School Employees Benefits Board
Meeting Minutes

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

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

Member Via Phone:
Alison Poulsen

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 December 11, 2017 SEB Board Meeting Minutes
Lou McDermott: Patty Estes moved and Pete Cutler seconded the motion to approve the December 11, 2017 SEB Board meeting minutes. Minutes approved by unanimous vote as written.

Prior Meeting Follow-up Questions
Dave Iseminger, Director, Employees and Retirees Benefits Division. I have four areas of questions that don't easily fit into the presentations this afternoon. The first one is a correction for something I said on the record last meeting that turned out to be incorrect.

I indicated there were six responses to the medical Request for Information (RFI). It turns out there were seven received. In addition to the ones mentioned at the last meeting, I inadvertently omitted Providence Health System. Lauren will provide more details about those responses later. All RFIs for the fully insured medical are posted on the Health Care Authority's contracting and bidding website in their redacted form.

There were ten carrier responses for the vision RFIs. Nine are on the HCA website in their redacted form. The tenth responder is finishing the redaction process. We anticipate it being on the website next week.

Sean Corry asked a question about the variability of employee contributions within the PEBB plans. Megan Atkinson indicated the contribution closely aligns with 15%. As we looked at that, it turns out that 15% is the average. There is some variability within the employee contributions in the PEBB plans. That variability ranges from 4% to 22%. The Uniform Medical Plan has the bulk of the population and is just under 15% because that's where you need to be for the average to hit the 15% mark for the state. As we go forward with additional finance discussions, we'll provide context as to why that variability exists.

Pete asked about dual enrollment and if there was a fiscal impact analysis available from its implementation in the PEBB Program about 16 years ago. That information couldn’t be found.

There were several questions related to the smoking attestation. Alison asked what the percentage of members are that attested to the tobacco surcharge in the PEBB Program and comparing that to state and national smoking averages. Using May 2018, the most current month in the PEBB Program, there were just over 4% of accounts that had a tobacco surcharge. The tobacco surcharge is assigned to the account regardless of how many smokers are on the account. If I'm on an account and I have four family members and only one smokes, there's one surcharge on my subscriber account. If all five family members smoke, there's one surcharge on my account. We are unable to identify how many people. When I say the number of accounts, that's not synonymous with smokers within the plan.

The Department of Health (DOH) reports that the adult smoking rate in Washington in the 2014-2016 period was 14.7%. It’s 10% more than is being reported by state workers in the PEBB Program accounts. Nationally, the CDC reports for 2015 the smoking rate for adults was 15.1%.

Pete asked if we could share information about the health care cost of smokers versus nonsmokers in the Uniform Medical Plan. Unfortunately, we don't have specific PEBB Program numbers, but you said a proxy was okay. We talked with DOH staff and their estimates are that smokers cost approximately $1,000 more per year compared to nonsmokers. When you think about the proposed tobacco surcharge, it's $25 per month which is a maximum annual amount of $300 compared to the $1,000 figure that I just shared from DOH experience.

The final questions related to the Uniform Medical Plan are in Shawna Lang's presentation coming up shortly.

Uniform Medical Plan (UMP) Follow-Up

Shawna Lang, Senior Account Manager, Portfolio Management and Monitoring Section, Employees and Retirees Benefits Division. During our last session, you asked about different utilization metrics on certain limit types. Slide 3 is information on both visits and unique members. The basis of this was how many exceptions overall and how is the exception processed when there is a limit? The number of visits that exceeded the limit are in the far right-hand column. Each of those goes through a group-level exception. It gets escalated to the account managers at Regence and then comes to the Health Care Authority (HCA) to either approve or not approve. This slide also shows the number of exceptions to those different visits last year.

Pete Cutler: Can you give us a generalized perspective, what is looked at, what is the basis for making an exception decision? Is it whoever squeaks the loudest or is there some objective basis that's used.

Shawna Lang: We receive a chart review that our clinical team at HCA reviews. It first goes through clinical review at Regence and then they share their clinical review with our clinical staff in our Chief Medical Officer's Office who reviews for any exceptions.

Pete Cutler: Can I infer that the exceptions are only granted when there is some perspective that it would be worthwhile medically?

Shawna Lang: If you get two hip replacements and you go above the physical therapy limit for that particular year, you would be most likely be granted an exception because of medical necessity.

We also put the maximum number of visits on Slide 3 for your reference. Chiropractic was ten, massage was 16, acupuncture was 16, and NT/PT/OT/ST therapies (neurodevelopmental therapy, physical therapy, occupational therapy, and speech therapy) were 60.

You also asked if there was history of how these limits were set. We could not find any historical documentation. There are different reasons for setting limits, one being administrative burden. It helps reduce administrative burden to providers. Cost containment is another reason for those particular services.

Dave Iseminger: Slide 3 is also intended to address one of Sean Corry's questions from our last meeting related to the neurodevelopmental therapy limits. I want to make sure we highlight again for the record that ABA (Applied Behaviorial Analysis) therapy is a separate benefit structure within the Uniform Medical Plan. It's not subject to this therapy limit. We wanted to show you by utilization that we actually haven't had instances where exceptions were necessary related to the NT/PT/OT/ST joint cap.

Shawna Lang: In calendar year 2017, no one person had more than five neurodevelopmental therapy services.

Dave Iseminger: Remembering that ABA is a separate benefit with a separate count.

Sean Corry: I'm stunned by that. In my experience, having been a Board Member of the Boyer Children's Clinic for ten years, I'm very close to them in Seattle, which provides neurodevelopmental therapies to children. I know that children, at least at that clinic, have had many more visits and services than what's implied by what you just said. It seems unusual to me. I'm having trouble comprehending.

Shawna Lang: I'm happy to come back with a list of codes so you can see which codes are actually captured in this statistic.

Sean Corry: That would be helpful.

Dave Iseminger: Shawna, can you describe some of the utilization for ABA that you're aware of to the extent you remember those numbers? Describe what you can about the ABA benefit for the Board.

Shawna Lang: Currently, there is no ABA limit on any of those services. We had our own system of trying to credential those types of providers until the Department of Health took over that credentialing process. We have both an in-facility and out-of-facility type. A day program and out-patient, ABA-type program currently available to all members. I believe we have somewhere around 300-400 different cases of varying intensities and many service levels and many treatment levels. A case review is done to determine how many visits are necessary, if they're going to school with them or not. There are different levels of support for ABA therapy.

Wayne Leonard: Shawna, could you tell me if you need a primary care physician's referral or if you just need approval to go over the maximum?

Shawna Lang: For each of these there is a prescription needed for massage. But I believe that's the only one. For chiropractic, acupuncture, and the other therapies, you may go on your own.

Pete Cutler: Can you tell us what ABA equals?

Shawna Lang: Applied Behavioral Analysis Therapy.

Pete Cutler: And is that primarily for patients with autism, or is it broader?

Shawna Lang: Yes, on the autism spectrum.

Patty Estes: I'm trying to understand all the numbers. The exceeded max, the exceptions, those are the ones that were made. And the ones exceeding the maximum limit, were those the ones that were applied for? What does that mean?

Shawna Lang: No, all the ones that were applied for were granted during 2017. One is the members and one is the visits. One is unique to the members and then to the very right-hand column is the number of visits that were approved.

Dave Iseminger: If I'm reading from left to right, I would say chiropractic, three people got a total of ten visits that exceeded the maximum.

Shawna Lang: Correct. Slide 4 is the process for extending group limits. Customer Service escalates to Regence and then Regence escalates to HCA.

A question was asked about what services were covered at 100%. Slide 6 is a list of general preventive services covered at 100%, such as annual physical exam, routine vision exams, vision hardware for children under 18, routine hearing exams, well baby, colonoscopies, to name a few. I would put these under annual types of screenings and preventative screenings.

Slide 7 is preventive services for women covered at 100%. Some covered services are STD screenings for HPV, Chlamydia, counseling for HIV, counseling for domestic violence and sexually transmitted infections, and different types of birth controls. You can pay for 12 months of birth control at one time.

Dave Iseminger: For the Board's context, especially in the birth control areas, there are state laws passed, including in this last session that I briefed the Board on, that framed a lot of the coverage policies outlined in the Uniform Medical Plan.

Patty Estes: Can we go back to Slide 6 and can you tell me what certain screening tests performed during pregnancies are?

Shawna Lang: Some of the ultrasounds, so two ultrasounds. Some genetic tests can be covered at 100%. Those are the ones that come to mind. I can get a complete list for you, too.

Slide 8 lists other services covered at 100%. These are more programs like diabetes control program, diabetes prevention program, intensive behavioral counseling, screening for Hepatitis B, respite care, hospice, sterilization, etc. This is a general overview of different types of things offered to our members.

Dave Iseminger: For those who aren't as familiar with diabetes control and diabetes prevention, control is when someone is already diabetic and helping them manage it and prevention is someone in a pre-diabetic phase and helping to possibly prevent the onset of diabetes.

Shawna Lang: Slide 9 shows immunizations covered at 100% and which recommended intervals. There was some question about immunizations and preventative coverage. We always want to cover all USPSTF (U.S. Preventive Services Task Force), A and B recommendations as well.

Dave Iseminger: The USPSTF is a task force that looks at and makes clinical and evidence-based decisions. For example, they make decisions on what immunizations and other services to cover. Under the Affordable Care Act, there are certain recommendations by USPSTF that must be covered by group plans. There's a federal requirement for covering different recommendations, depending on the level of the recommendation that the task force creates.

Shawna Lang: Slide 11 - April 2018 UMP Enrollment. You asked about the overall population for each of the different types of Uniform Medical Plans in Washington State. The total UMP population is 255,799. In Washington State, that drops to about 200,000. The Consumer Directed Health Plan (CDHP), in particular has about 19,000 and UMP Plus about 26,000. Those subscribers residing completely outside of Washington is about 9,600. The maps on Slides 12-14 show the population by county giving you a regional view of the PEBB Program portfolio for UMP. Slide 12 is the UMP Classic showing the 200,000 members within Washington State. Slide 13 shows the 19,000 UMP CDHP population within Washington. Slide 14 is the 26,000 UMP Plus population in Washington counties. The counties on the maps are highlighted to show which plans are offered in which counties. Also included on the map are the Puget Sound High Value Network and UW Medicine Program. Slide 15 is the 9,600 UMP population nationwide.

Pete Cutler: Do I remember correctly from a prior presentation that retirees who live outside of the United States, like Mexico, for example, can also be covered for routine, as opposed to urgent emergency care?

Shawna Lang: Absolutely. We have worldwide coverage.

Pete Cutler: Do you have any idea how many reside outside of the United States?

Dave Iseminger: I usually don't say numbers that I don't know but this one I know is under 100. It's a very small number and roughly 35 to 37 countries, primarily in Europe, Canada, and Mexico.

Slides 18-30 in the appendix of Shawna's presentation is a list of Uniform Medical Plan Classic Exclusions. We gave you the information at the last meeting to be able to go to the certificate of coverages, but this is an area of interest to the Board so we are providing the list.

Uniform Medical Plan Plus

Michael Arnis, Account Manager, UMP Plus, ERB Division and **Barb Lantz**, Clinical Consultant Policy Development, Implementation, and Oversight Manager, CQCT Division**:** Barb and I plan to cover three quick topics for the Uniform Medical Plan Plus. Where did UMP Plus come from? What is it? How does it work?

First, where did UMP Plus come from? Accountable care networks are offered in plans in Washington State. The Boeing Company offered this first within their self-funded

population. There are also plans in the private sector markets using accountable care networks.

Slide 5 – Value-Based Purchasing: Accountable care is part of our value-base purchasing initiative at the Health Care Authority, which was directed by the Legislature. The point of including an accountable care network is to aim for high value and low cost in the health plan. It's the network of providers that are accountable for their performance. When working with those network providers, we focus on quality of care and financial performance. In the Uniform Medical Plan Plus, we have two large networks, the Puget Sound High Value Network and the UW Medicine Accountable Care Network. Since we are large and cover many counties, both of these networks are a compilation of about six or seven major health systems.

What is UMP Plus? Slide 7. UMP Plus is offered in nine counties. In 2016, the green counties on the map are where we started. They extend from Snohomish County down to Thurston County. In 2017 we expanded to nine counties, adding the four counties in blue starting on the coast in Grays Harbor County. Both networks serve Grays Harbor County. Yakima and Spokane counties are covered only by the Puget Sound High Value Network. Skagit County is where UW Medicine alone covers. In 2016, we started out with both networks serving five counties. We then expanded, they found partners in other counties. That's when we had the networks sometimes just serving one of the counties.

Slide 8 shows a steady increase in enrollment. The bottom Total line shows we've gone from roughly 10,000 members, to 15,000 members, to 25,000 subscribers. Those are significant increases in enrollment for a new plan. UW Medicine is consistently about two-thirds of the enrollment with the Puget Sound High Value Network the other third.

