aggregate, maybe not substantially different but certainly different, and so if the funding itself is not necessarily tied to the risk pools would call for - am I thinking about that correctly that there may be too much money or not enough money because of this "no less than" restriction?

Megan Atkinson: Yes, I think, Sean, you're hitting again on a crucial point. The PEBB population and the SEBB population are significantly sized populations; and therefore, you could make some analytical argument that the demographics would start resembling one another because of the sheer size of them. There's likely to be some irrelevant differences in demographics, but then there's also the issue around the dependent load in each population. The SEBB employees might bring with them a different compliment of dependents than what we see in PEBB, as well as, how they enroll across the plan. It's not just the tiers that I described, but also across the plans. There are likely to be differences in the populations and in the risk pools that then would make adhering to this target more or less difficult. Once we have our models and once we have rate information for the plans, as we move down this journey over the next 12 months, having models, through collective bargaining this summer, nailing down procurement with the plans, nailing down rates with the plans - each step along that journey gets us better information. Any time we talk about this internally, we end up saying, "it's not going to be that big of a deal because the population's going to look so similar," and then all the way over to, "We don't know how it's going to lay out." Until we get more information, it could be right on or it could not.

Lou McDermott: You always tell us that we're going to guess wrong. There's just no way. There are many things we don't know with all the different plans that are going to be available. We don't know: what the membership is going to do; how many spouses are going to come on board; how many dependents are going to come on board; what the utilization will look like, somebody goes into a new different plan, maybe they all go in right away to see their doctor because they want to make sure their benefit works. It's going to be very difficult to tell. The one thing Megan's correct about is we're going to guess wrong, but experience over time will level that out and correct it and we'll be able to provide the Legislature and the Board with very accurate information on what the actual experience was, but it's just going to take time. There is no getting around that.

Megan Atkinson: I appreciate that clarification from Lou. I do want to set that understanding with you that as we bring you modeling results and model outputs, perhaps you will see those changing. It may or may not be significant changes as we move through these next 12 or 13 months. Understand that it's not intentional, it's that we're modeling a world that none of us have been in. Every time we get information, we can overlay an assumption with actual information, or maybe just a better assumption. As we do that, it's going to change. Keep in mind when we're looking at expenses for a population of this size, a very small change in a factor will drive tens and tens of millions of dollars. You will eventually become more comfortable with those conversations, but it

is startling how much just the tiniest tweak drives a significant sum of money because of the sheer size of the population that we'll be dealing with. Health care is expensive.

Dave Iseminger: Bullet three, Megan.

Megan Atkinson: We've talked a bit about the employee union. There is a Coalition that will bargain with the State this summer. That is a significant input into our modeling. We already discussed the eligibility criteria is standard. Dependent coverage and benefits package both set by you, and you're familiar with that because you're working through those resolutions. Then employer and employee contributions will be standard for all districts by plan and by tier.

Slide 5 – Headcount vs FTE. Headcount is the actual number of employees, regardless of hours worked. A full-time equivalent (FTE), the hours that must be worked for an employee to be considered full time. As you know from your life in the districts, the employment patterns can create a significant difference between headcount and FTE in that district. We are starting to learn more about that, and we're learning what many of you already knew. Seeing the data now, it is more significant on the classified ranks than on the certificated ranks. Slide 6 is an illustration; I liked it so much I put it back up, with the little people.

I did get some feedback that this perhaps seemed a little tone deaf that I was using the 2,080 hours. I wasn't trying to be tone deaf to real life in K-12 districts. When we worked through the math, the 2,080, by the time we started dividing it out, it worked better than starting with the 1,440 for a certificated staff member. Again, just illustrating the difference between headcount and FTE.

Slide 7 is a slide from last month. I did get quite a bit of feedback on this slide. We struggled a bit with it if you remember in the meeting last month. We simplified it and updated the numbers to be closer to the amounts in the current budget. This is illustrating that when you have an FTE-based state allocation, and yet you have employer benefit contributions required on a headcount basis, you end up with a difference. That's the crux of what Pete was discussing, what we've been discussing already. Who will pick up that difference? Will it be borne entirely by the districts? Will it be born somewhat or fully in the state funding model? We don't know yet.

Wayne Leonard: I have a quick question or comments on this slide. One of the slides, as I recall from the last meeting that caused so many of the questions, indicated that the Legislature intended for school districts to continue to pick up the cost of employees above the state funded level. That leads me to think that the Legislature is going to continue to do what they've always done, which is fund their formulas, which would still mean they'd be funding it based on the FTE model and local school districts would have to pick up the rest. There is some discussion around that because they had estimated, I think in your slide from the last meeting was about $200 million, that difference, the delta.

When we got to this headcount vs FTE funding, there was discussion on different aspects of this. This is helpful because I went back to my district and started looking at this and this scenario is probably bigger than my district. This probably would be applicable to a 15,000 - 16,000 student district, but your presentation uses the amount we currently get, and if this goes up to the new higher SEBB levels then this $205,000 would be higher.

Megan Atkinson: Correct.

Wayne Leonard: Is this difference a monthly difference? On an annual basis, that's close to $2.5 million for the school district, that difference in funding. If you use that higher SEBB level, it's closer to over $2.8 million, another $300,000, and then…

Lou McDermott: Wayne, can I ask you a question? I'm trying to follow. If they increased the number, like in the model, let's say they don't make any adjustments to the FTE count but they do increase the number, wouldn't it reduce the $200,000?

Wayne Leonard: Well, there would be an additional contribution for their model assuming this additional 250 headcount difference or this 250 difference between the FTE and the headcount is all on the local levy.

Lou McDermott: Right. I guess I'm thinking that the $820 satisfies a certain funding level, provides a certain service, and then the higher amount would be providing a similar service. There would be extra money there. I'm not trying to get in the weeds. I'm trying to say there's multiple levers the Legislature can pull. Am I thinking about this wrong, Megan?

Megan Atkinson: There are a couple things. I think the point Wayne is making is that even if the per employee or per FTE allocation goes up, and if we use the amount in the current year from the $820 currently in the K-12 part of the budget to the $916 on the PEBB side of the budget. Even if it went from $820 to $916, that drives more money out, but the amount the districts are expected to pay in per headcount also increases from $820 to $916. It doesn't address the gap.

Wayne Leonard: We get additional funding for the state funded employees, but for employees funded on the levy, there is no additional funding.

Megan Atkinson: Wayne, I want to address your concerns. On the slides used last month, and a little even on this slide, I've created a fundamental error that fiscal staff try not to do, which is I used real dollars when what I'm trying to show is an estimate. I'm trying to illustrate an issue. Last time, with the $200-$300 million, that was trying to illustrate the funding gap. That funding gap has not been calculated by anyone, and we can't calculate it until we get further along in our modeling. Your point is well taken, Wayne, the way the state is funding K-12 health benefits now on a per FTE basis, and the way we will need to collect from districts in the SEBB world on a per headcount basis that leaves that funding gap. What we don't know yet is how the Legislature intends to address that, if at all.

Wayne Leonard: Okay and I took your last meeting slide to indicate that they were not planning on addressing it at all, that they were going to leave it as it currently is with their current funding model.

Dave Iseminger: I think Megan was illustrating the potential extent of the problem, but not chiming in on the potential policy solutions that the Legislature has. That's a good clarification. That was not the intent of Megan's prior or current presentation to suggest the Legislature has made a decision one way or another on that particular issue.

Wayne Leonard: Right. I think this FTE headcount piece is the major piece of it but the 630 hours, also. Our current eligibility is 720 hours, so 630 hours is lower and would create additional insured eligibility. I think it was mentioned that substitute teachers and substitute employees, if they work more than 630 hours, would gain eligibility. That would further increase the costs to school districts, and the increase in the rate from the current school rate up to that SEBB rate also increases the cost of school districts. There are multiple factors driving the cost up for school districts if it stays as is. This addresses the major one, but those others add costs on top of that.

Megan Atkinson: Your points are well taken, Wayne. Slides 8 and 9 lay out roughly the next nine months or so of the state budget calendar. I thought it might be helpful for you to have this calendar as we're driving towards setting up the SEBB Program, working through collective bargaining, working through modeling. There are crucial time periods or activities that we're trying to feed information into. We've released an RFI on the fully insured medical plans; we talked about that last time. The next big piece of work is this summer when collective bargaining occurs, and that will nail down some critical pieces of information that we will use to inform the modeling. This summer we have an RFP process for the fully insured medical plans. That will help us nail down the carriers we will be contracting with. September of this year is when agencies submit their 2019-21 biennial budget requests to OFM. These requests feed into and inform the Governor's budget and that starts the budget debate in the Legislature.

In the Governor’s proposal, you will be able to see the Governor's proposal around this funding gap that we see in SEBB. January through April of 2019 is the legislative session, and hopefully if there are no special sessions, the final 2019-21 budget when we would definitively know what's happening. Around that same timeline is when we would finalize bid rates for the fully insured medical plans. The reason we have those occurring around the same time is finalizing those bid rates allows us to feed that information and final modeling into the legislative budget writing that happens during session. Finally, looking towards next fall, open enrollment and then, of course, January 1, 2020 when benefits begin.

Sean Corry: I have a question. It's sort of a general question with respect to the collective bargaining that either has just started or is about to start. Dave, do you know, is there an end date to when that has to be concluded?

Dave Iseminger: The collective bargaining process doesn't officially begin until July 1, so it hasn't kicked off yet, although our understanding is that there's pre-work being

done. At this point, the last number I heard is there are 912 unions that represent some aspects of the K-12 system. There's a lot of pre-work to understand how to bargain within a coalition that size, but under collective bargaining laws, the collective bargaining process is to conclude by September 30. So, July 1 through September 30.

The other piece that I want to be clearer about is the finalized contracts with the fully insured medical plans and the relationship of the agency versus the Board. Most of the time, whenever we execute contracts with carriers, our contracts have a qualification that's subject to final decisions made by the Board, because obviously if you don't authorize a plan, then the contract related to that plan doesn't work for everyone. We go through the process and tee everything up so you have the final decision, and then it's ready to go from the contracting standpoint. I want to be clear that we're not pre-supposing. We always have mechanisms within our contracts that can take into account the Board's decisions.

Megan Atkinson: Slide 10 is about the financial impacts and considerations of the tier structure. The premium tier structure is a mechanism to allocate costs between members with dependents and members without dependents, and there's no right or wrong way. It's not like you can research and say, "Oh, this is the blessed tier structure." It's not like that. They can be unique and often are unique to different populations, different companies, different employer organizations. The tier structure does not increase or decrease the aggregate program cost, nor does it shift cost between the employer and the employee. It is a way of distributing cost across your employee population based on how you subdivide the population.

Sean Corry: Does that mean, in the PEBB example, in the PEBB world, the employee contribution that is taken out of their paycheck to say employee only contribution is the same percentage for each employee, regardless of the health plan the employee chooses?

Megan Atkinson: There's a little bit of settling out that happens, but they are within the ballpark of the same percentage, yes. They might fluctuate between 13%, 14%, 15%, but they're right in there.

Sean Corry: The percentage of employee's share of the richest plan is roughly the same percentage as for the least rich plan for PEBB employees, all around, circling around that 15% premium?

Dave Iseminger: The collective bargaining agreement within the PEBB context is a tiered, weighted average. It's within a range, but it's not the same percentage for every person because the funding mechanism is based on an average person, and as we all know, no one's average, everyone's unique. The 85%/15% split that's talked about in the collective bargaining agreement on the PEBB side is an aggregate average. No one person is guaranteed an exact 85%/15% percent. It's an aggregate.

Sean Corry: I'm sorry for being thick. I understand the aggregate being close to 15%, but on a plan-by-plan basis? Is there a similar tight margin of a point or two around the 15% on each of the plans?

Megan Atkinson: We have the 85%/15% split agreed to in our collective bargaining agreement in the PEBB world. It is the weighted average across all plans, across all tiers. So, yes. In SEBB, we have a statutory requirement that the employee premium tier ratio be no greater than 3:1. We'll look at that on the next slide. The procuring of all benefit plans on a consistent tier ratio dampens the risk pool from selection risk by plan. Let me explain what those words mean. If we didn't hold all plans to the same tier ratio, then different plans could come in and bid their premiums according to different tier ratios to essentially cherry-pick certain segments of the population. We don't want that to happen. We want all plans to be competing on equal ground against one another so the employee uses his or her enrollment decision to act like a defacto market so the employee's enrollment behavior rewards or punishes the plan's financial performance and how they bid their product. It will be the same tier ratio across all the plans.

This last bullet is a reminder that no tier ratio is perfect. We'll talk about the values. Those are not as critical as the consistency of the application across all plans in the program.

Pete Cutler: By saying tier ratio is not perfect, does that go to the question of does it generate exactly as many dollars as you expect that tier level to cost the plan? That would be a question for any tier level. Are you collecting about the number of dollars that people will have as claims or as costs?

Megan Atkinson: What I meant is that pre-supposing a conversation about the tier ratios in SEBB being different from the tier ratios in PEBB, it's not necessarily that the PEBB ratios are perfect tier ratios for PEBB; and it's not that the SEBB ratios will be absolutely mathematically perfect tier ratios for SEBB. It's the principle of them and the strength of them, and what you get from them is the consistency of the application.

Pete Cutler: Okay. Thank you.

Megan Atkinson: Slide 11, I've again put a lot of information on a single slide. The heart of the slide is a requested scenario that Pete asked about last month in looking at the difference between the proposed SEBB tier ratios, contrasted with the current PEBB tier ratios.

The first column is just the four tiers. You have employee only, your single subscribers we often call it; employee plus a spouse or domestic partner; employee plus children - this tier is one adult and some number of child or children; and the fourth tier being the employee, a spouse or partner, and then some number of child or children. Those four categories are proposed to be the same in SEBB as they are in PEBB, and you can see the PEBB ones down below but they're the same: employee only; employee plus one adult; employee plus children, no additional adult; and then the employee plus one adult and children.

The next column over is the way the current K-12 population, according to the Office of the Insurance Commissioner (OIC), I think it was year five data, falls out across the four tiers. Over half of the current K-12 population is enrolled as a single subscriber. Only 9% enrolled with a spouse or partner. About 23% with a single adult with child or children, and then about 11% in the final tier. If we had a hypothetical 100,000 enrollees, and I used 100,000 for a nice round number, the simple math of 100,000 times 57.2% gets you 57,200 enrollees at the first tier, and then you follow the math down.

The next column over is the proposed tier ratio for SEBB. It's 1.0 for a single subscriber. Employee plus another adult is 2.0, that math is easy. Then employee plus child or children 0.75. Then ending up at the maximum 3.0 on the final fourth tier.

Stay with me as I explain this next part. You don't start with the rates. You start with the amount in aggregate you need to provide health care to the population, and for purposes of this illustration, that hypothetical amount I set is the $900 million at the top of the far right column. What I'm essentially saying in this example is, in our hypothetical K-12 world of 100,000 enrollees, providing health care to that population for a year, takes $900 million in total revenue. Then you solve for the rates and you use the tiering ratios and the population on each tier. In this example where we have 57,000 people on the first tier, or 57% of the population on the first tier, and we need $900 million in revenue, the rate for that first tier is $507. That would generate $347 million in revenue from people on that tier. That's employer and employee contribution. The tier ratio is silent to the split between employee and employer. If you follow down through, the $507 gets to $1,014, which is twice the $507. The $887 is 1.75 times the $507. The $1,521 is three times the $507.

What we wanted to look at for this scenario is how the rates change as you change the tier ratio. In PEBB, the tier ratio is a maximum of 2.75. It's not a maximum of three. Everything else in the example is the same between the two constructs: 1.0, the 2.0, the 1.75. What this shows you is if you lower the 3.0 factor on the fourth tier to a 2.75, you're still solving for the same amount of money. What that means is the rates on the other tiers would go up consistently 1.9% in each tier, and the rate for that final tier would go down about 6.6% because you've shifted.

Remember, your tier ratio is how you're spreading the cost across the different tiers, and one of the things we talk about in health care pricing is: are the single subscribers subsidizing the subscribers with families; and if so, to what degree? What you can see here is if you use the 1:3 tier ratio that we've proposed to you then you have less of a subsidization of the fourth tier. You would see that same type of shifting as you increased or decreased any of these.

Sean Corry: Understanding the math to the best of my ability, I have a more fundamental two-pronged question. We have in the upper section a full family number of 3.0, and then you compare it to what? Before I saw the bottom, I totaled up the top three, which came to 2.75, and so my first question is why did the full family become 3? Because that's an extra quarter point thrown in.

Megan Atkinson: That's a great question and we've had a lot of conversations about that internally. First, there is direction in the statute that it cannot be any more than a 1:3. The approved ratio doesn't have to take up all the capacity. We are uncertain what the dependent enrollment will look like in SEBB. We are uncertain if the number of children coming in under the employee and child/children tier versus the employee plus partner/spouse plus child/children tier would be more or less. The decision was to weigh our options and interpret the legislative direction as more than mere intent and to not leave any unused tiering capacity on the table. To my earlier point, it's not perfect. It is simply trying to use up all the tier capacity that we had in a world where we know little, at this stage in the game, about the population and its enrollment behavior for next year.

Dave Iseminger: There is already going to be a lot of shock in the system. Earlier I answered in the follow-up questions that there is a difference between what the carriers provide and how the allocation was driven out, and what employees are currently paying. When we look at the OIC year five data, the aggregate across the system looks like it's somewhere between an 8:1 to 10:1 ratio. There is variability of some school districts who were over a 10:1 ratio, some with a very large difference, and then the vast majority of districts fall under a 10:1. With this amount of shock that will be in the system, our recommendation is to not further shock the system by taking advantage of the full ratio that is allowed under State law. You could compress the tiers a bit further.

Also for the record, whereas there is a maximum 3:1 employee premium mandate within the SEBB framework, there is no comparable piece within PEBB. The PEBB Program historically has stayed within a 1 to 2.75 ratio without legislative mandate or direction.

Sean Corry: Finally, with respect to the ratios that are apparently going to be in the proposal that we'll discuss and vote on, how close are these ratios to the current PEBB population? Is it essentially the same or are there noticeable differences?

Megan Atkinson: You mean how close are the PEBB tier ratios to the way the PEBB population splits off across? They're pretty close. The actuaries did the math in the last couple of weeks and they are very, very close.

[Break]

Dave Iseminger: Before Shawna starts, I thought I would make sure the Board and public are aware where we are in the story arc of benefits design. I'd say we've closed chapter one with the Board. We did a lot of foundational information with you and the public. We talked with you and you had actions at the March meeting that said: these are benefits where the agency should go forth with its current vendors negotiate and others go out with a procurement.