Slide 9 - UMP Plus vs. UMP Classic. The questions we receive the most are always about benefits. Many subscribers are familiar with UMP Classic, or even UMP CDHP. Especially at the Benefit Fairs, we always stress that the same services are offered in all three of the UMP Plans, including UMP Plus.

Slide 10 - Cost Sharing. This is where things start to differ. For UMP Plus, there is zero out-of-pocket for a primary care office visit. The same goes for a naturopathic physician visit. The similarities are in the emergency room visits. For most other services, UMP Plus has the typical 15% coinsurance for cost share.

Slide 11 – Lower Deductible in UMP Plus. There is a difference in the deductible. The deductible in UMP Plus is lower. For an individual, it's $125 compared to the $250 for Classic. The out-of-pocket limit for UMP Plus is the same as Classic.

Slide 12 – UMP Plus vs. UMP Premiums. You see some differences in the premiums. Usually when you look at a self-funded or any private sector fully insured plan, what happens is that to get a lower premium, you need to purchase a plan with a higher deductible. What's unusual about UMP Plus is that it has both the lower deductible and the lower premium. The last column on this slide shows some annual savings we've

calculated. But for a subscriber and children, it's $79 for UMP Plus monthly. For Classic, it's $179 a month. Just on premiums alone, that family would net $1,200 in savings for the year.

Dave Iseminger: Before we leave Slide 12, I want to ensure the appropriate context on this. These aren't numbers that anyone should latch on to as the specific premiums for the SEBB Program and the monthly employee premiums for Plus, although they've been significantly lower than Classic in recent years. We hope that trend continues, but we can't perfectly predict the future either. I want to make sure we manage expectations. This is illustrative within the PEBB Program population, tier ratios, and enrollment. It's an historical fact and not an indicator of what the SEBB Program will or won't look like in 2020.

Pete Cutler: I was going to say, the lawyer in me appreciates the disclaimer.

Dave Iseminger: I just want to make sure it's clear for everyone.

Michael Arnis: These are year-to-year premiums. Thank you, Dave.

Slide 13 – Provider Network. This is where you see the biggest difference. Subscribers in UMP Classic know it's offered in all 39 counties. There are tens of thousands of providers in the UMP Classic network. The same worldwide coverage of emergency services is offered through UMP Plus as well. That's important because people know their doctors and hospitals come from those nine counties. They need to know that should they be traveling that it's the same emergency services available in Classic that are available to them under UMP Plus. UMP Plus has a smaller number of providers because we're offering only the providers within the particular UMP Plus networks, the Puget Sound High Value Network and the UW Medicine Accountable Care Network. This slide shows they have about the same number of primary care providers, thousands of specialists in the two networks, 16 and 17 hospitals, respectively, in those nine counties, and then well over 1,000 clinics and sites.

Barbara Lantz: Michael painted a picture of the structure of the UMP Plus Program and I'm going to talk about the quality aspects of the Program. There are four key quality ingredients to the UMP Plus Program. First, the ACP or Accountable Care Program partner clinics are required to: be PCMH or Patient Centered Medical Homes, certified or recognized; deliver case management services to very high-risk or complex members, members with multiple chronic conditions; report on clinical and patient experience performance measures annually; and implement eight different quality improvement projects around various topical issues.

Why does UMP Plus work? We believe the best way to improve health care is by focusing on improving the quality of health care. As providers focus on improving quality of care, you gain efficiency and effectiveness. Our contracted networks share a common interest in improving health and reducing the incidents of chronic conditions through effective prevention and screening. If successful, the intent is that they will prevent health care problems by ensuring that all members receive appropriate

preventive care based on their age and needs, such as routine cancer screenings; they provide the highest quality evidence-based care for chronic conditions; and insure that our members received optimal care at both the beginning and the end of life.

The policy emphasis for UMP Plus is to improve both primary care and specialty care. To perform well, there must be agreement on what constitutes ideal care. We look to both national standards as well as local standards to help define what that care looks like. We predominantly use two sets of standards: first, National Committee for Quality Assurance Standards and second, Bree collaborative standards, which are part of the Washington Health Foundation. Each year, clinical groups promulgate new clinical standards based on various clinical topical issues, intended for use by Washington State providers to deliver evidence-based care in our state.

The National Committee for Quality Assurance Standards provides us with standards around Patient Centered Medical Home and our expectations from clinics that have become Patient Centered Medical Home certified. They also supply us with clinical and member experience measures which are collected and reported by the networks annually. The Bree collaborative, as I mentioned earlier, provides us with sets of requirements around various topical clinical issues focused on the delivery of primary specialty care. These networks are required to implement eight different clinical improvement projects aimed at meeting the Bree specifications. Accountable Care Programs have very ambitious goals and work to do.

Slide 17 – Patient Centered Medical Home. Patient Centered Medical Home now is one example of the four I talked about earlier. Any clinic that is a partner with either the University of Washington Network or the Puget Sound High Value Network who has seven or more primary care full-time equivalents within a clinic setting, are required to seek recognition or certification as a Patient Centered Medical Home. This is a rigorous process by which the clinics are evaluated against a set of standards. Some of the standards are: offer flexible access and scheduling, provide health care advice electronically, deliver team-based care, and use clinical practice guidelines. They are re-evaluated every three years to ensure they continue to meet those standards.

Dave Iseminger: A potential question from a member or school employee is, "You have these standards to have preventive screenings. How does that relate whenever I walk into my doctor and want to get my broken leg taken care of? Does it mean they're focusing on cancer screenings rather than treating me for what I've actually come in for?" I know that sounds kind of silly, but I was reminded of the sensitivity and educational reform arena of teaching to the test. I want to be very clear that when we talk about value-based purchasing strategies, it's not to the detriment of other services within a medical plan. It's while your leg is being taken care of, the provider is expected to look and ask, "Did you know that you're eligible for, and you should be by all standards, receiving your colonoscopy?" Encouraging people to get up to date on various metrics that include preventing long-term chronic conditions. This whole idea about promoting quality and avoiding chronic conditions isn't to the detriment of the conditions or diagnoses that individuals are being treated for. It's supplementing,

encouraging, and requiring the plans to make steps forward to decrease future chronic care and work on preventive services.

Uniform Medical Plan (UMP) Pharmacy Benefits

Ryan Pistoresi, Assistant Chief Pharmacy Officer. I will be discussing the UMP pharmacy benefit with an emphasis on pharmacy management. Prescription drugs are an integral aspect to member health care. They can present a unique challenge to manage. The national media is talking about rising drug prices and different strategies on how to address that at a national level. Specialty pharmacy, which accounts for about one percent of pharmacy prescriptions, but approximately 50% of pharmacy costs. These are two issues we see when managing the pharmacy benefit.

By the end of my presentation today, I hope you have an understanding of the UMP pharmacy benefit and plan design and how we plan to manage it in the future. I will review basic concepts about pharmacy management.

Slide 2 – Formulary Models. The formulary is perhaps the most important concept for pharmacy management. It's sometimes called the preferred drug list. The formulary is a list of medications covered by the health plan. Slide 2 shows some of the different ways that health plans can manage the formulary.

Open Formulary – List of covered FDA approved drugs. An Open Formulary is often called a tiered formulary with different tiers for different drugs and different member cost shares. The UMP formulary is currently an Open Formulary.

Closed Formulary – A limited formulary. This was popular back in the 1990s and early 2000s. The Closed Formulary was a very limited formulary that excluded certain drugs from coverage in order to drive members to low cost drugs. Nowadays you may see these formularies blocking drugs to maximize rebates in order to reduce the cost to the health plan or the pharmacy benefit manager.

Hybrid Formulary – A Hybrid Formulary is a mix between the Open Formulary and Closed Formulary. So certain drug classes may be treated as open whereas other drug classes may be treated as closed.

Value-Based Formulary – This formulary is gaining traction in the industry today. It emphasizes the clinical effectiveness of the drug over the cost. Non-preferred drugs are only covered when they are medically necessary and clinically appropriate after completing a review of the individual member circumstances. If the individual member cannot use some of the preferred drugs and needs a non-preferred drug, there is a process for the member to get access those drugs.

Slide 3 – Other Pharmacy Terms. This slide has a list of terms used in this presentation with their definition.

Slide 4 – Overview of UMP Pharmacy Benefit. The UMP pharmacy benefit is managed under the Northwest Drug Consortium, which is administered by Moda Health. In 2005,

the state Legislature was dealing with the issue of rising drug costs and other pharmacy management issues. The Legislature created the Washington Prescription Drug Program to administer state purchasing of prescription drugs (RCW 70.14.060). It requires that state purchased health care programs must purchase through this prescription drug consortium. However, if a program is able to demonstrate that they are able to achieve greater discounts and cost savings through other mechanisms, they are free to do so.

In 2006, the prescription drug program joined with the Oregon Prescription Drug Program to create the Northwest Drug Consortium. Washington and Oregon pooled our populations to reduce the amount of drug purchasing costs. By combining our two state populations, we were able to achieve greater discounts than on our own. In 2007, the consortium selected Moda Health to administer the program. Moda bid on the UMP business, was rewarded the contract in 2008, and has had it since.

Slide 5 – NW Drug Consortium Growth, shows its growth over the years. As different programs joined the Consortium, either from Washington or Oregon, the size of the population and the purchasing power has continued to increase. From Washington State, Department of Labor and Industries and Department of Corrections joined. From Oregon State, Oregon Public Employees Benefits Board (OPEBB); Oregon Educators Benefits Board (OEBB), Salem Health, Oregon Health and Science University (OHSU), and other different managed care organizations in Oregon have joined. It continues to grow.

Dave Iseminger: On Slide 4, I want to be clear that when you see things in state law that say, "State purchased health care is subject to …," you can insert that the SEBB Program is part of state purchased health care going forward. SEBB benefits would be subject to the same provisions described here. By creating a uniform medical plan or a self-insured plan that mirrors the Uniform Medical Plan, this Board would implicitly be starting the process to joining the Consortium and adding its purchasing power and being able to leverage the purchasing Ryan has described.

Ryan Pistoresi: Slide 5 shows there is a little over one million members covered in the Consortium between Washington and Oregon. If a large number of school employees join the Consortium, it will provide another steep bump and achieve greater rate savings for both the SEBB Program population and the PEBB Program population.

Slide 6 – Overview of UMP Pharmacy Benefit. Moda Health administers the Consortium but they don't do it alone. MedImpact Healthcare Systems, Inc., Ardon Health, and Postal Prescription Services are some of the partners that help administer the pharmacy benefit for UMP. The collective services are under the umbrella name of Washington State Prescription Services. Moda Health does the administration and the customer service. They also handle member support, billing and reconciliation, reporting and analytics, and clinical services.

MedImpact manages the pharmacy networks. They contract with the different pharmacies and set the different reimbursement rates for the prescriptions. They also handle the claims processing, rebate administration, and provide after-hours support.

Ardon Health is our network specialty pharmacy. UMP members have access to the specialty drugs through Ardon. They provide clinical support. They are very high-touch for these very expensive, very delicate drugs for the members. They ensure the members are taking the medications appropriately - right patient, right dose, right time. If the member is experiencing any side effects or other issues, Ardon can provide clinical support.

Postal Prescription Services is our network mail-order pharmacy for UMP members.

The Health Care Authority is not listed, but we do actively administer the Consortium for the UMP Program. We oversee the contract and make sure that we are meeting our contract guarantees. We work directly with Moda Health to administer our pharmacy benefit.

Slide 7 – Overview of UMP Pharmacy Benefit. This is the structure of the UMP formulary. As I mentioned earlier, UMP has an Open Formulary. There are five different tiers. The Preventive Tier is drugs required under the Affordable Care Act or as recommended by the USPSTF. These drugs are covered at a zero dollar cost share for members. We cover these services as preventive.

The Value Tier is specific to high-value medications that treat certain chronic conditions. This Tier is a select mix of drugs at the lowest cost share.

Tier 1 drugs are primarily the low cost generic drugs. Tier 2 drugs are some of the brand name drugs and certain high-cost generics. Tier 3 drugs are the non-preferred drugs, which are mostly limited to brand name drugs.

Pete Cutler: On Slide 6, you discuss the administration of the Consortium by the Washington State Prescription Services. Do I understand correctly that while Moda has the overall responsibility for providing the prescription drug benefit to UMP members and the Health Care Authority contracts with Moda, that the Health Care Authority also separately contracts for, in this case, the Washington State Prescription Services?

Ryan Pistoresi: The way it's set up is that we contract directly with Moda. These are subcontractors of Moda that provide these services. We don't directly contract with them.

Pete Cutler: Thank you for that clarification.

Terri House: On Slide 7, on the value tier, what is an example of a chronic condition?

Ryan Pistoresi: Some of the drugs in the Value Tier are for high blood pressure, hyper-cholesterol or high cholesterol. We have certain medications for depression. The

Selective Serotin Reuptake Inhibitors are part of the Value Tier. We also have some insulins for diabetes in the Value Tier, as well as other oral therapies for diabetes.