We're entering chapter two of the story, which over this meeting, the next meeting, and the June meeting, we talk with more granularity about the self-insured benefit plan options and the Uniform Medical Plan that the State has. The Uniform Medical Plan is an umbrella that has a substructure of multiple plans within it. We will go over medical

this month. We'll go over follow-up medical pieces next month, and do pharmacy next month. I want to be very clear that just because pharmacy isn't in today's presentation doesn't mean that there's not a pharmacy benefit. It just means we've bifurcated and put pharmacy at the next meeting instead of putting everything into one meeting. We will ultimately be asking the Board to take action on some to-be-written resolutions in June that we will present at the May meeting.

After June is done and hopefully we round out self-insured plan benefit design with the Board, we would then move into chapter three, which is the more granular benefit design of all the other benefits.

Uniform Medical Plan

Shawna Lang, Senior Account Manager, Portfolio Management and Monitoring Section, ERB**:** The objective of this presentation is to inform you about PEBB's Uniform Medical Plan and options for the benefit coverage levels and member cost-shares for SEBB self-insured plans starting on January 1, 2020. UMP's third party administrator (or TPA) is currently Regence, who provides customer service, claims administration, provider network, and clinical policy administration for UMP's medical benefits. UMP's pharmacy benefit administrator is MODA, who provides customer service, claims administration, retail, and specialty pharmacy network for UMP's pharmacy benefit. More on pharmacy at the May meeting.

To summarize the UMP, there are three plans. UMP Classic plan is a wide-ranging preferred provider organization (PPO). Currently, about two-thirds of PEBB membership have selected this plan. UMP Classic has worldwide coverage. UMP consumer-directed health plan (CDHP) has a health savings account (HSA). This plan was first offered in 2012 as a high deductible health plan with an HSA and allows members to pay a lower monthly premium in exchange for a higher deductible health plan. They also can save money in their HSA for use in IRS-approved medical expenses. For clarity there is an RCW requiring PEBB to offer a high deductible plan, but not for SEBB.

Dave Iseminger: That means this Board has discretion as to whether to offer a high deductible health plan with an HSA, whereas the PEB Board does not have discretion and they offer one.

Shawna Lang: The third plan is called UMP Plus. It was first offered to members in 2016. Members in this plan have the ability to select one of two accountable health networks: The Puget Sound High Value Network and the UW Medicine Accountable Care Network. UMP Plus expanded to nine counties in calendar year 2017, and will continue to look for more growth opportunities throughout Washington State. Membership also expanded from 17,000 to 26,000 from calendar year 2017 to 2018. Members in UMP Plus have access to a primary care office visit at no cost-share and have lower deductibles. UMP Plus also has a higher out-of-network cost sharing to incentivize in-network provider use for more coordinated care.

Slide 5 you saw in December when Scott Palafox first presented, but I have added current UMP memberships as of March 2018. Current membership in UMP classic is 210,000, membership in UMP's CDHP is 20,000, and UMP Plus is 26,000.

Dave Iseminger: One thing to add is when the Uniform Medical Plan Classic was created in the 80s, there was not 210,000 people. Over time, people began to see the value and understand the quality of the benefit offered within the Uniform Medical Plan and there was a migration over the years that resulted in the numbers you see today.

Shawna Lang: Year after year, UMP receives very high health plan ratings through the Consumer Assessment of Healthcare Providers and System surveys, also known as the CAHPS survey. These surveys ask consumers and patients to report and evaluate their experiences in health care. The survey covers topics that are important to consumers and focus' on aspects of quality that consumers are best qualified to access such as communication skills of providers and ease of access of health care services. Slide 6 includes quotes from UMP members. As you can see, they have all given UMP health plans high health plan rates and praise year over year.

Sean Corry: Is this 100% representative of all the comments? There are three very glowing comments here.

Lou McDermott: Yes, it is.

Shawna Lang: We do have a lot of people who love UMP but, of course, we always have our appeals and complaints and we always take that into consideration. We have processes to make sure we get back to every member who actually has any type of concern or issue with UMP.

Lou McDermott: And we have processes in place where if somebody complains to their Legislator or the Governor's office, those get transferred to us and we move those through the system. There are various complaints that happen within the program and some of them are technical issues that happen; some of them are needing additional information; and some of them are just clarification of benefit issues where the person will not be satisfied because x, y, or z is not covered. We handle all kinds of complaints and praise, depending on the individual and circumstances.

Dave Iseminger: I also want to add that once benefits go live, if you as individual Board Members start to get member complaints of appeals or requests for exceptions to coverage policies, we ask that you forward them to the Health Care Authority. We'll look into the matters, get back to you with whatever information we can. Keep that in the back of your mind as you start to get individual circumstances about benefit issues that you can always refer those to the Health Care Authority and we'll work with the member.

Pete Cutler: Back on the chart with the three comparisons, on the CAHPS scores. Were the CAHPS scores calculated separately for the Classic PPO, the consumer-directed plan, and the UMP Plus, or were they all rolled together?

Shawna Lang: They're calculated separately.

Pete Cutler: Did their numbers vary by any material amount between the three types of UMP?

Shawna Lang: I would say UMP Classic and Plus don't have much difference between them. UMP CDHP is lower than the other two, and that goes with the consumer-directed health part of that.

Pete Cutler: Great, thank you.

Shawna Lang: Slides 8 through 12 provide a high-level summary of the benefit coverages and member cost-shares. These are in categories of highly utilized member service categories or where member inquiries typically come in. Although SEBB self-insured plans must be very similar to the benefit offerings in the PEBB Program, during the review please highlight any particular benefits you think have unique aspects for school employees and may warrant different benefit levels. We want to bring detailed information in the May meeting for those types of issues. For example, state and federal laws that are guardrails on benefit levels. Examples of this are Health Technology Clinical Committee (HTCC) coverage decisions. UMP has to follow those HTCC determinations, and that will also be part of the SEBB self-insured plan, if that moves forward as well.

Dave Iseminger: I saw a couple inquisitive faces so I'll try to describe this a bit more. Bullet 2 on Slide 7 is to remind you that in order to launch a self-insured plan, the TPA procurement that we recently did for the PEBB Program took two and a half to three years to write the RFP, go out for procurement, select, and then another year and a half to two years of implementation.

If this Board wanted to launch a completely separate from-the-ground-up self-insured plan, it would not be viable and available for 2020. We'd be talking several more years out for a completely separate self-insured plan.

As the agency was going forward, coincidentally, the PEBB contracting and procurement process was around the time SEBB was starting to be an idea in people's minds. We went ahead and created the contract mechanisms through the procurement to be able to pull that lever immediately if this Board wanted to offer a self-insured plan for 2020. It does not need to be identical. Shawna's least favorite words are "substantially similar." I can't tell you exactly how different a plan could be to be able to pull our self-insured plan contract lever. But it does need to be very similar, substantially similar, materially the same, those types of words.

We're asking you as we go through the next couple of slides, to highlight benefits that you think there might be something unique about school employees. We'll bring back the complex federal and state law framework that overlays each of them. We didn't want to go through all 40, 50, or 60 core benefits. There are many different benefit pieces and we could go through and describe each of the overlapping different

frameworks, but to launch a benefit in 2020, something pretty darn similar to UMP is needed. We want to narrow in on areas that you think may warrant benefit differences, and then talk about your discretion.

Sean Corry: We talked about this at the last meeting. I questioned it then. When I looked at the material here, I circled it as well. Where it says "very similar to," which is not clear enough yet for me, and I'm not complaining about that, but I did give some thought since our last conversation about what's driving this. It's not legislative. It effectively has been because of the Health Care Authority contracting with the administrator that was likely to pick up this business, too. I mean, it's sort of an agency dynamic in negotiating with the administrator that's giving us the restrictions in what we can do, as opposed to legislative intent or legislation.

Dave Iseminger: There are a couple of different pieces. The timeline for launching the benefits is certainly a factor. The agency stepped back and said if the SEB Board wants to have a self-insured plan, because it certainly has that discretion within statute, how could we go about administering a plan for 2020? The potential SEB Board - you weren't even named at the point we were starting to have these conversations - how would we give you the ability to pull that lever versus the agency coming to the Board and saying: "There's no way to do a self-insured plan for 2020. You're only in the fully insured market. Let's talk about whether you want a self-insured plan for 2022," just to throw out a date.

Instead the agency took it upon itself to say, "What can we create as a mechanism to be able to have a self-insured benefit that could be launched under the timeline that was set by the Legislature." It's really a confluence of a couple different pieces, and the agency came up with a way to present you with an option rather than no option. The alternative would have been to not engage in that conversation with the TPA and say, "we don't have an option for you to do anything in this part of the book of business." I think the agency was very thoughtful in trying to come up with a way to present you with something that you could leverage. You still don't have to do this.

Shawna Lang: For Slide 8, we're going to talk about medical deductible and out-of-pocket limits. UMP Classic medical deductible for subscriber only is $250 and for family deductible it's $750. The out-of-pocket limit for UMP Classic is $2,000 per subscriber, and $4,000 per family. The UMP Plus deductible for subscriber only is $125 and family deductible is set at $375.

Out-of-pocket limit for UMP Plus is the same as UMP Classic. UMP CDHP deductible is $1,400 per subscriber and $2,800 per family for two or more. UMP CDHP meets the minimum qualifications for a high deductible health plan. Out-of-pocket limit for the UMP CDHP plan is $4,200 for a subscriber and for two or more people is $8,400. Once an individual meets $6,850 in covered out-of-pocket expenses annually, the plan will pay 100% for services after that point for that individual.