Dave Iseminger: Ryan is describing the current UMP formulary. We have been presenting to the PEB Board changes to the formulary. We're presenting to you what the current status is, which is this Open Formulary process. As Ryan goes through the subsequent slides and talks more about that value-based option that is picking up steam within the market, that is the path we have been presenting to the PEB Board about inserting Value Formulary principles within the UMP benefit. We are going to be presenting to you what it is currently, how we're moving it forward, and asking you when you move into the resolution process to hopefully create the process on the SEBB side that we're also presenting to the PEB Board, to change it's current Open Formulary to have value-based principles.

We've had multiple PEB Board Meetings recently talking about the Value Formulary and you may have heard different parts of that. I want you to understand how this is synching up because we are presenting to them to change from their Open Formulary to include high-value-based principles within it. To you we're presenting the Open Formulary, the value-based principles, and hoping you create and establish that as the pharmacy benefit at the same time for 2020.

Ryan Pistoresi: In just a few slides, we'll be moving into more detail about that Value Formulary.

Slide 8 – UMP Plans Pharmacy Comparisons. There are different costs in the current structure of the UMP pharmacy benefit for the UMP Classic, UMP Plus, and the UMP CDHP. The middle row for the prescription drugs lists what those cost shares are, as well as what the cost share maximums are, for the different drugs. SP in that middle row stands for "specialties." Traditional drugs have a 50% maximum. Because specialty drugs often cost $1,000 a month, and sometimes $10,000 a month or more, we have a cap. We are not expecting the members to pay the maximum out-of-pocket at that pharmacy visit.

Pete Cutler: Specifically, under the UMP Plus column where you mentioned, for example, the SP max, is that $150 the maximum per 90-day filling or is it for an annual max?

Ryan Pistoresi: Those maximum amounts are for a 30-day supply or one-month. If you have a prescription for a specialty drug and it's a Tier 3 specialty drug, it would be $150. For a Tier 2 drug, you could spend $75. If you had a three-month prescription, it would be $225.

Pete Cutler: So your actual cost over the year could, if it's a $10,000 drug -- if it's a maximum $150, you're not going to hit your out-of-pocket maximum just with that, it doesn't sound like. That's the ultimate cushion you have if you have a lot of drugs that are in that class. Thank you.

Dave Iseminger: Ryan, could you explain how you get from $150 to $225.

Ryan Pistoresi: On Slide 8, in the middle column for the UMP Plus, the Value Tier is 5% with a maximum of $10. That is for each 30-day supply. If you're taking a medication in the Value Tier and filling the prescription one month at a time, it would be $10 for each visit to the pharmacy, $120 in a plan year. You could also get a three-month supply at a time for $30. With a three-month supply, you're making less visits to the pharmacy, going only four times in a year, with the same $120 maximum. For the specialty drugs, if it's a Tier 3 specialty drug, it would be $150 for a 30-day supply or a one-month supply. For the Tier 2, it would be $75 maximum. The $225 is if you got a three-month supply each time.

Patty Estes: On Tier 3?

Ryan Pistoresi: On Tier 2.

Dave Iseminger: The $225 was the additive annual amount for a Tier 2 drug. It had sounded like it was for the Tier 3 drug. Thanks for that clarity.

Ryan Pistoresi: Slide 10 – Principles of a Value Formulary. This formulary is being presented to the PEB Board as a way to manage the pharmacy benefit for UMP in 2019 and beyond. This slide lists some of the principles and core values used to build the value formulary for the pharmacy benefit. We're focusing on the drug classes that have the potential for cost savings without reducing quality of care for our members. We're looking at drug classes where we can direct members to utilize the highest value drugs without impacting quality of care, as well as hoping to make a difference in premiums.

As part of the Value Formulary, there will be some cost savings, which will result in reduced premiums. We are looking at transitioning members who have used drugs for a long time, or who are in a refill protected drug class, into some of these preferred drugs. If the drugs are not clinically appropriate and other preferred therapies are not effective for member, we will look at a way to manage them on those existing drugs. The industry is starting to move in this direction. A few of our consortium partners have already started using a Value Formulary. Oregon PEBB started January 1 of this year; OEBB, the Oregon Educators Benefits Board, is starting their Value Formulary in October of this year; and we are looking to start this for UMP in PEBB on January 1, 2019.

Dave Iseminger: Moving to a Value Formulary is still subject to PEB Board vote. This is our recommendation for both Boards as we move forward. The Boards do not have to pass the same things. The SEB Board would be able to manage things differently. However, we do believe the recommendation to both Boards should be the same.

Ryan Pistoresi: Slide 11 – Implementing a Value Formulary, includes different ideas we are exploring as part of the Value Formulary for the UMP PEBB Program. Some of the drug classes that could be part of this formulary are medications such as diabetes, cholesterol, beta-blockers, and androgens. These are just some of the drug classes

we've been reviewing and identifying that have a potential to be on the Value Formulary. The drug classes not subject to this would be structured with the preferred and non-preferred status similar to the UMP formulary for that plan year.

Dave Iseminger: Ryan, to be clear, that means it would be subject to the typical five-tier structure described on the prior slides.

Ryan Pistoresi: Yes. We are also looking at the transition periods to allow members to continue their medications while implementing the Value Formulary. We would direct new users to the preferred medications. Or, if they had been stable on some of the non-preferred medications and meet certain criteria, then they could be transitioned on those drugs.

Dave Iseminger: You see the word "inequity" on this slide. That inequity is one of the reasons for pushing for the Value Formulary. In the current UMP structure, there are individuals on Tier 3 non-preferred drugs who can show through an exception process that it's the most clinically effective drug. They are then eligible to pay the Tier 2 cost. The system that has developed in UMP has resulted in this inequity where Ryan and I might have the same disease state, but because my provider put through the paperwork, I pay half the cost for the same exact drug that we're both taking. I pay $100 but Ryan pays $200 because my provider turned in the paperwork. A way to solve that inequity is through this Value Formulary process. But because it doesn't apply to all drug classes, that inequity would still exist for those drug classes that aren't subject to the Value Formulary.

I wanted to point out how the value formularies came to be. The Value Formulary wouldn't apply to all drug classes so it wouldn't solve that inequity for everyone. There would still need to be member education and continued provider education for those drugs subject to the normal formulary principles for individuals who were on a Tier 3 non-preferred drug to be able to pay a Tier 2 cost share. We wanted to be transparent and make sure you were aware that there is that challenge that exists within the formulary. It's also one of the reasons we're recommending a Value Formulary. It helps with that inequity in the drug classes it's applied to as well as bending some of the cost curve of the pharmacy trend.

Ryan Pistoresi: The lower half of Slide 11 is a Value Formulary that would just be the multi-source brand. All of the multi-source brands have generic versions available. This would be a lower impact but also a potentially lower cost savings version of the Value Formulary. It would be easier to direct members to the preferred products. If there is a medically necessary and clinically appropriate reason, the members would be allowed to continue on those multi-source brand drugs. And to Dave's point, we do have another line about the inequity issue that would be resulting for the single source brands.

Slide 12 – Member Transition Examples. This is an example of what this may look like for school employees. There are different examples listed.

Patty Estes: With that second scenario, we all know that most of our school districts in the state are not currently contracted with PEBB. How are we planning to manage that influx of all of these recommendations and forms from all these doctors?

Ryan Pistoresi: We are looking at that with the transition period. We are looking at having a few months where we stagger some of the different drug classes in order to accommodate that. We realize that the members coming into this benefit may be using different preferred drugs from their plans and may not have used the same ones as us. We don't want to have that disruption all on January 1 causing delays in patient care. We recognize the challenge.

Proposed Self-Insured Medical Plan Resolutions

Dave Iseminger: At our April meeting I described chapter two of the Board's work in creating self-insured plans. Shawna described the nuts and bolts of the general benefit structure and asked you to identify specific areas that you wanted us to provide more information. We provided some of that information earlier today and then Ryan presented on the pharmacy benefit. That leads us to the recommended resolutions before you now for your consideration in establishing various self-insured plans. As a reminder, in the big picture of all the medical offerings, although we're focusing only on self-insured offerings in this presentation, there are still financing issues to be determined by the state. The language in these resolutions indicates they are subject to final financing decisions. We need to know if you are interested in having these plans. Financing decisions can be the follow-up piece that happens over the next several months as we march towards the benefit launch of 2020.

Later today we'll be taking about the fully insured potential medical plan portfolio and discuss the fully insured benefits that could possibly be on the table for school employee benefits in the launch.

Self-insured. We are specifically calling it self-insured because we need to work through the branding piece of making sure it's very clear what the benefits are. Sometimes our presentations imply that the name will be the Uniform Medical Plan Classic. We're really talking about a self-insured plan that mirrors UMP Classic but the name has yet to be determined. That is the administrative function of the agency. We are asking you to take action on what the structure of that benefit would be, which is within your authority.

There are five resolutions to review today. They would create four different plans. The fifth resolution is about the Value Formulary and pharmacy benefit within all the plans that you could potentially create.

Proposed Resolution SEBB 2018-20 – Self-Insured Plan Offering. This resolution is to have a plan essentially identical to the Uniform Medical Plan Classic, which is roughly an 88% actuarial value (AV), has the exact cost shares that have been described to you, the same coinsurance levels (typically 15%), and the deductible level that was described in Shawna's materials from the April. It's the same coverage services,

exclusions, provider network, clinical policy, etc. It's essentially a copy of the Uniform Medical Plan Classic.

Proposed Resolution SEBB 2018-21 – Second Self-Insured Plan Offering. This plan is similar to SEBB 2018-20. It has some different cost shares structures than the Uniform Medical Plan Classic. Everything would be the same as it currently exists within the information on Slide 4. It would be a slightly higher deductible plan compared to the current Uniform Medical Plan Classic. A higher annual deductible and 20% coinsurance instead of the 15% coinsurance. This would create a Uniform Medical Plan Classic type plan with an actuarial value of approximately 80%.

Basically, Proposed Resolution SEBB 2018-20 is a copy of UMP Classic at roughly an 88% actuarial value plan and Proposed Resolution SEBB 2018-21 at roughly an 82% actuarial value version of that plan. This would allow some stratification and allow employees to buy up to a higher AV plan or stay in a PEBB UMP-like plan that they may already enjoy if they're one of the school districts already contracting with the Health Care Authority for benefits, but also allow another option, depending on individual school employee circumstances. As we saw looking through the comparators over the last few months, we're acknowledging and seeing that there's a wide range of AV plans and making the recommendation to the Board to essentially establish two plans that are very similar but have different AVs in these different cost share structures. That is the difference between these two proposed resolutions.

Katy Henry: I have a question around the line in both of those proposed resolutions around subject to financing decisions. Because of the cost share, are these part of the Collective Bargaining that would be taking place? Would we want to put in something around that language?

Dave Iseminger: The authority for the Board is to set, for example, the deductible and out-of-pocket maximum. I don't think that's exactly what your question was but I wanted to be clear that the Board's authority is with regards to the exact benefit level and the cost share structure. When we're talking about the final financing decisions, it's somewhat in tune with what the state's contribution will be as determined by Collective Bargaining. It's also the reserves necessary to set up a self-insured plan. The state still needs to identify the best mechanism for, and the extent of, reserves and how to build those reserves to ensure they meet OIC's requirements for cash reserves for a self-insured plan. Not all financing pieces have to do with Collective Bargaining.

If you remember, for a self-insured plan at the end of the day, the state is picking up all the liability for the claims if the premiums or the contributions from all the various sources don't add up and cover those claims costs. So this is really making sure and caveating that if the state doesn't want to take on that claims liability, these resolutions would not need to come back to the Board since it was approved subject to final financing.

Sean Corry: Dave, earlier today, you reminded us that we're not fixed yet on benefit coverages and we have some leeway here. Am I remembering that correctly?

Dave Iseminger: Yes.

Sean Corry: These resolutions talk about having the same coverage services and exclusions, the same networks, the same everything, the cost shares, deductibles will be the same. How would the passage of these resolutions not preclude us from making choices that differ from this when we begin looking at benefits?

Dave Iseminger: Sean, our recommendation is for the launch to have it the same. However, we could easily add to Resolution 2018-21, for example, adding a fifth bullet that says acupuncture visit limitations will be 20 rather than the 16 on UMP Classic on the PEBB side. We could add additional bullets to this piece. If you have differences, now would be the time to highlight them within this plan structure because we're asking you to take action on these proposed resolutions at the next meeting, to essentially create the plan with that benefit structure for the self-insured side.

We'll go through the same journey with you later in the fall on the fully insured side. But for now, we're asking you to take action on what the structure would be for the self-insured piece. You can always come back for plan year 2020-21 and 2021-22 and make refinements within the benefit design as well. Our recommendation at this point is to start with the same piece but change some of the cost shares and create a second plan that has a different AV with different cost share pieces. If you want different granular benefit pieces, this would be the time to bring that up in the context of the self-insured.

Sean Corry: That process is troubling to me. It effectively asks us to come up with our ideas now and put them on a list as opposed to understanding that we have some flexibility during this next year in the decision-making process to look at choices on a particular type of benefit with respect to copays or levels of coverage, number of visits, those kinds of things. This sort of precludes that except for punting it into the next two years from now, essentially.