Dave Iseminger: Two things. Shawna is not going to read every chart for the next four pages; she will do highlights, but this is a particularly important one. The second piece

is I wanted to highlight the CDHP, which is our high deductible health plan on the PEBB side. That $1,400 sounds like a lot of money, and it is a lot of money. At the same time, many times you'll see high deductible health plans that have much larger deductibles. This is what some people call a generous high deductible health plan because it has a lower high deductible compared to other high deductible health plans. I want to assure you that the plan does meet the requirements under federal law to qualify as a high deductible health plan.

Lou McDermott: Isn't there also an HSA contribution from the State?

Dave Iseminger: On the PEBB side there is an employer contribution. There's still some evaluations that have to occur with regards to how that could work on the SEBB side, but regardless, there's an HSA that comes with a CDHP and then the employee can contribute funds to that HSA alongside of any employer contribution that might exist.

Shawna Lang: For most in-network procedures, a 15% coinsurance will be paid by the member after the deductible is met in each plan. UMP CDHP plan does not have copays for ER or in-patient. Instead, it has a straight 15% coinsurance after the deductible is met. Examples of benefits in these slides are covered as if the member is using an in-network provider. UMP Classic pays 85% for in-network services and 60% for out-of-network services, and then UMP Plus pays 85% for in-network services that aren't provided by a Primary Care Physician (PCP). All PCP visits in UMP Plus are paid at no cost and then it has an out-of-network benefit of 50%.

Dave Iseminger: Shawna was describing the 85% and the 60%, which is what the plan pays. These slides are from the member's perspective and the "you" in these sentences on this slide is what the member would pay. Whereas the plan pays 85% of a preferred provider acupuncture visit for UMP Classic, the member pays 15%. As we're going through these slides, if there's any specific benefit you want to ask questions about or want more detail on at the next meeting, let us know. As an example, if you wanted to say, "We think with acupuncture there's something unique about school employees that we want, as a Board, to evaluate acupuncture visits. Tell us more about the framework that resulted in a 16-visit limitation." That's the type of thing we'd bring back at the next meeting. So identify benefits you want us to describe the framework behind which that benefit was born in the original UMP or in the current UMP.

Shawna Lang: I'm going to highlight limits and differences between the three plans. Acupuncture has a limit of 16 visits per year. Chiropractic has a limit of 10 visits per year. Chemical dependence in-patient for UMP Classic and UMP Plus has an in-patient copay of up to $600. For UMP CDHP, it's a straight 15% coinsurance. ER has a copay of $75 in UMP Classic and Plus, but is waived if the patient is admitted. There are no copays for the UMP CDHP.

Dave Iseminger: For clarity, if you're not highlighting a benefit, we're going to be under the operating assumption that as we move forward, we would start to align what's on the

page as the foundational structure of the benefit for the launch of a SEBB self-insured benefit. We want you to be questioning and highlighting areas that you want to focus on as a Board as potential changes of benefit design. In addition, eventually, you will have to answer the question of which of these benefits structures, Classic, Plus, CDHP do you want to offer? You'll have that choice as well, columns, as well as, any differences within the rows. Sean, I'm sure I'm not saying this clearly enough.

Sean Corry: No, I think that was clear. I'm really asking this question on behalf of others who represent employees and other constituents. Just with respect to the timing because, frankly, I didn't look at this until this weekend. When do you need these suggestions back by? When's the drop dead? It's certainly not this meeting. It's got to be before the next meeting.

Dave Iseminger: Correct.

Sean Corry: How much time do Board Members and others have a chance to bubble up?

Dave Iseminger: We are in constant Board preparation mode at the Health Care Authority. Every week, if we're not meeting with the Board, between the two Boards, we're preparing for a Board meeting. We would need feedback by the middle of next week to be able to get the adequate information, put it together, and vet it through the process to make sure we have everything as cleanly prepared as we've been trying to produce for the Board. If we're unearthing different parts of federal law and then talking about the best way to present it, succinctly yet comprehensively, that building process takes time. It's a very fast four weeks between meetings here at the agency.

Partly why we're on this chapter two journey that I described earlier, culminating in the middle of June with votes about the structure of the plan is so we can work with vendors and our own IT systems to build the actual group structure, to build the eligibility framework from an IT perspective. We need the Board to start to coalesce around what the benefits will look like for 2020, knowing that you will be able to revisit different pieces as we get more experience with the population. We'll track complaints and appeals, you'll hear concerns come up at Board meetings in public comment. Over time the benefit will get refined as you learn more about the population you're serving, but we need the Board to coalesce around different parts of it so we can actually build the IT infrastructure to support the benefit selection process and the administration of the benefits.

Alison Poulsen: I'm curious about the limits on these things and how that's set. Not so much thinking that we need them to be more but can you provide some feedback on that?

Shawna Lang: These limits have been in place for since 2007 at least. This will take some research to understand historically where they came from. I can get back to you.

Alison Poulsen: I think part of my interest is as we think about preventive care, acupuncture, chiropractic, massage, all three things that I think have been important to my health, those are pretty limited benefits. I'd be curious about the evidence-based practice for the limits?

Dave Iseminger: We will bring more back about the generality of the creation of treatment limitations at the next meeting.

Lou McDermott: Shawna, if I'm correct, there are exceptions, correct? You can extend beyond the limits.

Shawna Lang: In some cases, yes.

Patty Estes: I would have said exactly what Alison said with the chiropractic and the massage. Not so much the acupuncture. In my experience with my members that I've been in contact with, but definitely the mental health treatments. I know that there has been some limitations in some of the plans that have been offered by PEBB, only because my school district is in PEBB. So, some of the members that I know, I think they're on the Kaiser plans that are offered through PEBB, so not the UMPs, but knowing some of those limitations within mental health, in addition to the ones that Alison said, would be great.

Shawna Lang: Mammograms are covered at preventive rates, at 100%, as long as they're billed with preventive codes; and they're covered at 15% coinsurance when billed with diagnostic screening codes. Massage has a limit of 16 visits per year and members must use an in-network provider. Mental health treatments for UMP CDHP only has coinsurance and no copays. Naturopaths are covered as a PCP type for UMP Plus, so there's no cost-share for them.

Obstetric care in UMP CDHP only has coinsurance and no copays on all services. Office visits for UMP Plus, for all office visits with PCP providers, are covered at no cost to the member. Again, that's why we're different on the office visits. Preventive care and immunizations are covered at 100% in all plans. Skilled Nursing Facilities are limited to 150 days per calendar year. Surgery for UMP CDHP only has coinsurance and no copays for all services.

Patty: Under preventive care, does that include birth control?

Shawna Lang: That's a pharmacy-related question.

Patty: Okay. If it's administered by a doctor?

Shawna Lang: If it's administered by a doctor, yes. For example, IUD is covered at 100%.

Dave Iseminger: We will bring back more detail about what is within preventive care within these plans. That builds off of Alison's prior question.

Shawna Lang: Next we're starting with therapy; both physical therapy, occupational therapy, speech therapy, and neurodevelopmental therapy. This combined benefit does not include ABA therapy. I want to make sure that's noted.

Dave Iseminger: Shawna, because ABA therapy is covered under a separate benefit line, not in this chart but it's a separate benefit line within the plan?

Shawna Lang: Yes. Back to the combined therapy benefit, In-patient the limit is 60 days per year; outpatient is 60 visits per year. Routine eye exams covered at no cost-share and vision hardware for adults is $150 every two calendar years. Vision hardware for children is one pair of eyeglasses, frames and lenses, covered at the allowed amount once per year.

Dave Iseminger: Shawna, will you make sure it's clear for the Board, on the PT/ST/OT/NDT, the 60 visits, that's with a referral and a member can get additional visits that are needed and supported by medical necessity determinations.

Shawna Lang: Yes, we've had that happen.

Dave Iseminger: 60 visits in a year is a little more than once a week and it's a combined limit between all of those services.

Sean Corry: Thanks for bringing me back to this row because I see that neurodevelopmental is in there with limits, and in the insured world, there are some neurodevelopmental therapies covered by the Mental Health Parity Act because the codes are in the DSM5. Help me understand whether those requirements of coverage apply to the self-funded plans here and if you know whether the outpatient visits, 60 visits maximum per calendar year, apply to things covered under the Mental Health Parity Act.

Dave Iseminger: I'm going to recommend we bring this back as part of the next presentation. I know we start to get complex real fast and I don't want to say something wrong on the public record or force Shawna to say something wrong on the public record. This is exactly the type of thing I wanted the Board to identify. We'll bring back more detail about this particular benefit and its relationship with the Mental Health Parity Act. I think implicit into that is the question is what would be your discretion to have different treatment limitations. Katy Hatfield, we'll be needing some assistance.

I do want to highlight, in the Uniform Medical Plan, vision is embedded within the medical benefit. From the Board's actions last month, we are working on the procurement and completing the RFI for a standalone group vision benefit. You'll be able to compare and contrast with what exists within the embedded, and you still have the choice before you as to whether you want to embed it in the medical benefit plans or have a standalone benefit. If you want to have a standalone group vision, then we would come back to this piece and talk about carving out vision from the Uniform Medical Plan in our contract with the TPA. We already have the idea that we may want to, on both programs, have carved out vision benefits. One of those reasons being the

Cadillac Tax. There are many reasons why it might be appropriate to have a carve out. We have a contract mechanism to be able to work on carving out the benefit within the existing Uniform Medical Plan. That vision question will be for another day for the Board once we have tested the hypothesis as to what a standalone group vision benefit could look like and compare and contrast it with this.