Dave Iseminger: Sean, part of the challenge is that there is the need to work with plans. For example, with Regence on the self-insured side, we have to work on the implementation for the plan. It may seem strange to ask for this information now, to establish a plan with a 20% cost share, but the realities of it are, decisions need to be made soon in order for this to actually be a benefit that's launched on January 1, 2020. If we assume open enrollment is in fall of 2019, we have to communicate before that decision, adequately prepare members for what the plans would look like. That will be a multi-month process.

We have to assume that the Legislature, given recent history, will get out on June 30. We hope for late April but history shows on odd number of years setting the bi-annual budget, we're not able to set rates early. We wouldn't be able to set rates with the Board for the premium contributions until July. At the same time, the legislative process needs to understand what they would be purchasing with the benefits to be able to balance the budget that they are proposing. We can ask for what we want, but

ultimately as the process goes forward, the Legislature says this is what they will fund. We may have to come back to you with the new information and recommend a solution.

First, you need to let us know what you think the general portfolio should look like and we can present it in the other parts of the process. We will then refine that on the back end for the launch. Once the benefits launch on the year-over-year process, we will be able to work with you to refine different parts of it. It's the chicken and the egg argument that exists with many aspects of launching the program. We need insight from one part of the authorizing environment to move forward and you're the area that we're able to start with now because the Legislature is not in town. We are working on different financing pieces. We need some of this critical information about what the portfolio might look like for that launch.

I recognize that it's very challenging and it seems early in the process, but the reality is, we're less than 15 months away from open enrollment. We have to build something so we can give you, school employees, business officials, the Legislature, and all the different stakeholders within this benefit process what the benefit structure could look like and what components that could be. It's the operational realities of launching the program.

It's hard to say this in an open public meeting but we're giving you all the time that we can with the timelines we have for being able to launch this program. It's the different operational pieces that we have in place with the potential vendors, or in this instance, on self-insured, we already know what the timelines are for implementation for a self-insured plan. If you aren't able to make a decision to launch or create a self-insured plan, that simply means there won't be a self-insured plan for 2020.

We don't have to go forward with a procurement for this piece, which is why we can talk about it with you now. We have April, May, and June to talk about self-insured plan. At the July, August, October, and November meetings, we'll discuss life insurance, AD&D, dental, vision, and fully insured medical. We have to start where we can on the different pieces of the moving parts.

Pete Cutler: Dave, it's my understanding, or am I correct in my understanding, that the primary factor requiring a Board decision on the self-funded plan for the SEBB Program, or multiple self-funded plans, and that the benefit design and those factors be decided presumably by next month, is being driven primarily by the third party administrators, Regence in this case? It's what it would take for them to operationalize the self-funded plan in the school employee context? Are they the ones calling the shots on that?

Dave Iseminger: No, there's a confluence of pieces prompting where we are. One is being able to move forward with implementation pieces with Regence. A bigger piece is being as prepared as the state can be for Collective Bargaining processes. We're anticipating needing to be able to describe to stakeholders what benefits might look like in the portfolio. We need something from the Board that can help explain what a benefit could look like, at least one piece of the medical offering. That's an important reason for needing to have the Board establish a plan while we're in the midst of the fully insured

procurement. This piece can help give context to what the medical benefits might look like, which will help give context to the summer's Collective Bargaining process.

Pete Cutler: Is the PEB Board under the same timeline constraint for making benefit changes to the Uniform Medical Plan? Would they have to make a decision in the next month or so of what the benefit design should be in 2020? Or is the fact that they already have a Uniform Medical Plan that they administer, put them in a different context with that Collective Bargaining issue?

Dave Iseminger: In the PEBB side of the world, the Board from any benefit design changes, both on the UMP and fully insured side, really finalizes that when they set rates, which is in the early July phase. That's for 2019. But that's because they're not launching the benefit for the first time. They don't have the same extra constraints as to where different pieces are.

In the PEBB side of Collective Bargaining, they've had benefits for years. Generally, people know what the benefits might look like because they're similar to the benefits they experience and they see the amount of change that does or doesn't happen between the PEBB benefits year-over-year. The on-ramp here for the launch of the SEBB Program, in that context of the initial benefit, is what's prompting it to be further ahead than what people might anticipate, but it's really right on time for what's necessary.

As we go forward, we're not going to ask you in 2020 and say you can't make this change until 2022. In 2020, we're talking about 2021. In 2021, we're talking about 2022. But for the initial launch, we need more context for all of the various moving parts. In order to get into the financing questions, we need to have a semblance of what some of the plans could look like to be able to build modeling around it. That's another driving need for something to be created by the Board, even if it is subject to final financing determinations in the self-insured reserved aspects. It's multiple things. I would not say that it's primarily Regence's implementation, but that is a piece of it. By late summer, it would become problematic to build the group structure for 2020 in the way it's needed, but not necessarily the only or primary reason.

Pete Cutler: I could see with the Collective Bargaining that there certainly would be a strong desire to be able to explain that this is a package of benefits that' anticipated to be offered to employees in 2020. In the past, you explained that in order to launch a self-funded program or plan for school employees in 2020, it would have to be initially not identical but substantially similar. I guess rubber meets the road. It's come time to decide if there's some adjustments that the Board wants to recommend or have included. Do you have any greater guidance to offer in terms of what kind of changes could be made and still meet the substantially similar standard? I think that is the question in terms of the Board. What is the Board's practical latitude if a Board Member strongly wants to offer a self-funded program that's similar to UMP? How much latitude is there for adjustments on the margin?

Dave Iseminger: It's like saying, "You know it when you see it," as to whether it's substantially similar or not. If the Board were to change every single benefit and change all the treatment limitations, that would probably be too far. Changing a few would probably be fine. If you look at Shawna's presentation, in chiropractic, it was a maximum of ten visits. If you wanted to make it 15 you could. The problem is we haven't recommended any of those different treatments because we don't have a full understanding yet as to what the utilization patterns are. We are saying start with similar. That's where our recommendation is born from. If you have a reason to think that a specific one should be a different number, then propose that. Changes wouldn't be minor from the member's perspective; but from the overall benefit structure perspective, may be relatively minor and wouldn't necessarily change the AV of the plan.

That's not really where this is coming from. At some point, the benefit design would be so different you would need a different call center trained just on SEBB benefits and one trained on PEBB benefits. That's where we start to ask if it falls in the scope of the procurement we have for our Third Party Administrator.

Most of the items on the exclusion list are there because of the Health Technology Clinical Committee (HTCC) decisions, which are mandatory applications in the self-insured plans from the state. There are different reasons for many of the exclusions listed. If there is something you desperately feel should be different within the plan or covered, we can review and let you know if you have any discretion. If you don't, we would tell you why. There are 105 on the list, too many to go into individually. We're asking you to trust the agency in the sense that these have all been born for a variety of different reasons, whether it was a legal case, a statutory provision from the Legislature, from Congress, something from USPSTF that is either required or excluded. There are so many different facets as to what might prompt something to be an exclusion.

If you have pieces you want to change, like the cost share pieces, that is what people relate to most. It gives more variance within the plan offerings. But it doesn't overlay into the open enrollment experience. Do I have to check to see whether this drug is covered under this plan or that plan? Is this service covered under this one but not under this one? We wanted to recommend keeping the services the same across all of the different self-insured plans that you could potentially create and then add that extra layer. Those people familiar with the PEBB plans would have that extra comfort of knowing exactly what is already in those plans because they've also experienced that. We try to take that into account as well.

Pete Cutler: Thank you. That's very helpful. I have to add that I spent about seven years trying to promote administrative simplification in health care. I applaud any and all efforts at that Don Quixote-type of cause. So go for it. Thank you.

Patty Estes: Say we pass these resolutions at our next meeting in two weeks. In July, we discover that some of the things that are in these are not what we need. Can we add those extra bullet points to do that? Is that still within that timeline? What does that timeline look like to change and add?

Dave Iseminger: Depending on how the legislative process works out, we may have to come back to the Board to do refinements. It's hard to say exactly when the last piece is due. We need to be able to communicate the general structure. If there are pieces that you discover later, we'll figure out at that time if it still fits and explain why there isn't the ability to change it for 2020 and put it on the list for 2021, or agree that we have the ability to change it. We'll have to address each one as they arise. I can't say that you're completely done but you need to be 95% done. Then we're down to refinements, not wholesale macro changes.

Patty Estes: Right. Okay.

Lou McDermott: I think Dave's saying, "It depends." [laughter]

Patty Estes: He's saying no.

Lou McDermott: No, he's not saying no. I think he really is saying, "It depends." If Collective Bargaining occurs and certain things are hammered out during Collective Bargaining, we can't just go in and make it different because the agreement has already been set. So it really does depend. It also depends on whether or not there's a legislative component. Is there a law that says you have to do this or you can't do this, or HTCC decisions? If there are requests to change things, we may or may not be able to do it. Timing will be part of it. Collective Bargaining will be part of it. Current rules and regulations at the state and federal level are part of it. Financing is part of it. If you really don't want anyone to pay a deductible, that would be awesome; but there would be a financial consequence to that. So it depends.

Patty Estes: Right. Okay.

Dave Iseminger: The other piece to this is part of what we're hoping to include in the Request for Proposal (RFP) for the fully insured procurement for the fully insured side to make any suggestions for differences in benefits exclusions they would recommend based on their experience. There may be different benefit structures that occur, different covered services, or slightly differences in the coverage services exclusions that appear on the fully insured side compared to the self-insured side. We're going to ask for recommendations as to what might be changed or be different on the fully insured side. We'll be able to bring that to the Board as well. That may prompt you ask if that is a recommendation on the fully insured side, is that something that can be changed in UMP? There are different legal frameworks for the fully and self-insured world. It may prompt additional questions when we see what comes out of the fully insured procurement.

Wayne Leonard: I want to make sure I understand the dilemma. It seems like as the SEB Board, we're in a catch-22. We are supposed to have some kind of discretion, but not until the plans are adopted and up and running. To get them up and running, they have to be essentially PEBB-like.

Dave Iseminger: Not for all benefits. The fully insured medical plans could have a wide range of differences. But for launching a self-insured medical plan for 2020 with under two years notice, yes. Substantially similar, some refinements, but pretty similar.

Wayne Leonard: Okay. I think the concern is, at least from my experience and maybe others as well, that once plans are set, they're very difficult to change.

Dave Iseminger: There are a variety of changes. Maybe Lou might be able to speak to that, especially with his experience with PEBB over the recent years.

Lou McDermott: We're in a fortunate position to be one of Regence's largest customers and they make it happen for us. They figure out how we can make it happen. If we need to make a change, if there's some uniqueness to the population that we want a certain bell or whistle added, they'll do it, but they need time. They need to understand the nature of the change and what system changes need to be made. On our end, we have to communicate changes to our members.

Wayne Leonard: Is that just the self-insured or fully?

Lou McDermott: For the fully insured, we have the ability to talk with our plans and tell them what we want to do, but they come to us with a package. They're trying to make us happy. With Kaiser, we have over 100,000 members with them. When we make suggestions, they normally try and make it work. They also try and shadow some of the things we're doing in the self-insured plan. Sometimes when we make a change in the self-insured plan, we very rapidly see that change roll into the fully insured plan. I would imagine from their perspective they're trying to achieve some parity with the self-insured plan to ensure there's not the have and have-nots. Being a large purchaser, we have a lot of latitude with our partners.

Terri House: I understand from our last meeting, you said it takes approximately three to four years to create a self-insured program. So basically, that's why we're marrying PEBB at this point. Could you bring forth a resolution that we could create our own? We could begin work on that?

Dave Iseminger: If the Board wants to start down the path of a separate self-insured plan, we can talk with the Board about more of the details as to what that would take. If we wanted to completely create a separate self-insured plan, we would have to go through a separate third party administrator (TPA) procurement because to have a plan that's not substantially similar, we would not necessarily be able to leverage our recently executed TPA contract with Regence. We would have to go through what ended up being a two- to three-year procurement process for a TPA. The answer to your question is yes. If the Board wants to pursue a separate self-insured plan for launching at a separate date, we can evaluate that further and bring that to the Board. If that's something the Board wants, we can go through that process and talk with the Board about that.

Terri House: That seems reasonable.

Dave Iseminger: It would not be for 2020.

Lou McDermott: One thing I would ask the Board is what is it about the current self-insured plan you don't like? A self-insured plan is basically a plan that's developed over a number of years where certain things happen, certain complaints happen, clinical changes happen in the world, and political changes happen. The transgender benefit recently became part of our portfolio. I would want to understand from the Board, what is it about the Uniform Medical Plan, the way it's constructed that we would want something substantively different. There are some primary advantages with UMP, and part of it is rates. By creating a brand new plan, we would lose some of our preferential rates that we get with UMP.

Dave Iseminger: Which would increase plan costs and then trickle out in larger premiums, potentially.