I also want to use the vision lines as an illustration of the complexity of federal and state law. On Slide 12 you see two rows for vision hardware distinguishing between adult and children. Pediatric vision and hardware must be covered and the 100% coverage is to ensure compliance with federal law in a way that is not mandated for adult hardware. It's an example of how complex it gets when you're looking at overlapping federal and state regulatory frameworks.

Before we move on, I want to catalogue what I think we're bringing back, and if there are any other additions from the prior slides let us know because we need to get to work on that next month, which is tomorrow! I have us bringing back information about general treatment limitations, specifically chiropractic, acupuncture, massage, and mental health treatments. We will bring back what preventive care includes, talk about the preventive benefit and how it intersects with the pharmacy benefit. We'll bring back information on speech therapy, occupational therapy, physical therapy, and neurodevelopmental therapy, the intersection of that with the Mental Health Parity Act, and any discretion you have as a Board to have a different range of treatment limitation options.

I think we should bring back more about how the provider networks work. We've talked about the preferred provider network and how it's a 15% member cost-share when it's in-network and it's 40% when it's out of network. Especially when you get into the Uniform Medical Plan Plus, it's a bit more complicated than that and I think it would be important for the Board to have an understanding of the provider network interactions and how that plays out whenever you're part of these plans. I've added that to the list as well.

Shawna Lang: Slide 14 – Appendix. In the appendix you will find a description of fully insured and self-insured plan types, coverage counties for UMP Classic and CDHP, coverage counties for UMP Plus, UMP membership population that resides outside of Washington State, and medical benefit comparisons to other school districts that were presented by Scott Palafox.

Pete Cutler: As a follow-up on that last point. I noticed that the coverage by county for the UMP Plus has enrollment numbers but the coverage counties for the classic and CDHP do not. Can we get a version of coverage counties with the enrollment?

Shawna Lang: Yes.

Policy Resolutions

Barb Scott, ERB Division Policy, Rules, and Compliance Section Manager. Today we have two policy resolutions that were introduced at your last meeting that we're going to ask you to take action on.

As Dave noted earlier in the meeting, SEBB 2018-12, which is the resolution titled Effective Date of Coverage, we are going to continue to work with stakeholders to refine it and then bring a resolution back to you. We're still working with them and figuring out how that would best look. You're not going to see that one in front of you today.

I'll walk you through the feedback we received, give you time to discuss, take public comment, then vote. As is our typical process, we've included a piece of the RCW that ties into the policy resolutions you're going to take action on today so you'll have that as a reference point. Staff have been shading the text in blue in order to help you focus on the area they believe is the area of your authority that you're working under as you look at these policy resolutions today. You'll see staff do this on each slide set as we walk through both the ones we're introducing, as well as the ones you're taking action on.

The first policy resolution for you to take action on today is Policy Resolution 2018-13 - Election Period. The recommended policy was slightly changed, from the one originally introduced to you, based on a recommendation from the Board. We added clarity at the end of the resolution. The policy resolution addresses all elections are due regardless of whether they are employee elections for benefits that the employee's paying for versus employer paid. We added the word "all" at the beginning so it reads, "… resolved that all of the school employees' enrollment elections…," not just a part of them. It's every election is due.

We also have clarified the trigger for measuring the 31-day deadline is eligibility for the employer contribution rather than hire date. I'll give you an example. Oftentimes an employee is hired and may not originally be anticipated to be eligible. We see this in the PEBB population, so after their hire date, they're determined to be eligible. To tie anything to the hire date was tying it back to a date that didn't matter. The employee's eligibility for the employer contribution is a much better date to measure from and that's why you're seeing that on this resolution as well.

We did receive questions back from stakeholders and we received feedback recommending the words "employer paid" versus "employer contribution." However, we believe using the word "employer paid" may lead to confusion that benefits are fully paid by the employer so you'll see in the resolution before you we're using the words "employer contribution."

Dave Iseminger: There was no phrase "employer contribution." The recommendation was "employer-paid contribution," but because of the concern stakeholders highlighted, our recommendation is "employer contribution". We took the feedback provided, considered it, and added words to the resolution that give the clarity that's necessary.

Barb Scott: We did receive questions from stakeholders regarding what the default enrollment plan would be as far as the medical plan or dental plan. Since plans aren't determined yet, we didn't include a specific plan or talk about a default plan at this time. Once the SEBB plans are determined, we'll bring back a resolution for this Board to decide what the enrollment of an employee who doesn't take action and elect during their 31 days will be. We'll ask you to adopt several policies related to what is the default position when an employee doesn't take a needed action. We also received questions regarding the ability for an employee to waive coverage. We will work on a policy to address which SEBB benefits could be waived, as well, and we'll bring that back to you in the future.

Sean Corry: I have a question about process. This is a complicated issue for school districts because of the way they currently do eligibility and put people into coverage. I fear that in the future we're going to run into circumstances we haven't discovered yet about difficulties with respect to this process. So my question is a little broader. If we run into those circumstances and we understand that it might be something we need to address, what's the process for rethinking what we're about to vote on and maybe changing it to meet the needs that we don't now know?

Dave Iseminger: I think I've said in many environments, but I don't think I've said it to this Board, if you look at the PEBB rules, they're about 30-40 pages in length. That didn’t happen overnight. That happened over a many-year process, and as we learn more about the system, we'll bring refinements to you.

You will raise issues saying you are hearing about something in the school districts. Can the agency look into this? The staff can investigate and understand circumstances with more granularity. We will then report back to you if and why your current policy actually meets the needs of members or the districts. In other instances, we will recommend a refinement of your eligibility rules. This is an iterative process, where we are at this juncture with the knowledge we have. At the same time, with the amount of change that's happening in the system, there will be pieces that have to be cleaned up as we're stabilizing the program. We're not anticipating that with this particular resolution, but I understand, Sean, your question about the larger process for all of the resolutions and the eligibility framework. It's building the ship as we go along and recognizing that we may have to change course on some pieces. There may be pieces that we pick up and are able to refine before launch.

We're thinking that the things we're bringing to you we feel reasonably confident that, after stakeholdering, it is a good solid foundation for the launch of benefits on 2020. As you identify pieces and stakeholders identify pieces, we will have an annual iterative process where we look to you to refine different parts of the eligibility framework, hopefully for the next 30 or 40 years, and get to the same level of detail as PEBB rules. When you look at the PEBB rules, there are many different parts. Just as there are hundreds of different types of employees in the PEBB population, there are hundreds of different types of employees within the SEBB population. Is this Board and the agency going to come up with recommendations on every single iteration of all those employees for January 1, 2020? Absolutely not. As we learn more about the

population and we identify different parts of the population that don't quite fit the rule, we'll work with you to create a policy that fits that situation and addresses that part of the population.

Sean Corry: Thank you.

Patty Estes: I have a concern with the "becomes eligible" because of the wording now with “anticipated to work 630 hours.” With this “becomes eligible,” does that mean when they hit 630 hours or when the district anticipates them to work 630 hours?

Barb Scott: This was written in a way that we hoped would take care of both situations. The "becomes eligible," we thought could come two different ways and that's why I said we didn't anchor it back to the hire date. You will have folks anticipated to work 630 hours and deemed eligible maybe as early as at-hire. You will have others who may gain that over time because they were not originally anticipated to work 630 hours, but the reality is they did work 630 hours. We tried to write this in a way that it would function in both of those scenarios.

Patty Estes: My concern is that some school districts will wait until those employees hit the 630 hours to let these employees be eligible versus saying, "Oh, we didn't anticipate them to work, so they weren't eligible." Then they worked 630 hours but they've been working for four months without benefits when they originally could have been anticipated to work that. That's where that ambiguity could hurt members. When they should have been eligible they were not eligible because of that anticipation versus this wording that says, "just becomes eligible." It’s concerning.

Barb Scott: Is there another word you were thinking of that could work?

Dave Iseminger: Let me interject a couple of different pieces. First, the way the rules will be written and codified in the Washington Administrative Code will flush out some of the extra details. We’re getting the Board to make a policy direction and making sure you understand the implications of this. Barb is putting on the record the intent and your understanding of the intent, if you were to adopt the resolution, is it takes into account both of those worlds of anticipated, as well as actually worked 630 hours. In the rule, we may write a subsection one that describes it in a new hire way and a subsection two that writes it the other way so there's even more clarity as district officials make those eligibility determinations. I wanted to be clear the rule that's written from this will probably be longer and describe even more granularity. I can’t remember the second piece I want to highlight! I'll think of it.

Barb Scott: I think Dave is describing that we will end up writing rules that will talk about when an employee becomes eligible for the employer contribution. Those rules, those resolutions, that will help to build those rules, haven't been brought before you yet. I think those are ones you're describing so there can't be gaming of the rules. How that will be resolved we're not prepared for yet; but at the same time, we thought writing this the way we did would allow for any situation by which an employee is deemed eligible. They would have a period of time in order for them to know they were eligible

and be able to make elections. Under Cafeteria Plan administration, IRS rule allows employees 30 days to make an irrevocable election. The reason it's written as 31 days is because a rule will be written to say you must have your form in no later than the 31st day. We expect it's turned in by the 31st day and that gave the employee the full benefit of the 30 days allowed under Internal Revenue Code rules to make decisions about their election.

Patty Estes: Okay.