Lou McDermott: True. But if there's a substantive reason that the Uniform Medical Plan is not meeting the needs and we need to do something completely different, I would be interested in understanding what that is. The Uniform Medical Plan is a very broad global network with tens of thousands of providers that we get pretty good financing rates on. The limitations are pretty liberal. The deductible is pretty low. And the deductible, those changes, that's not a plan change. That's just a number. The number is $200 instead of $250 or $400 instead of whatever. That's just a number. But if there's just something about the plan that we want to explore, understand, we need to talk about that a little bit because it's a pretty wide open expansive plan. And if you wanted to build something more wide open and more expansive, I honestly don't think you could. It's about as wide open as it can be, which is a good thing and a bad thing.

I think that's one of the reasons why we created UMP Plus because wide open also has a lack of coordination. You could be in Seattle receiving services. You could be in Olympia. You could be in Spokane. You could go down to Oregon. You could go anywhere you want. That feels good as a member. I can do anything I want. But when you're trying to get into coordination of care, it can also be frustrating, especially when you have a spouse or a dependent who is having medical issues. When you become the coordinator of that care, that can be very difficult. We actually constructed a smaller network to try and be more efficient and optimize that. I'd be interested for the Board and I'm not going to put you on the spot right here, to say exactly what it is you want to be different. What is it about a new self-insured plan that you would want that is different from this plan besides the numbers? Fifty visits instead of 60 or 80 instead of 60. Those are things that can be juggled around. But that isn't really changing the nature of the plan.

Sean Corry: I'd like to ask a question about that in a slightly different way because I've heard two different things about the limitations and where those lines are. I've heard a couple of times, maybe more than a couple of times, that we can make changes within limits. I've heard you say a couple of times, at least, that Regence has a fixed template with very minor changes that could occur. But I heard Lou say just a minute ago, if we, meaning the Health Care Authority, ask Regence for a change, they are pretty likely to

accommodate it. So could you help me understand how fixed it is or how fluid it is in terms of changes that we might ask for?

Dave Iseminger: There will be a couple of things, Sean. If this Board says, "I think all treatment limitations for everything should be 40 instead of 15, for anything that's 15," we'd want to understand why? Do you think that utilization is higher? Then there might be a reason to present to the PEB Board, utilization here in both these programs suggest that this change should happen. And then we prompt a change systemically within the plan for both programs. There might be reasons that you prompt something that in the SEBB population suggests there should be a benefit refinement and we agree that it makes sense. When we look at the utilization for PEBB, we'll recommend the same thing to both Boards. Maybe there'll continue to be alignment in that piece.

Like I said earlier with Pete, it's hard to say exactly what substantially similar means. You are able to make refinements at some point. There is a tipping point and I can't tell you exactly when that is. That's frustrating for me and I'm sure it's more frustrating for you. But it's equally frustrating for me to say, "I can't tell you that you can do 1, 2, 3, 4, 5, 6, 7, 8. Oh, 9. That's it. You've hit the tipping point of not substantially similar," when it really depends on the nature of what all of your changes are.

It's certainly easy to change the cost share structures, the 15% coinsurance, the annual deductible, the out-of-pocket maximum. All of that impacts the actuarial value. It's more the specific benefit pieces, whether something's a covered service or not a covered service; how many treatment limitations? That's where we start to get into how many of those things are so different that suddenly the plan is different from the customer service experience and we need to work with Regence saying it's just too different. That doesn't meet the spirit of the contract in the substantially similar.

I know that's not an answer that fully answers your questions because I can't tell you what that line is exactly. I can tell you that it's not the cost shares. Those cost shares can be changed and that's a relatively easy part. The treatment pieces, there's a tipping point at some point and whether something's a covered benefit or an exclusion or a combination of those. I just can't tell definitively where that tipping point is.

Lou McDermott: There's also the network. Let's say this Board decided nobody's allowed to get services outside their county. So whatever county you live in, that's the only place you can receive services. That is your network. They would have to build 39 separate networks. I don't understand why you would do that, but if you decided you wanted to do that, that's probably a no-go. We probably couldn't build 39 separate networks within the UMP system to create in-network and out-of-network costs. So actually, some of the changes, considering the fact that UMP is so wide open, some of the changes that you would think of would actually be restrictive, would be making it smaller. You have to look at where you're starting from, your initial point. Can you envision a world where it's bigger, it has more? Do you want every single provider in the state? Is 90+% of the providers in the state good enough or do you want every single provider? I don't know if they could get that contracting in between now and

2020, so it's really about where you want the self-insured plan, what you want it to cover.

Feel free to ask us as many questions to understand the scope of the network, how many providers, how many specialists, how many of this, how many of that. Of all the providers in the system, how many do we actually cover? How many are in there? How many are on the outside? Understanding the exclusions, we can show the list of what's excluded and where that exclusion comes from, whether it's an historical insurance practice. Some things just aren't covered because they aren't covered by insurance, like plastic surgery. There are other exclusions because of legal reasons. Some things are covered at 100% because of legal reasons. It's really understanding what your thoughts are about what should be different and trying to figure out how we can we make the plan fit. Or is it something that you want so different that we just can't manipulate it within the Uniform Medical Plan?

Pete Cutler: I just want to say I do think it's reasonable for the HCA to basically put the burden on us Board Members to come forward with what we would be missing or could be changed for the better, in this case, we're dealing just with the self-funded plan, so the UMP. Because there is a huge maze of different kind of clinical services that could be provided under different structures and trying to anticipate every possible combination that might be of interest would take a lot of time and probably not very worthwhile. I do think the timeline might be that some Board Members between now and June 13 will, through conversations and in doing some research, come up with ideas. But I certainly agree with the Health Care Authority that it makes sense to first identify what is it you think you'd want that you don't have. But, of course, there may be some of that list where there's a really strong desire to move sooner than later. My guess is we won't be ready for a vote if somebody comes up with ideas in June and it may be July is the soonest there could be a reasonable vote. At least I do like that.

The one area where I do have a question going way back has to do with network and the network adequacy. I do think the Classic UMP Program has a very large network. And it's likely that there's a lot of overlap with Premera, Aetna, and whomever. Of course, Premera, Aetna, United Health, and some of the carriers in Kaiser that are offering coverage to school employees now have put in their intent to bid. It's possible that there won't be a question of whether you can't get your provider. Maybe that the array of options provided is so broad. You have somebody who the only network they're in is Premera? Well, we do have a Premera option. But I do know from working in the Insurance Commissioner's Office, and previously here at the Health Care Authority, that while people can understand the idea that the clinical services are covered, they can be tweaked, they shrug their shoulders and say, "That's life." But if they can't work with the provider they want and that they've worked with for some length of time, that rises to a whole new level of concern. That would be an area of provider adequacy and overlap where I hope at some point we can get more details of how many people may end up not having access to their current provider.

Patty Estes: Piggybacking on that for me is seeing that this is a little scary because it's locking us into something, but also trying to remember that we also have the fully

insured options. As a Board, I think we need to make sure that we are considering all of the options to be able to cover all of our members. If somebody has something so specific, making sure we have that as an option. It doesn't necessarily have to be a self-insured option, it could be a fully insured option, but making sure they have an option in general.

Speaking from somebody who's on PEBB, there hasn't been anything in my district that somebody hasn't been able to do. There hasn't been something so catastrophic that they haven't been able to see their provider or anything of that nature yet. We've been on it for this entire school year and part of last year. That's a good amount of time. The only grumbles that I've heard is premiums went up. But, again, it was the whole pooling thing that changed that we kind of don't really have options of changing. I think to Terri's point, making sure that when we're looking at the self-insured, just knowing what our options are. It's not that we want something different, necessarily, but maybe seeing what other options are out there for self-insured. I don't know if that's what you're meaning. That's what I took out of it, as to see, maybe that's something we can look at for the future. I think we all are getting the point it's not feasible for launch in 2020. Am I understanding all of that correctly?

Lou McDermott: That is correct.

Dave Iseminger: Proposed Resolution SEBB 2018-23 – Fourth Self-Insured Plan Offering. This Resolution would create a Uniform Medical Plan Plus-like plan in the SEBB option with up to the same two provider networks, UW Accountable Care Network and Puget Sound High Value Network.

Proposed Resolution SEBB 2018-24 – Self-Insured Value-Based Formulary. This Resolution may be tough to follow. If you were to pass Proposed Resolutions SEBB 2018-20 through SEBB 2018-23, they already have the embedded pharmacy benefit included within it, which is an Open Formulary. All you would need to do to then execute the Value-based Formulary would be pass a Resolution like Proposed Resolution SEBB 2018-24, which says there are some drug classes that will be subject to the Value Formulary. That's how Proposed Resolution 2018-24 interacts with the others.

Patty Estes: I have a question. Speaking of those people that are going to be in transition from whatever into the SEBB Program with the drug coverages, can we get an outline of what that process looks like to be approved for those value-based drugs? What paperwork, how long does it take, any of those timelines? I'm not asking necessarily for the next Board Meeting because I know that's kind of hard, but in general for us to know so we can start explaining that to our members. This is something I have been asked over and over again.
Dave Iseminger: Let me make sure I'm capturing that. What would the administrative process be like for the transition period? That certainly is an area that would be an FAQ and a piece that we need to communicate.

We will be bringing back these five resolutions with any modifications or suggestions you make between now and our preparation for the next meeting. We will ask you to take action on any of these, or a subset of these, that you want. You could certainly pass some but not all of them and create some, not all four self-insured. We wanted to give you the maximum opportunity to create multiple self-insured plans. You could certainly do a subset of the four.

Fully Insured Medical Plan(s)

Lauren Johnston, SEBB Procurement and Account Manager, Employees and Retirees Benefits Division. Slide 2 – RFI Summary. On March 15, 2018, the Board adopted a resolution to procure for a fully insured medical plan. Subsequently, our Request for Information (RFI) was released on April 2, 2018 with responses due back on April 27, 2018. We wanted to get an idea of available plan designs and costs. We also wanted to make the market aware of the intent to procure benefits. We hadn't procured for a fully insured medical plan in over 20 years. We wanted to see if there were any changes we might want to make within this procurement. We also wanted to learn about current and proposed geographic coverage areas and the service area where fully insured plans are currently offered in Washington, as well as some Idaho and Oregon counties.

Slide 4 – Respondents. We received seven responses to our RFI: Aetna, Kaiser Permanente Northwest, Kaiser Permanente Washington (HMO), Kaiser Permanente Washington – Options (PPO), Premera Blue Cross, Providence, and United Healthcare.

Dave Iseminger: The way that the RFI was structured, if you wanted to participate in the upcoming RFP, you had to respond to the RFI. Slide 4 represents the maximum carrier world for participating in the subsequent RFP.

Lauren Johnston: Slide 5 – RFI Highlights. All respondents are accredited by one or both of the National Community for Quality Assurance - NCQA or the Utilization Review Accreditation Commission, which is URAC. One of the questions we asked in the procurement, was whether or not they preferred to bid as an HMO or PPO. Two plans wanted to be an HMO and five bid as a PPO, a preferred provider network. The actuarial value (AV) range was between the mid-70s to low-90s. The AV median was in the low-80s.

We also asked whether or not they could add providers to their network. They all said yes and they do a thorough review each year of the providers within their network. If a member or a client, such as an employer group came to them and recommended another provider be added to their network, they would go through the application process and make sure they were a credentialed provider. As they go along through the application process, they could ultimately end up in a contract with that provider. Slide 6 is the potential 2020 county coverage for the carriers that responded for Washington, Oregon, and Idaho. There are seven total carriers, but not seven total carriers in every county. The most we would have in a county is six carriers.

Dave Iseminger: Under the RFI, it was their potential service area. The carriers were not locked in as part of the RFI process to commit to be in the counties. This represents a high watermark for their potential coverage areas.

Pete Cutler: Are there maps like this, or at least the text, that shows what counties a carrier would propose or expect to operate in, or offer coverage in, included in the RFI responses? Is that posted on the web?

Lauren Johnston: For the RFI, we provided an Excel spreadsheet with all the counties listed and asked them to mark the ones they could potentially provide service. Slide 7 is a better overview of the counties that the different will be in. You can see which ones won't be in what counties. Aetna, Premera, Providence, and United Healthcare, which all said they were interested in bidding a PPO, are in all 39 counties.

Slide 8 – RFP Summary. The estimated release for the RFP is early June. We are requiring compliance with the Office of the Insurance Commissioner's (OIC) regulations for transitions of care for members between their existing carrier and the receiving carrier. This would include things like honoring prior authorizations already completed under the prior carrier and making sure the treatment plan continues under the new carrier until the new carrier can process a new pre-authorization for that member. We also wanted to make sure there's alignment with the Triple Aim (Better Health, Better Care, at Lower Costs). We are hoping to do this by having a provider network that is cost-efficient and delivers high-quality services to your members. We wanted to make sure the carriers engaged their membership through a number of different communication channels and resources. This could be through text messaging, instant messaging, telephone, email, etc.

Slide 9 – RFP Summary (cont.). We also wanted to make sure the plans offer a number of different online self-service tools, like a provider search tool, cost transparency tools, and the ability to communicate with their providers. We're also including performance guarantees within the contracts. This is around implementation, customer service, answering time for phone calls, abandoned call rates, reporting deliveries - so how they deliver reports to us that are requested, making sure they're timely and accurate. We also have performance guarantees around account management, making sure they're responsive to members in HCA, as well as having performance guarantees around quality metrics, so certain measures such as the common measures set for Washington State. The last thing to highlight is compliance with Engrossed Substitute House Bill 2408.

Pete Cutler: Will the RFP require the carriers to comply with the administrative simplification standards adopted through the Insurance Commissioners Office?

Lauren Johnston: I believe because they're fully insured plans, they have to follow the OIC's regulations.

Pete Cutler: That makes sense. But it's also something that a purchaser can also add that as a contract provision, just to make clear that it is something they care about.

Dave Iseminger: Pete, we'll find it. As we are reviewing some of the highlights in the document we're preparing for procurement, let us know if there are other things you would like to see included. We can look at rolling things up in the next week as we finalize different parts of the document or be able to make some shifts in the document. We are open to your suggestions.

Lauren Johnston: Slide 10 continues with the RFP Summary. Bidders will be asked to propose plans with specified actuarial value (AV) limits. These AV limits will be provided to them by HCA within the RFP document. The RFP will also provide the UMP Classic list of covered services and exclusions. We are asking the bidders to highlight any variations within their proposed plans that they want to make to those covered services or exclusions. Bidders will also be asked to propose, by plan, deductibles, co-pays, coinsurance, and out-of-pocket maximums.

Dave Iseminger: I do want to make sure the Board is aware that we go through the RFP process, we're anticipating a release of sometime next week and a return of responses back at the beginning of August. As we move forward, we're not actually asking and finalizing rates on those plans until the beginning of 2019. With fully insured plans, the further you are from the launch of the benefit, the more risk there is on that side of the equation. Since they bear the risk, that impact plan cost, and then ultimately the premium cost to members. We're going to build the structure of the benefit with them, working on implementing the benefit, and then come back to the Board and work with the carriers on plan rates in phase two. You shouldn't expect finalized plan costs on these fully insured plans this calendar year.

Lauren Johnston: Slide 11 – Follow Up to KPNW's Dental Presentation. On March 15, 2018, Kaiser Permanente Northwest presented on their integrated dental benefit to the Board. HCA staff had conversations with KP Northwest to better understand their benefit. We learned that the dental plan itself is actually a separate line of business, in other words, a standalone benefit. It has separate rates, separate explanations of coverage. The plan selection, when you go to select your plan during open enrollment, is even separate. Although the care is coordinated in KP Northwest systems and through their electronic health records, the medical and dental plans are actually separate benefits. The Board voted to leverage the PEBB dental plans for January 1, 2020. In order to do this, you would need to vote to procure for fully insured dental plans in order to potentially add a KP Northwest dental benefit to the portfolio.

Dave Iseminger: You'll remember back in March with the procurement resolution, Kaiser Northwest brought forward this concern and we committed to the Board that we would look at what it meant. At the time, we were trying to figure out what it meant to have "an integrated benefit." We weren't sure whether that was an embedded product offering or whether it ended up being separate benefits. It's more about coordinating that care within the system. Now we've understood it is really separate business lines and separate benefit products, there isn't a way to go forward with that without doing a whole dental procurement for 2020. And if you'll remember back in March, the eight procurement resolutions, this was the only one that actually set up a timeframe for

starting the ball rolling on the commitment to come back and work with the Board on evaluating a fully insured dental benefit procurement.

It would be difficult to do an entire dental procurement in addition to the disability procurement and the fully insured medical procurement. That's where this starts to become a challenge. We did evaluate whether there was a way to embed it within the fully insured medical program, but when it got to the point that it was a separate business line and a separate product, it became a challenge.

Pete Cutler: For the RFP, has the program decided about whether they're going to indicate that it's possible they could accept bids from all of the carriers who qualify, meet all the qualifications? Or have they said they're going to try to have some lesser number as a target? I know in the past carriers often wanted to know how many people are going to be included in this pie that you have of covered lives that we could compete for. How many other people are going to be taking slices from the pie?

Dave Iseminger: We're going to suggest, and I'd be curious your thoughts on this, a cap on the number of plans that an individual carrier could respond to. If you look back at Slide 6 in Lauren's presentation, if you're in King County and there's six carriers, an unlimited amount of plans that somebody could bid, and all of those are in, that's fractionating the population way too much. That also wouldn't be sustainable. I believe we're considering a cap of three or four plans in response to the RFP from each carrier.

Somewhere around four with one of them being a CDHP and the other three, whatever you want, but refining the world because at some point, staff have to score these. To have an unlimited number of plans would be challenging if every carrier were in every county with dozens of plans. That also wouldn't work. I'm glad you asked that, Pete, because I did want to make sure that we described to the Board that you could expect to see some sort of plan limitation, number of plans that a carrier could respond to, to help winnow it down a bit.

Pete Cutler: There's a follow-up and Lauren did catch it. I was actually thinking number of carriers because it didn't even occur to me that the carrier might be able to propose multiple plans for a given location. By inference, it is possible. Take any one of the carriers and they may have four plans that are distinctly different in terms of actuarial values. They may propose, in King County, offering all four of these to the SEBB members. You could have up to six carriers wanting to offer plans in any given location. You could potentially have an awful lot of plans. The impression I get is that there's nothing in the RFP that promises there is a limit on how many they can offer as plans. That's four, but there's nothing saying we promise there will be no more tan "x" number of carriers or "x" plans offered to employees. I take it there's nothing like that in the proposed RFP?

Lauren Johnston: We are looking into those issues now. Take Asotin County, for instance. If all four carriers were to offer plans in that county, what would that do to the market in that county?

Pete Cutler: One person in each plan?

Dave Iseminger: There are a couple of different pieces we're looking at like is there some sort of sliding scale? If there's "x" number of carriers, it's so many plans. If it's "y" number of carriers, it's so many plans. We need to balance those interests, taking into account different markets within different regions of the state to make sure that there is choice, but not so much choice that the market becomes so fractured it's not viable. You could expect something in that realm.

Katy Henry: Will the carriers be required to offer similar benefits in the request for plans?

Lauren Johnston: They are starting from the UMP Classic. Technically, each of them could make any kind of variations to that plan they wanted to and they could all be different. I think there is a basic set of services that most carriers offer.

Dave Iseminger: We are asking them to compare to the UMP Classic so there is one comparator point across all documents. We are not implying that they have to be UMP Classic covered services. We want them to describe, as a reference point, what the differences are in covered benefits or exclusions. That expedites the review process.

Policy Resolutions

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

Policy Resolution SEBB 2018-15 – Dual Enrollment in SEBB Benefits is Prohibited

Stakeholder feedback: One stakeholder did not support the policy because school employees are used to dual enrollment in order to lower their out-of-pocket costs in their current environment. It was suggested the Board at least allow dual enrollment for children. The stakeholder also suggested that the Board might consider a separate policy for medical coverage compared to dental and vision products. While we understand that position, this policy is expected to decrease the cost within the overall pool since that's the experience we saw in the PEBB pool. This resolution is unchanged.

Lou McDermott: Policy Resolution SEBB 2018-15 – Dual Enrollment in SEBB Benefits is Prohibited:

Resolved that, School Employees Benefits Board (SEBB) medical, dental, and vision coverage is limited to a single enrollment per individual.

Pete Cutler moved and Wayne Leonard seconded a motion to adopt.

Comments:

Katy Henry: I agree with comments made by the stakeholder. I didn't realize the impact that some of the school employees would feel until I went back and asked a few

questions. It definitely would be a significant change for school employees, many who have spouses who are also school employees. They are very used to that dual enrollment, especially when it comes to dental and vision and/or for children. That's one of my hesitations that I wonder if this might not be a place where SEBB could be different than PEBB. While you saw that lower cost for PEBB, do we have all the information we need? Is there more information we could get from school districts around how it looks before we move forward with a vote?

Barb Scott: I don't know if there's anything in the data that showed how often this is the instance in the current environment for school employees. I do know that when we implemented it for PEBB, it was a significant shift for state employees because they were used to being able to double cover. My husband and I were state employees at the time and we double covered our children. At that point in time, there wasn't really a large out-of-pocket cost for a monthly premium for a state employee. When you think about the employee cost share for the monthly premium, at that point in PEBB's history, it was next to nothing for some plans. Since dental was fully paid for then, there was no cost to enjoy that double coverage. As the costs went up across the pool in order to be able to continue to offer employee coverage, the Legislature needed to look for places to cut costs. They had to make some hard decisions about either increasing the cost to employees as far the premium share that they paid each month or pulling other levers within the system like prohibiting dual enrollment. Originally, the possible cost saving was around $4.5 million. The overall number was a bit different. Rather than increase premiums, the Legislature cut dual enrollment. It wasn't a PEB Board decision.

Dave Iseminger: I would add that Barb was describing cost to the state. You can also think of it as cost to the plan, the overall system. Megan Atkinson, our CFO, has talked about this at other meetings. Although it's hard to imagine, a billion dollars is a finite number. It only goes so far when you're dividing by 100,000+. Remember, if the cost for dual coverage is allowed, it is spreading the eligibility and putting the pressure somewhere else in the benefit system. You do have choices to make regarding these pieces, but there is that relationship between a proposal that would come forward and allow dual enrollment for dental and vision and the benefits package. That relationship between benefits generosity and eligibility generosity that Megan has talked about before may have consequences. You do not have to be exactly like the PEBB Program. I just want to ensure you are thinking about that cost. The cost to the state is cost to the program, which does relate to cost to members as well because of that generosity and eligibility benefits relationship.

Sean Corry: If we were to make a change that would increase cost, it would increase cost but we don't know by how much. If I remember the context of the question an hour and a half ago about whether any data's available about this, the answer was no. It's in some dustbin someplace? But lots of school districts do this now and data would be available from school districts about their own experience, the take up rate, the effect on the premium. It might even be available through the carrier that handles dental coverage for the vast majority of employees in the state. We might be able to get information there to see what the trade-offs are before saying no just because we know

that it would come at some cost. There may be sources of information that would inform our decision that would be helpful in taking that step.

Barb Scott: The other piece of information I would share is that when the Legislature required the PEB Board to implement this, they assumed a funding rate in the budget bill. The funding rate assumed that the Board would put this in place. Then the Board had to decide to either increase costs in one place or no longer offer dual enrollment because there was that finite set of funding made available for them to work with.

During the Board's consideration, it helped when we walked them through the increases in out-of-pocket costs, as far as just a monthly premium. At some point, it's no longer going to be cost-effective for a family to double cover the family when you start hitting premiums that are $50 a month premium for the employee portion of it or $100 a month for the employee portion of it. You end up paying more monthly than what you're actually saving in double covering and getting rid of those co-pays. Not knowing what SEBB employee premiums will look like at this point, I can't do that type of work for you to know what the premium for this product would be. For most families, it will not be cost-effective for them to continue double coverage for each other.

If there is data available on what's happening in the current environment, I would ask that you think about how that will look in the future environment based on where things will end as you go forward. That's one of the things I know the PEB Board struggled with in putting this in place trying to preserve something where the premiums are going to be reflective of that. It ends up not being a viable for employees.

Sean Corry: I entirely agree that there would be a rate impact. The examples you gave didn't ring true for me though because we're talking about a relatively small percentage of employees married to employees who are looking for double coverage opportunities. It would definitely have a rate impact on the dental plans, for example. But the question is, is the effect so great that we would reject it? Or is it not so great that we maybe would consider allowing this to continue for the school district employees across the state? Without knowing what the numbers are, we're making our decision based on a statement that it's just going to be more money.

Lou McDermott: To me, when I look at this issue, it sounds like are we saying it's okay with this policy choice for certain situated individuals to be advantaged. The fact that one person is working in the school district and their spouse is working in the school district, too, and because they both work in the school district, they're going to have a financial advantage over a person who works in the school district and the other person who works for the county. And yes, there are dollars involved and we can have Milliman go and crank a calculation and come back and say everyone in the system is going to have to pay an extra five dollars a month, or two dollars a month, or whatever it is. That's fine, we can charge people more and then that sub-population will be advantaged and that's how this system is built.

I know there's subtleties to this discussion. But when I look at it that's what I'm seeing. Do we want to advantage that group on the backs of everyone else? Or don't we? I have my opinion about it and you all have your opinions, but that's how I see this issue.

Barb Scott: When I talked about not knowing how that would play out with school employees, when we did this for PEBB, we had data. Unfortunately, I don't have that in front of me. We ran through a number of different scenarios. We looked at what are the numbers in the state where we see that there's double coverage. There were thousands. We looked at if you eliminate that, what could the possible savings be? We ran through scenarios that showed if the family looked like this and this was the type of services they received, then what might that look like for the family? That's what I was speaking to. It wasn't that I was trying to guess at what the numbers might be within your current population.