Dave Iseminger: Patty, I remember the second thing I was going to bring up. There will be an eligibility appeals process crafted and put in place where HCA could identify an employer not following the rules as envisioned by the Board. There's an opportunity to train and educate an employer who may not understand the rules. We have staff that work with employers on the PEBB side now and will work on the SEBB side, too, to help them understand the intent and requirements of the rules. Ultimately, if we have a particular employer, I think this is on the SEBB side as well, not following the rules, HCA can recommend that this Board take action against that employer to help them understand the ramifications of not following the Board's rules.

Patty Estes: Okay, thank you.

Lou McDermott: Policy Resolution SEBB 2018-13 - Election Period:

Resolved that, all of the school's employee's enrollment elections, including an election to waive if allowed, must be received no later than 31 days after the date the school employee becomes eligible for an employer contribution for SEBB benefits.

Wayne Leonard moved and Alison Poulsen seconded a motion to adopt.

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-13 passes.

Barb Scott: The next policy resolution for you to take action on is SEBB 2018-14 - The SEBB Program Premium Structure. The recommended policy was changed to clarify that it will apply to benefits where there is an employee and employer contribution. I think this was a question or we noted it last time for you. We did receive comments on this policy and stakeholders were not concerned with the use of this premium structure and these four tier categories.

Lou McDermott: Policy Resolution SEBB 2018-14 - The SEBB Program Premium Structure.

Resolved that, within the premium structure for the SEBB benefits where there is both an employer and employee premium contribution, there will be four tier categories. The premium tier ratio and the employee premium contribution for each tier will be:

Tier Category:	Premium Tier Ratio:
Subscriber Only	1.00
Subscriber and any Child(ren)	1.75
Subscriber and Spouse/State-Registered Domestic Partner	2.00
Subscriber and Spouse/State-Registered Domestic Partner and any Child(ren)	3.00

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-14 passes.

Barb Scott: The next step will be to incorporate the policy resolutions into program rules and benefits.

Eligibility and Enrollment Policy Development

Barb Scott: These are new Resolutions you haven't seen yet but we're introducing. Today we have five Resolutions and we are looking for discussion and feedback on them. Staff included language from RCW to support you as you walk through them. We have included additional ones from the budget bill as well to help you look at language that supports the decisions in front of you. Highlighted is the part that indicates the Board determines the terms and conditions for school employee and dependent eligibility criteria and enrollment policies.

The first proposal is SEBB 2018-15 – Dual enrollment in SEBB Benefits is prohibited. School Employees Benefits Board (SEBB) medical, dental, and vision coverage is limited to a single enrollment per individual.

This policy mirrors one the PEB Board has in place to prohibit an individual who had more than one source of eligibility for PEBB coverage to a single enrollment. They did that subsequent to the Legislature including language in the budget that assumed within the PEBB funding rate that dual enrollment would be prohibited by the PEB Board. Knowing that the Legislature went down that path for the PEBB Program, we're bringing this to you to think about in the context of SEBB.

For example, with PEBB eligibility, because my husband also happens to be a state employee, I could be covered on my own PEBB eligibility as an employee, or I could choose to be enrolled on his coverage as a dependent. But the Legislature said although I may have eligibility from both places, I don't get to draw money out of the State coffers in order to support me being enrolled in both of those places. When that was allowed in the PEBB Program, I benefited from not having any out-of-pocket copay when I went to the doctor's office. My children were young at the time. I didn't pay out-of-pocket, necessarily, because of coordination of benefits when I took them to the doctor or when we filled prescriptions.

When PEBB went down this path, one of the things noted was that as employee premiums increased over time, the employee's share that was the cost of coverage for medical coverage became less and less important to employees. By the time you're paying a significant cost out of your own paycheck in order to cover those family members, then not paying a $20 copay at the doctor's office becomes less valuable to you. You would have to use more and more office visits, so this policy gets to that. Only one eligibility could be used.

Dave Iseminger: You can think of this as a fundamental assumption that we believe the Legislature has, even though there aren't many things known about the funding questions. We believe this is an underlying tenet about the funding solution will need to be created, as well as a potential cost containment piece.

Katy Henry: Does this apply to dependents as well? If you had two spouses who were going to be in SEBB, could they both enroll their children, employee and children under each of them, or does this prevent that?

Barb Scott: In my personal example, when my husband and I were both state employees and we had children at home, the advantage was that we both double covered the kids because they were the ones who were using benefits more than us. This type of resolution when passed by the PEB Board prevented it prospectively. We had to make a decision which one of us would cover the children based on preference in the same way we made the decision whether I would waive my medical coverage, I could have waived my medical and been covered on his medical along with the children. The PEB Board left up to the individual to decide how best to cover family members. This policy would allow that as well. It just limits it to a single plan enrollment.

The other place we saw folks sometimes had dual eligibility was as an employee and also as a dependent child - young adult children still being able to be covered on their parent's coverage. That young adult who's working and eligible for SEBB benefits would have to decide to between their own coverage versus they could waive and be covered on their parent's coverage. That might be advantageous if there were other children already. The way the premium rate structure is, there is one cost regardless of the number of children you cover. Families would be able to make decisions but they would be limited to pulling dollars out of the pot one time.

Dave Iseminger: Katy, the answer to your question was yes. [laughter]

Barb Scott: I could have gotten there much faster by saying yes.

Dave Iseminger: I do want to put on the record that this is just one piece of dual enrollment. We know that there are other situations to be addressed by the Board, for example, when an individual and their family circumstance has dual eligibility between PEBB and SEBB. Now that both of those funding structures will be coming from the state, if you have a school teacher and their spouse who is a faculty member at a higher education institution, is dual enrollment something that's allowed? We're not asking the

Board to determine that now. We still have a lot of evaluation to do in that area, but we felt this piece could be brought to the Board to at least address within-the-program dual enrollment.

Pete Cutler: Do we have fiscal analysis on this either for SEBB or the combined SEBB/PEBB dual enrollment policies? My understanding, and I probably was on a budget committee at the time, was that there was a certain amount, it had an impact on the funding rate whether or not you allowed double coverage. I'm just wondering whether we have any kind of fiscal analysis around that?

Dave Iseminger: Duly noted request, Pete.

Barb Scott: Staff included language out of the budget bill to provide you with language related to the next couple of resolutions. In the budget bill this last year, there was language included requiring a $25 per month surcharge related to tobacco use and a $50 per month surcharge for a spouse or domestic partner who had coverage available to them through their employer that has benefits and premiums with an actuarial value of not less than 95% of the Public Employees Benefits Board plan with the largest enrollment. PEBB's plan with the largest enrollment is the Uniform Medical Classic Plan.

Dave Iseminger: It might sound counter-intuitive to have the benchmark for a SEBB surcharge be the PEBB plan, but in reality, it is just that, a benchmark. One of the reasons the PEBB plan was selected was there are no plans in SEBB to use at this time. Second, the agency has already implemented surcharges using this benchmark and it eases implementation. HCA also won't have dueling surcharge calculators on the website that inevitably somebody uses calculator A when they're supposed to use calculator B. It's just a benchmark for an actuarial equivalency and premium equivalency.

Barb Scott: The agency did implement surcharges consistent with these for the PEBB Program in 2014. In implementing those surcharges, we learned a lot. We recognized that there are a number of decisions within the HCA's purview, and then there are policy decisions we will bring before you that are consistent with those we brought before the PEB Board. I want to run through some of the HCA decisions so that you'll be aware of them. HCA rules require a subscriber's attestation for both the tobacco use, as well as for whether or not their spouse had coverage through their employer. We chose not to do any tobacco testing. There was a conversation about what testing is available and whether or not we would just rely on the subscriber's attestation. We also made the choice to not audit whether or not a spouse's employer is offering coverage to them. Instead, again, we take the subscriber's attestation at face value. We assume that we're going to do the same thing for the SEBB Program as we implement these surcharges.

Dave Iseminger: We have made clear that if individual employers learn about an individual not accurately providing information, it's up to the individual employer to decide whether that's something they want to review under their HR policy. HCA is not

the tobacco police. The employer can decide what it wants to do, but the Health Care Authority would take the attestation and apply or not apply the surcharge based on what the member provided.

Barb Scott: We also plan to implement in the same way we did for the PEBB Program, but the $25 tobacco use surcharge will be a single amount added to the premium for the subscriber, regardless of the number of members on the account who use tobacco. For example, if Dave and I were married, I have him enrolled on my account, and he smokes tobacco and I don't, I would have to pay the tobacco surcharge. If we both used tobacco, I would still only pay a $25 tobacco surcharge. It will be one surcharge per account, not multiples.

Another HCA decision is a subscriber will not be assessed a tobacco use surcharge if all members enrolled in medical coverage age 13 or older who use tobacco products are enrolled in a tobacco cessation program. If they're enrolled in a tobacco cessation program we don't charge them a surcharge. We plan on doing the same with the SEBB Program population. You note I said "age 13 or older." When we implemented for the PEBB Program, we found there are no smoking cessation programs that can be put in place for a population under the age of 13. That's why there is an exception for a tobacco use attestation for children under age 13. We also found that if there were failures on the employee's parts about attesting for a child, it was usually a newborn child.

Lou McDermott: We were deeming newborns as smokers for a little while, right?

Dave Iseminger: We did hear from members whose babies were deemed smokers. That decision was modified.

Federal laws also require reasonable accommodations for tobacco surcharges. To comply with them, a member must be able to avoid the tobacco surcharge if they are in a tobacco cessation effort.