Dave Iseminger: Even if we got data from the school districts that described what was happening, remember that's in the context of the fractured pool setting where the pooling happens at the local level. There is that ability for people to simply pay to add their dependents if they have the ability to pay for that. When you're consolidating into a single pool at the state level, that dynamic changes. While that may provide some insight, it might not be an apples-to-apples comparison to the future world. The data wouldn't necessarily be completely analogous to the world that's being created post-2020.

Pete Cutler: I agree that the data won't be perfect. However, actuarial firms like Milliman earn their living by coming up with educated guesses knowing what they know about the claim state of school employees, state employees, and other cohorts. I have to admit, as a Board member, this is so different than being on the PEB Board many years ago where every proposal about establishing a benefit or eligibility standard included that financial analysis, and a pro and con on the policy implications. It frankly feels awkward to be asked to vote on something where, as Sean said, maybe it's 50 cents per member per month impact. For that cost, maybe Board Members would accept that premium cost impact.

As Lou said, spreading cost around everybody in the pool so that a certain subset who happen to be dual employed within school employment get a benefit. Maybe if it's $5 a month, and I think that was more in the range when we dealt with it in PEBB, there was a sense of maybe we'd rather lower the premium by five bucks a month. I'm here not knowing which side it's on.

In terms of policy and equity, I do think that what the state's trying to do is provide a family with a certain level of health care coverage that provides a significant amount of financial support for health care expenses that is not way beyond what other employees in the state of Washington get. It's a sense of we want to have good robust benefits. But certainly having worked for a budget committee for the last three years before I retired, I know that most members of budget committees do not want to pay for platinum level. You're going to be able to have the best health benefits of all workers and tax payers in the state. It's like trying to figure out for the amount of dollars we have to work

with, do you want to prioritize like this, providing an extra benefit for people where they both work as school employees? Or do you want to try and keep your costs down so you can keep your premiums down?

The only thing that has me wavering in terms of the support for the policy resolution is that we have a very different situation here where you have a transition of 100,000 or more people from a wide variety of benefit structures that they're used to going on to a new set, not through their own choice. This might be one way to, at least initially, reduce one source of friction by allowing for dual enrollment, since apparently quite a few school districts permit that. Then later when there's a better sense of the fiscal impact, make a decision about whether it's really worth keeping dual enrollment, which is essentially what happened with the PEBB Program at one point. I'm at 51%/49% . I'm wavering myself in terms of where I will land on this.

Katy Henry: I don't have the depth of knowledge that Lou or Dave or even Sean and Pete have in health care and so it is intimidating to sit here and ask these questions. But I think that I'm representing the members that you're going out to reach. This is a big deal. I don't feel comfortable voting on this without having a little more information and being able to ask the question. I disagree with what Lou said about it advantages only certain people. I don't know that that's the intent. I do think, though, asking for more information is reasonable. It is a big deal to a large number of people. It's something they've been used to so I think it's appropriate to ask for more information so I feel comfortable voting on this and feel like I'm informed. That's why I asked.

Lou McDermott: Dave, do you want to defer this and see what Milliman can do, if they could crank some numbers?

Dave Iseminger: We could certainly put it on the June 13 meeting agenda and see if there's something we can come up with and defer this one. It sounds like the consensus of the Board is if two more weeks gets us more information, you'd like more information. Let's see what we can find in the next two weeks.

Lou McDermott: And just for the record, any policy choice we make, on any benefit, in any cost share does have groups that are advantaged and disadvantaged. It's just the nature of the benefit. If you have a very generous pharmacy benefit and you collected all your cost share on the medical side, then people who don't have much stuff going on in medical, but they have a lot of pharmacy, they're advantaged. We have those choices to make all through the benefit. On any given day, the benefit does have advantages and disadvantages and this is only one of them.

Pete Cutler withdrew his motion and Wayne Leonard withdrew his second on the motion of adopting Resolution SEBB 2018-15.

Lou McDermott: The motions are withdrawn. HCA staff will work with Milliman to provide more information to the Board at the June 13, 2018 SEB Board Meeting. Board Meeting. Next policy resolution, Miss Barb.

Policy Resolution SEBB 2018-16 – Definition of "Tobacco Products"
Stakeholder feedback: We received feedback from one stakeholder and they supported the policy. There were no changes made to the definition of tobacco products since the version was introduced at the last Board Meeting.

Lou McDermott: Policy Resolution SEBB 2018-16 – Definition of "Tobacco Products:

Resolved that, "tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any compound, part, or accessory of tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or the United States Food and Drug Administration (FDA) approved quit aids.

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-16 passes.

Policy Resolution SEBB 2018-17 – Definition of "Tobacco Use"
Stakeholder feedback: We had one stakeholder who commented in support of the policy. There were no changes made to the definition since the version that was introduced at the last Board Meeting.

Lou McDermott: **Policy Resolution SEBB 2018-17 – Definition of "Tobacco Use"**

Resolved that, "tobacco use" means any use of tobacco products within the last two months. Tobacco use, however, does not include religious or ceremonial use of tobacco.

- "Religious use of tobacco" means the use of tobacco products as part of a formal tradition, rite, or ritual.
- "Ceremonial use of tobacco" means the use of tobacco products for ceremonial purposes in connection with the practice of a traditional ceremony or ritual.

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-17 passes.

Policy Resolution 2018-18 – Tobacco Surcharge Attestation Default
Stakeholder feedback: We did receive stakeholder feedback on this policy proposal from multiple stakeholders. One stakeholder suggested clarifying language, which was added to the resolution. Another stakeholder recommends that these attestations be incorporated into online enrollment processes so employees would be blocked from moving forward in enrollment unless they attest. I chatted with our IT staff about that. Although it would be ideal, we don't yet know what systems will be used as far as front-end systems and what technology will be available on the front end for enrollment processes. We don't know if that something that will be available.

I'm going to come back to you with two specific changes to the resolution. Since we don't know about the functionality, we are asking the Board to establish a default position as far as the attestations are concerned. One change to the policy is adding $25, the amount of the monthly premium that the Board questioned at the last meeting, so that dollar value has been added. We also added words at the very end of the attestation, the words within the HCA's enrollment timeframe so it's clear as to the time period that we're referring to for them to make an attestation before a default would go into place.

Lou McDermott: **Policy Resolution SEBB 2018-18 - Tobacco Surcharge Attestation Default**

Resolved that, a subscriber's account will incur a $25 monthly premium surcharge if he or she fails to attest that any member, age 13 years or older, enrolled in medical on his or her account does or does not engage in tobacco use within the HCA's enrollment timeframe.

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

Pete Cutler: We have the current process where somebody can go without making an attestation, they start having a surcharge charged, they notice it, and they come to you and say they've never smoked and I'm willing to attest it now. Is it currently the process that the surcharge would stop, at least prospectively?

Barb Scott: For the tobacco surcharge, that is the case. Our plan will be to include in the Cafeteria Plan document a provision. Taking it back to Cafeteria Plan elections, those are irrevocable elections. They can be made each plan year prior to the beginning of the plan year, or they can be made during the plan year if there is a special open enrollment. Our plan would be to include in the Cafeteria Plan document the same way that we have for the PEBB Program, a provision to change the irrevocable election based on a cost change to the premiums. That would allow for the tobacco surcharge to change prospective based on a mid-year attestation. In this particular case, a cost change provision based on surcharge is in there for tobacco. If somebody comes to us and says they quit using tobacco two months ago, it's a prospective change under the Cafeteria Plan. Does that answer the question?

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-18 passes.

Policy Resolution SEBB 2018-19 – Spousal Surcharge Attestation Default
Stakeholder feedback: We received multiple stakeholder comments regarding this policy. One stakeholder suggested clarifying language, which was added to the resolution. Another stakeholder would prefer that all employees be able to add dependents equally. The policy decision for requiring a surcharge was legislatively mandated. What's within the Board's authority is setting the amount of the surcharge. In this Resolution it's $50, which is the minimum. It would be within the Board's authority to set an amount higher than $50, but we assumed the amount that was in the budget bill that was required, which was $50. It's within the Board's authority to decide that. The stakeholder also recommends, again, that these attestations be incorporated into the online enrollment processes so employees would be blocked from moving forward with enrollment unless they positively attested. We do not know whether that functionality will be available for SEBB. Our recommendation is for the Board to move forward and take action on putting in place a default position for the attestation. As far as changes made since the policy was introduced, we added the words "to the applicability of the spousal surcharge" toward the end of the Resolution for clarity.

Lou McDermott: **Policy Resolution SEBB 2018-19 - Spousal Surcharge Attestation Default**

Resolved that, when a subscriber has a spouse or state-registered domestic partner enrolled in medical on his or her account, the subscriber will incur a $50 monthly premium surcharge if he or she fails to attest to the applicability of the spousal surcharge within the HCA's enrollment timeframe.

Katy Henry moved and Pete Cutler seconded a motion to adopt.

Pete Cutler: Once again, this is actually an issue that is near and dear to my heart. I think this is actually a very watered down provision. Frankly, I think if somebody, especially because of statutory language, provides for this surcharge only if the benefits are equal to or within some close percentage to what the UMP benefits are, and the premiums are not greater. I know from my prior work that there are an awful lot of employers whose perspective is if your spouse is employed fulltime with an employer and has access to employer coverage, then that is where they should probably be getting their coverage from rather than as a dependent. Therefore, we won't provide any coverage to dependents in those circumstances. I think this is at least a good policy, as far as it goes, and someday if I stay on the Board long enough for us to revisit this policy, and if the political environment permits, maybe I'll suggest raising the $50. But for today, I'm happy to go just with what we have.

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-19 passes.

Dave, I have a random question. I know it's probably not the best place to ask it, but the spousal surcharge as it relates to the very first issue with double coverage, does that have any intersection at all?

Barb Scott: There's a prohibition on dual enrollment so you're not seeing it there.

Lou McDermott: Just trying to think that one through and see what we're doing. Because obviously it does meet the 95% actuarial value. Would we have to charge those accounts then the $50 if they are double covering?

Barb Scott: I think I can answer the question. In the current implementation of the surcharges for PEBB, the agency has implemented those so that the surcharge really only applies if the spouse could be covered under their employer's plan and they are not. So if SEBB were to allow for dual enrollment, then the surcharge wouldn't apply because they are covered under their other employer's plan.

Lou McDermott: Okay, interesting.

Barb Scott: The next steps will be to incorporate the policy resolutions passed today into program rules. Staff have already started drafting those rules.

Eligibility and Enrollment Policy Development

Barb Scott: Slide two is a list of six policy resolutions I am introducing today for discussion. It includes reintroducing a policy establishing the effective date of coverage and introducing five new policy proposals. As we get into some of these policy resolutions that are more difficult, staff have included a number of examples show how the policy would be applied. We're hopeful that those scenarios are helpful as you consider the policy proposals.

Sean Corry: Barb, will you help us understand what it means to be more difficult. I'm not sure what that meant.

Barb Scott: If I came across as judging policy proposals, I think that policy development is a difficult thing in general. As far as the policy resolutions you'll see coming before you, they will have to do with when coverage begins for school employees, for example. For the team and for me, it was very difficult to walk through because there are so many different existing hiring scenarios and we wanted to ensure we didn't miss something. As we started, we decided that we were really falling back to storytelling and scenarios so staff have incorporated some of that storytelling into these slides in order to help you. I was thinking that you would have some of the very same problems we had, and Dave

was as well. As a matter of fact, Dave added an additional example. For the team it was difficult, Sean. That's what I'm referring to.

Sean Corry: Thank you for that. And just for framing, as we go into these more difficult issues, with respect to final adoption of these new proposed rules, how much time will we have to talk with our constituents and bring back our ideas? We're not going to be voting on this in two weeks, are we?

Barb Scott: My plan was to have very little for you, hopefully, at the June 13 meeting. Or maybe you have to only vote on effective date of coverage, which is the first policy in this packet. I'm hoping to, within the time we have today, get this whole packet out to stakeholders for feedback, and then have you take action on most of these in the July meeting. There will be some time.

We've included an excerpt from RCW 41.05.740, which reflects language as it was amended by Engrossed Substitute Senate Bill.

Policy Proposal Resolution SEBB 2018-12 – Effective Date of Coverage for School Employees Eligible for the Employer Contribution. This is effective date of coverage for school employees eligible for the employer contribution. It's being re-introduced with this new title. We've been working with stakeholders to make certain that we're addressing the many circumstances they've described for us. The new title includes added clarity that the resolution will establish when coverage begins for employees who are eligible for the employer contribution.

This version recognizes that September is a special month; and as such, is treated differently from the rest of the school year. Of note, while considering this policy, it will align coverage to the actual school year, so when we look back to RCW Title 28A and the definition of school year, it's September 1 through August 31. We understand that districts have been starting coverage prospectively and ending coverage September 30. It's my understanding that current practice is centered around a need for prepayment of premiums and the way paychecks are issued. We've worked with both Washington Association of School Business Officials (WASBO) and others in understanding how paychecks are issued. We also have worked with our IT division at HCA.