Barb Scott: Most medical plans have a tobacco cessation program for 18 or older. For a member age 13-17, what we did for the PEBB Program was described resources aimed at teens on the Washington State Department of Health's website. Our medical plans weren't able to put a smoking cessation program in place for teens. So, we are utilizing what Washington Department of Health has in place.

For the spouse and domestic partner surcharge, we created a worksheet and a calculator tool. When you look at the budget bill, it requires comparing actuarial values. The easiest way to help our members was to create a tool to help them compare plan AVs with the UMP Classic AV.

Dave Iseminger: There are so many different employer situations that we couldn't centralize and do the calculator on behalf of everyone. We had to create something that allows a member to input a couple key features of a plan to say this is equivalent or not equivalent to the AV of the benchmark plan, and then a premium comparison, too.

Barb Scott: We also plan to include a provision in the Cafeteria Plan document for the SEBB Program that will allow a member to change their tobacco use status mid-year. Also a provision if there's a change in their dependent's employment.

Dave Iseminger: What Barb's saying here is that although an individual may have to pay a tobacco surcharge, they can use pre-tax payroll dollars to pay and they are able to change that attestation and get out of paying it within Cafeteria Plan rules.

Barb Scott: Those would be a couple of the special open enrollment events that Tristin talked about earlier, and our purpose in including them in the Cafeteria Plan document then meets the requirement of being able to administer using payroll dollars on a pre-tax basis.

If the Board adopts a policy that allows an employee to waive enrollment in medical, we'll create an exception to the spouse and domestic partner surcharge so an employee is not assessed a surcharge because their spouse waived their own SEBB medical in order to enroll as a dependent. For example, if Dave and I were married, we were both SEBB eligible, and we decided it was best to be covered on one person's coverage versus the other, then we wouldn't have to pay a spousal surcharge if one of us waived and was covered by the other.

Sean Corry: In the definitions of tobacco products, it specifically excludes e-cigarette or whatever, other terms apply in that general category. Why is that?

Barb Scott: If we flip to the proposed resolutions we can talk about that. The first resolution is the definition of tobacco product, and as Sean noted, tobacco products excludes e-cigarettes. The definition of tobacco product is closely aligned to the definition used by the FDA. However, it differs from the FDA's definition of tobacco products in that one area where we have exempted e-cigarettes. The reason we exempted e-cigarettes is because, in working with our Chief Medical Officer, the science behind e-cigarettes is still evolving. Whether e-cigarettes actually help folks who are trying to stop using tobacco products versus them having a negative effect in and of themselves, is still undetermined. The FDA does now include e-cigarettes in their definition of tobacco product, but based on just the science itself, we have exempted them at this time.

Dave Iseminger: When the tobacco surcharge was originally included in the PEBB population by the Legislature, the FDA had no rulings on e-cigarettes one way or the other. The tobacco surcharge was implemented without e-cigarettes counting as tobacco products by the recommendation of our CMO and then the PEB Board's action. Since then, the FDA did take action and included e-cigarettes within its tobacco product definition, but only for the consumer marketing regulatory framework. The FDA did not put e-cigarettes within their framework of treating them as chemically equivalent. The FDA included e-cigarettes in its ability to regulate packaging and marketing. The FDA wasn't focused on necessarily the health implications, and so while the FDA has started down the road of some e-cigarette regulation similar to tobacco products, it's not full regulatory equivalent authority that they are applying.

Another piece we looked at is how the state treats e-cigarettes. We looked at a similar piece where there is some regulatory authority regarding consumer marketing aspects of e-cigarettes. But e-cigarettes are not taxed in the same way as other traditional tobacco products. Those distinctions prompted a recommendation to the PEB Board that this is still an evolving area, and the PEB Board should continue to exclude e-cigarettes from the definition of tobacco products. For those same reasons, we are making the same recommendation to you as you launch the definition of tobacco products for these surcharges.

Barb Scott: The FDA was looking at the marketing to those under the age of 18 because e-cigarettes were coming out in multiple flavors. They were trying to protect children under the age of 18 from starting to use tobacco products. They really were focused on that population with the changes they made.

Wayne Leonard: Given the divergence in the federal and state regulations around cannabis, would it someday be included since our bus drivers can't have marijuana in their bloodstream to maintain their Commercial Driver's License (CDL). All school districts have drug-free workplace policies, but we're going after tobacco and not other forms of inhalants with this surcharge.

Barb Scott: The budget bill was very specific to tobacco products and did not just say "smoke." What we brought forward is tied directly to what is in the budget bill. If there is an interest to apply something beyond that, it isn't required by the budget bill.

Dave Iseminger: If this Board wanted to take additional action, we could evaluate that, but again, in this context, the phrase "tobacco products" was deemed not to include cannabis or marijuana because it's not from a tobacco leaf. We learned all about tobacco leaves several years ago. In fact, there is tobacco infused vodka and there was a question, "Is that considered a tobacco product under this definition?" Our members never cease to amaze me with their creativity. [laughter]

Barb Scott: I don't remember the tobacco infused vodka. I do remember the one sprinkling tobacco on food, and any way you ingest tobacco would be considered "use."

Dave Iseminger: In the instance of tobacco infused vodka, that was infused, not derived from the leaf, and I think the derivation matters. It gets granular very quick.

Lou McDermott: This is bringing back a lot of good memories. [laughter]

Pete Cutler: I would note that the surcharge, when it was implemented in PEBB Program, pre-dated the legalization of marijuana so the policymakers didn't have to address that question. It really is a question going forward, something the Board could look at, but it would be going beyond what the Legislature has in the budget bill.

Dave Iseminger: We crafted the tobacco product resolutions and put them in the Briefing Book and then realized we needed to explain surcharge implementation for

context. I apologize for you not having slides about some of the implementation aspects of the surcharges to read in advance.

At a later point, we'll give a presentation to the Board about how the surcharge implementation. But I wanted Barb to give a framework of some of it so these weren't resolutions without any context.

Alison Poulsen: I'd be curious when we do that deeper dive, the percentage of folks who attest to using tobacco products and how it compares to state or national average use, or however you might look at that.

Dave Iseminger: Before Barb moves on, I'll add one more thing about the surcharges because I know it's something that kind of permeates this topic. I said we weren't the tobacco police, but you'd be surprised that members come forward and say, "I said no, but I really smoke. I feel bad. Can I pay it?" And we say, "We'll change your attestation." Divorcing couples, nosy neighbors, and colleagues try to turn in people they see smoking or suspect lied on their attestation form. We say, "Feel free to talk with their employer about your concerns." We take the attestation on its face.

Barb Scott: That is true. The next definition is the use of tobacco. Proposed policy SEBB 2018-17 would define tobacco use to mean any use of tobacco products within the past two months. Tobacco use, however, would not include religious or ceremonial use of tobacco. We've included definitions for religious use and ceremonial use of tobacco in order to add clarity to tobacco use. Religious use would be for part of a formal traditional, rite, or ritual, and ceremonial use would be connected with the practice of a traditional ceremonial ritual.

Dave Iseminger: Federal law requires exemptions of this nature.

Barb Scott: This is consistent with the PEBB definition.

Dave Iseminger: The two-month look back is something that we need a tobacco definition regarding the life insurance benefit, and we've been able to coordinate on the PEBB side the look back period for the surcharge with the look back period for life insurance. If this Board adopted a similar two-month look back, that would provide additional framework and context for the agency in negotiating with our vendor to have a similar two-month look back on the life insurance benefit.

Barb Scott: Proposed policy SEBB 2018-18 - Tobacco surcharge attestation default. This is the default position. If a subscriber doesn't attest to tobacco use, then how would districts complete that portion of the employee's elections. The recommended default would be to charge a subscriber's account a surcharge if he or she fails to attest that any member, again age 13 years old or older only, enrolled in medical coverage on his or her account does not engage in tobacco use.

Lou McDermott: Barb, why do we mention the dollar amount in the spousal surcharge and not the tobacco surcharge? Is there a particular technical reason?

Katy Hatfield: The budget bill says it's $25 a month for tobacco, but it says it can be no less than $50 for the spousal surcharge. So, the Board could set the spousal surcharge higher if they wanted.

Dave Iseminger: Some of the policy reasons you might want to do this are probably obvious but I want to state them for the record. If you had the default be that nobody is a smoker, then no one would engage in the surcharge process. The other piece is there are known claims cost risks to a plan because of the health effects of smoking, and you want to mitigate this cost by getting people into tobacco cessation programs or quitting tobacco.

Pete Cutler: I'm not sure exactly how germane this is to our deliberations because I understand the Legislature, if I remember correctly, has said it will be a $25 smoker surcharge. Have the actuaries for the Health Care Authority and for the UMP specifically done analysis, or have data that's done through any other national studies, on the average additional cost that is incurred by health plans for smokers versus nonsmokers? My understanding is the surcharge is only a small portion of the additional cost that the health plan probably incurs because of a person smoking.

Barb Scott: I don't know if we'd have any of that from our wellness stuff or not.

Dave Iseminger: We will see what we can bring back at a future meeting, Pete, on the relationship between the $25 and plan costs.

Barb Scott: The next proposed policy is SEBB 2018-19 - Spousal Surcharge Attestation Default. Just like the tobacco surcharge, we'll use a premium payment plan to collect the premium surcharge on a tax-preferred basis. An irrevocable election is required in order to do that. This policy would set the default at charging a $50 monthly premium surcharge if the employee failed to attest. Again, the Cafeteria Plan will be written to allow the election to be changed annually or when there is a change in status. An example would be if a spouse stopped working, then the employee could attest to no employer coverage being available and change their attestation going forward.

We will get these to stakeholders and bring them back to you at your next meeting to take action on.

Public Comment

Fred Yancey: My name is Fred Yancey and I am here today on behalf of Washington State School Retirees Association. I also work on health and pension issues for school administrators and school principals. I would draw your attention to a particular slide. It was page three on tab five, and it talks about the current K-12 health benefit funding structure, and I just take issue with the words: "State funding is provided on a per FTE basis. For school districts it's on a formula per FTE basis." Now, that's a different distinction. I don't know if, when I look at a state budget, they'll show an agency, they'll show a number of FTEs, and maybe that is the number of full-time employees that a state agency might have, but school districts have a number of FTEs. Many of them, particularly, and it was pointed out, the classified employees are in excess of the

formula allocated to school districts. So, it's important to understand that. I think your comparing apples to oranges when you talk about FTE basis. The FTE basis for the state is, I believe potentially, different than the FTE basis for a school district. So, I just wanted to make sure, and it was spoken to, but it's an important distinction because that's exactly the financial hit that school districts are going to have is because the difference between headcount and formula funded FTE employees.

Lou McDermott: That was something Megan was addressing, that the Legislature when they come back to town, have an opportunity to address that with the formula: making a modification to the formula and also the funding rate or a combination of both. I think everyone is aware of that issue and we'll definitely bring that up with the Legislature as we go through the next session.

Fred Yancey: We're all eagerly awaiting a more educated guess as to what the financial obligation is going to be for the State. I understand that $200 to $300 million was just a rough figure, but we're moving towards a little more definition towards that, but we know, we, meaning representing school districts, know it's going to be a substantial hit to districts.

Lou McDermott: I think as the claims data comes in, as the modeling begins, as collective bargaining takes place, it'll put everything into a finer focus to be able to determine that hit.

Fred Yancey: That's correct. When you talked about the biennial budget and this is my question and I can do this offline, and Dave and I could email, but the collective bargaining negotiations that occur, whatever agreements they have, are not run through a Health Care Authority budget for the SEBB piece? Or is that a separate ask of the Legislature?

Dave Iseminger: After the CBA process is completed, an agreement has to be run through a financial feasibility and cost study by the Office of Financial Management, but there's not a special process that goes through the Health Care Authority. There may be consultation that OFM asks of HCA as it does its fiscal feasibility analysis, but there's not a special HCA one.

Lou McDermott: What happens is, if we were to modify the collective bargaining on the PEBB side, for example, and let's say we went from 85%/15% to 80%/20%, that would have an impact on the total funding available to PEBB from the state, and we would incorporate that in the Health Care Authority's budget. There will be a budget item, depending on how collective bargaining goes and what the model looks like. So, yes, it is taken into consideration.

Fred Yancey: Although the budget item would not be, if I understand you correctly, do you ask for the state match of benefit payment. That would not be part of the Health Care Authority budget.

Lou McDermott: Probably not. It would probably be part of the K-12 budget and it would go through that. Wherever the money lies, they're the ones getting allocated the money. The Health Care Authority, we might get set a funding rate and then that's the funding rate that embedded into the agencies or, in this case, the school districts, and then the school districts need to pay us that money. It's all addressed in global budgeting.

Fred Yancey: Gotcha. Thank you very much.

Dave Iseminger: To be clear, we use modeling during the CBA process to help everybody understand the potential cost. We're aligning the budget with the CBA agreement, but the actual fiscal study is done by OFM. We're reflecting it within our budgetary ask. That's what I meant by there's not a special analysis done after the CBA. It's really done by OFM, but we do have to reflect it in our budget documents.

Fred Yancey: That was my question. Thank you very much. For whatever it's worth, the policy in prohibiting dual enrollment, I think school districts would be speaking from the management side would be very much in support of that.

Speaking as an individual that uses the vision plan, I think it's ridiculous the low figures they reimburse for glasses. $150 for a frame is nowhere near what frames cost nowadays, particularly when 90% of the companies that furnish frames are owned by one company. It's quite a monopoly in terms of furnishing that, and as two lenses, the coverage doesn't reflect the aging population and the offset that you need for bifocals is an example. That's just feedback there.

My last piece is you still have the retiree issue and what to do with the K-12 retiree population. If you choose to put them into a separate risk pool, that's one thing that will reflect on rights. If you choose to put them in the K-12 pool as a total, that will say something regarding rates. If you choose to put them in the PEBB pool generally, or as they are now, separate, in the PEBB. All of this will be rates, but all of these, what you do with retirees are going to affect program design and rates, and that recommendation from your committee, if I understand the law correctly, is due in December.

Dave Iseminger: There is the K-12 retiree study that has to be performed. We've begun work with our actuaries to provide a couple of different potential impacts for different scenarios. Under state law, both the PEB and SEB Boards have to be consulted in that process and we have plans this summer to bring you information. The report's due in the middle of December, we will get your insight and provide it along with the agency's report to the Legislature.

This Board doesn't have, nor does the PEB Board have, the authority to move the risk pools. That's the legislative piece, but certainly your insight about the implications of different risk pool arrangements is the purpose of the report. We're working on this topic and it's another important moving piece of this SEBB Program puzzle.

Fred Yancey: We believe, meaning school retirees, that should it be more affordable for retirees to get insurance by combining in the regular risk pools that we are prepared to seek legislative change to change the law to have that done and, assuming we're successful, there's enough timeline to do that before SEBB has to be implemented as a whole. So, thank you very much for your time. Thank you for this service on this committee, too. I tell you, it is highly technical, very confusing to a layperson. So, I appreciate the fact that you're willing to spend the time you do to understand it. Thank you.

Julie Salvi, representing the Washington Education Association. I wanted to pile on a little bit to this FTE headcount discussion and mainly just to point out one part of the law. When, in one of the presentations, I think it may have been Megan's, it was referencing the requirement for the two systems to be funded at the same rate, and that was from section 33 of Senate Bill 6241. The following section after that, section 34 really talks about the intent of the Legislature to review the state funded staffing assumptions and to consider the assumptions to reflect the proportionate share of headcount eligible employees. So, it is true, there's no solution out there yet, but in the latest legislation that was enacted just this year, the Legislature took a nod towards noting that it does need to be considered and adjusted. They didn't have a solution yet, but it is on the radar and so I don't expect it to be, in the end, continue to be funded just on the FTE basis that it has been in the past. They just haven't decided on the next step.

Then I had a question on the process coming forward on the effective date of coverage of what was anticipated. Is it anticipated that it will be presented at the next meeting for action? Is it substantial revision? If there are substantial revisions, would it be another process where the Board gets time to both consider new language and time to consider that before they vote at maybe a following meeting?

Dave Iseminger: Because of the likelihood of substantial changes, we would basically restart the process and re-propose to the Board. We'd keep the same number because the concept is still Resolution 2018-12, but we wouldn't present and ask you to take action in May. We would bring you a new proposed resolution, discuss the stakeholder feedback that led to it, get your new feedback, and ask you to take action at a subsequent meeting, not at the May meeting.

Julie Salvi: Okay, and then one other process question. It was mentioned in the work coming forward that the RFP would be issued, it was in the summer months, I believe. I was also curious to know the delineation of work between agency and the Board on this. Presumably, there are policy decisions embedded in any RFP and how would the Board be brought in on those?

Dave Iseminger: Previewing next meeting's agenda, we're anticipating sometime in June that the RFP would go out. We're planning to bring to the Board insights and information from the medical RFI responses received last Friday and gather Board insight to be able to work that into the final RFP. We won't present an RFP for ratification or anything like that, but we will ask you and bring up a couple of different

issues that we know you'll want to chime in on. An example of that is: we're planning at the May meeting to bring back that question about an embedded dental within a medical plan that Kaiser Permanente Northwest brought up at the January or March meeting. We want to engage with the Board on that discussion so we can clarify how that needs to be addressed in the RFP. We will then turn around and release an RFP in June, probably before the June Board meeting.

Julie Salvi: Okay, thanks. That's all I had today.

Lou McDermott: The next meeting is scheduled for May 30, 1:00 p.m. to 5:00 p.m., same location.

Preview of May 30, 2018 SEB Board Meeting

Dave Iseminger: I just previewed a few things we already know are going to be on the agenda. We'll also follow up on the UMP's specific benefit issues that were identified earlier in this meeting and present about the UMP pharmacy benefit. We'll likely present what we call the Centers of Excellence Program, which is a benefit that Dr. Lessler alluded to in some of his presentations back in November and December. It's a bundle payment, or at least right now, it's set for total joint replacement and we'll explain how that builds upon the Uniform Medical Plan as another benefit option for you to consider.

We'll have the resolutions presented today by Barb and the stakeholder feedback, for your action and we'll present a variety of new resolutions. The timeline between the May meeting and June meeting doesn't fit the typical stakeholder review process. We would be asking you to take action on them in July, but we want to go ahead and start teeing them up in May and June. That way stakeholders still have an ability to provide feedback, but we want to take advantage of that time and begin teeing up issues for your consideration.

We'll also be providing you insights from the RFIs and specifically focus on that medical one so we can get insight from you as we craft the final RFP for release. That's generally what four hours looks like in May.

Lou McDermott: Dave, thanks to you and your staff; lots of work. Appreciate it. This meeting's adjourned.

Meeting adjourned at 4:16 p.m.