In the SEBB world, SEBB coverage will not have to be prepaid. Instead, we'll make sure we're able to run an invoicing cycle. Coverage will be paid for in the month that coverage is received, which is different from the current environment.

We got positive feedback from stakeholders because in starting coverage with the beginning of the school year, it should result in new employees being able to get coverage at the beginning of the school year, where in the current environment, it's my understanding, they do not get coverage until the next month or a month after that in many cases. You may want to refer to this as I walk through the examples.

Slide 5 is an example of a new employee who's anticipated to work 630 hours or more during the school year and his first working day will be the first day of school. For his

district it's September 9, 2020. Paragraph number one of the proposed policy would apply in this case because the employee's first day of work is on, or after, September 1; but not later than the first day of school, September 9, as established by the SEBB Organization for the current school year. In this case, coverage will start on the employee's first day of work, September 9.

I want to note that coverage is for a full month of coverage so payment is collected for a full month of coverage. We walked through this with stakeholders trying to figure out how this can work in the school environment and what's the best policy to put forward. We do realize that an employee who receives coverage beginning September 9, the full premium for the month of September is collected. For a new employee, there's eight days of paid coverage that isn't available to the employee, where for an employee who is moving from one agency to another, there's no gap, which has functioned well. September truly is a different month and is treated very differently under this policy.

This is the same for PEBB coverage, but it's not as big of a gap. PEBB coverage begins the first working day of the month. Usually, for PEBB, the maximum is a five-day span. For SEBB, as we worked through all the different numbers, it could be as much as an 11-day span, as far as when school starts.

Slide 6, example two, is a new employee who's anticipated to work 630 hours. Her first working day is September 15, 2020, although for her district the first day of school is September 9. In this case, paragraph number two of the policy would apply because the employee's first day of work is after the first day of school. SEBB coverage would begin October 1, 2020, the first of the following month.

The Board has already established through adopting an election period of 31 days from the date that they're eligible for benefits, they need to turn in paperwork. This employee is eligible for the employer contribution beginning September 15. She would have 31 days from September 15 to get her enrollment elections paperwork submitted. The deadline would be October 16 with coverage then beginning October 1.

Dave Iseminger: When Barb said "paperwork," we're hoping there's not as much paper in this system. When she says "paper," she means election in whatever form that is.

Barb Scott: Slide 7 is example number three, an employee who's anticipated to work greater than 630 hours during the school year. Her first working day will be August 27 so she can get her classroom ready for the new school year and the district's first day of school is September 9. Paragraph number two of the policy would apply in this case because the employee's first day of work is not on or after September 1 for this current school year.

Pete Cutler: The impression I'm getting is that no school district has a school year that begins in August. Is that the case in Washington State?

Barb Scott: School year, as defined in RCW Title 28A, is September 1 through August 31. Schools can start either earlier or later than September 1. One of the school

districts the staff looked at does start school toward the end of August. Employees could have coverage starting September 1 because their district starts the end of August.

Pete Cutler: Even though they were in front of kids in August, their health benefit coverage would begin September 1. So that is how it works. Thank you.

Barb Scott: Slide 8 – **Proposed Policy Resolution SEBB 2018-25 – When the Employer Contribution for SEBB Benefits Ends**. This policy resolution is another one that required much thought. SEBB eligibility only requires that an employee is anticipated to work 630 hours in the school year, September 1 through August 31. This resolution addresses under what circumstances eligibility for the employer contribution towards SEBB benefits would end early. We are recommending the policy include allowing eligibility for the employer contribution to end the last day of the month, in which an employer-initiated termination notice is effective and the employee's resignation is effective, or if the employee's work pattern is revised, such as no longer anticipated to work 630 hours in the school year.
In talking with stakeholders and looking at booklets, this appears to be mostly what's occurring today, with the exception that districts don't end benefits early when they receive a resignation from someone who's worked the required hours during the school year.

Slide 9, example number 1, the school employee was anticipated to work 630 hours or more during the school year and has been receiving SEBB benefits. On November 13, 2020, this school employee received an employer-initiated termination notice effective immediately. In this case, bullet number one of the policy would apply because the employer has initiated a termination notice. Benefits would end November 30, 2020.

Slide 10 - example number two. This school employee was anticipated to, and did, work more than 630 hours during the school year and was been receiving SEBB benefits. On April 13, 2021, the school employee turns in a resignation letter effective immediately so he can work for another employer. In this case, bullet number two of the policy would apply because the school employee has resigned effective immediately. Eligibility for benefits would end April 30, 2021.

Slide 11, example number three. A school employee was anticipated to work 630 hours or more during the school year and has been receiving SEBB benefits. On October 13, this school employee's work pattern was revised such that the school employee is no longer anticipated to work 630 hours during the school year. In this case, bullet number three of the policy would apply because the school employee's work pattern was revised and they are no longer anticipated to work 630 hours during the school year. In this case, eligibility for the employer contribution toward benefits would end October 31, 2020.

Sean Corry: I have a question about example number three. If an employee is anticipated to work 630 hours, gets benefits, continues to work, and has worked 630 hours but then goes to a lower number for the rest of that year, the coverage is made

available to that employee for the rest of the year because the 630 hours have already been met.

Barb Scott: On example number three, the employee was anticipated to work 630 hours or more, but on October 13, they had a revision to the work pattern and is no longer anticipated to work 630 hours. Although they had started working and that was what was anticipated, the work pattern was changed such that they no longer were expected to make that 630 hours.

Sean Corry: And that employee had not yet worked 630 hours.

Barb Scott: Correct.

Barb Scott: Slide 12, example number four. A school employee was anticipated to work 630 hours or more during the school year and has been receiving SEBB benefits. On October 13, 2020, he is notified that he is no longer anticipated to work 630 hours during the school year because one of the students he's supporting is leaving the district over winter break, resulting in a drastic cut in hours, effective January 2021. When does the employer contribution for SEBB benefits end? In this case, bullet number three of the policy would apply. Because the school employee is no longer anticipated to work 630 hours during the school year based on knowledge that the work pattern is going to be changing, it would be October 31, 2020.

Dave Iseminger: Barb, I think with regards to Sean's other question, once somebody has worked 630 hours, it would be challenging for an employer to say they were not anticipated to work 630 hours in that same year because they will already have worked 630 hours.

Barb Scott: That is correct. As we walk through the proposed policies, you'll see that we have a policy resolution to address when an employee wasn't anticipated but actually does work.

Slide 13, example number five. A school employee was anticipated to work 630 hours or more during the school year and has been receiving SEBB benefits. On June 13, 2020, in order to help her district plan for the next school year, she turns in a resignation letter indicating she will not be returning to the district the next school year. The effective date of the resignation letter is August 15, 2020. In this case, bullet number two of the policy applies because the school employee has resigned. The effective date of the resignation is what drives the date eligibility for when the employer contribution would end. In this case, that would be August 31, 2020.

Barb Scott: Slide 14 – **Proposed Policy Resolution SEBB 2018-26 – SEBB Eligibility for the Employer Contribution Based on a Revision to the School Employee's Anticipated Work Pattern**. This policy would address when eligibility is established for an employee who's anticipated work pattern is changed during the school year. Staff looked in the benefit booklets and found very little on this particular subject that would describe how that's handled today. In conversations with WASBO,

it's our understanding that this does occur today so we're asking the Board to establish a policy to address the eligibility.

Slide 15, example number one, is a school employee who's not anticipated to work 630 hours in the school year. The district doesn't offer SEBB benefits to her at the start of the school year, which was September 9. On January 22, 2021, the employee's work schedule is updated and the district now anticipates that she will work 630 hours within the school year. Eligibility would be established based on the proposed policy, which aligns to paragraph number two of the Proposed Policy Resolution SEBB 2018-12, effective date of coverage. Coverage would begin for this employee, on February 1, 2021, which is the first of the month following the date the work pattern was revised.

Slide 16, example number two. A school employee was not anticipated to work 630 hours or more during the school year and has not been receiving SEBB benefits. On October 13, 2020, he is notified that he is now anticipated to work 630 hours during the school year because he's being assigned a new student starting January 2021. Eligibility would be established based on proposed policy resolution SEBB 2018-26. That resolution would align to paragraph two of the proposed policy on when coverage begins. In this case, that would be first of the month following, which would be November 1, 2020.

Slide 17 – **Proposed Policy Resolution SEBB 2018-27 – SEBB Eligibility for the Employer Contribution Based on Actual Hours Worked.** This proposed policy resolution addresses eligibility being established when an employee is not anticipated to work 630 hours in the school year but actually does work 630 hours. It will create an expectation that eligibility be reevaluated for employees not anticipated to work the 630 hours during the school year. Very little was found in the benefit booklets reviewed by staff on this topic. It's our understanding, based on conversations with stakeholders, that this does occur so we're asking the Board to establish an eligibility policy.

Slide 18 is an example of an employee who is not anticipated to work 630 hours within the school year. The district does not offer SEBB benefits at the start of the school year. On February 9, 2021, the employee has actually worked 630 hours within a single school district so eligibility is established, again, based on SEBB 2018-27. This resolution aligns to paragraph number two of the proposed policy resolution SEBB 2018-12, when coverage would become effective. In this case, it would be March 1, 2021, first of the month following.

Pete Cutler: What if you hit the 630 hours and then the person, especially with a substitute teacher, may not be obligated to accept another day of teaching, going forward or may only work one day a month. Would their coverage continue until the end of the school year as long as they had not terminated the work relationship in terms of a retirement or a resignation? That would be a case where it would seem like somebody could continue coverage for quite a while, potentially, without actually working.

Dave Iseminger: Pete, I think we'll talk about that at the next meeting. You're asking the relationship between policy resolution SEBB 2018-27 and SEBB 2018-25, which I

think also underlined what Sean's question was earlier. I don't want Barb to speak off the cuff. We'll make sure to get that example back to the Board.

Sean Corry: I have an observation, a scary one in that in talking with some of our district clients, there's some consternation about figuring out whether an employee who might have multiple job assignments is going to hit 630 or not. That's going to need to be tracked. I hope not, but I expect that sometimes errors will be made and coverage will not be offered when it should have been and there'll be a time of a month when coverage should have been in place and it wasn't and there's going to be some sort of medical loss. I'm wondering who's going to be responsible for that and what remedies will be available to the districts to fix this.

Dave Iseminger: There is an error correction rule within the PEBB world. It's probably something that will be brought before this Board at some point to address how to handle those situations.

Barb Scott: Staff have already been thinking that through and are chomping at the bit to get those resolutions in front of you, on how agencies or districts employers are expected to correct their errors. What should that look like? That will be coming.

Slide 19 – **Proposed Policy Resolution SEBB 2018-28 – SEBB Eligibility for the Employer Contribution Based on Stacking of Hours.** This policy will ensure all school employee hours are counted to determine eligibility. It addresses cases where a school employee fills more than one position. We're recommending that stacking up hours is only within one SEBB Organization because they are unrelated employers. It seemed most reasonable to mirror what PEBB did with state agencies and limit stacking to a single employer.

In PEBB, in higher education, when it comes to faculty, the Legislature has legislated that stacking could occur across institutions. That's very difficult to administer and very difficult to track hours. There's a lot of self-reporting that has to occur. Because SEBB Organizations truly are unrelated employers, it seemed most reasonable to bring forward a policy proposal that would limit stacking to a single employer. Employees would be able to count multiple positions within one employer but not multiple employers. Stakeholders indicated that the numbers are fairly small of employees that work across districts. I don't have those exact numbers to share with you. We are recommending it be within a single employer.

An example would be if a part-time employee is offered additional work after the school year started. With this additional work, the employee would now be anticipated to reach 630 hours.

Patty Estes: We have a couple bus drivers who also work for another school district. Does that create a dual coverage problem, if they can be covered? If they work 630 hours in both, they can cover themselves under both employers?

Barb Scott: If the Board were to adopt a policy that prohibited dual enrollment, they wouldn't be able to be dual enrolled even if they were dually eligibility under multiple employers. That is what the PEBB Program has today. We do have some shared employees and they would be eligible under multiple PEBB employers. They only allow them to draw on those benefit dollars one time out of the pool.

Patty Estes: Okay.

Barb Scott: Slide 20 - **Proposed Policy Resolution SEBB 2018-29 – School Employees are Required to Provide Evidence of a Dependent's Eligibility to Enroll the Dependent**. The proposed resolution requires employees to provide evidence of the dependent's eligibility in order to enroll the dependent in coverage. This is a best practice for group health plans and prevents non-eligible individuals from being enrolled. Since every enrollee in the pool will impact SEBB Program costs, it's written to ensure only those dependents that are truly eligible are enrolled in the coverage. Our administration of dependent verification includes providing lists of acceptable documents that employees are able to provide in order to show evidence of a dependent's eligibility. We know that some documents are easier to have available than others so we've allotted for that. Clear communication of timelines and communication in instances where the timeframe is to provide dependent eligibility aren't met, the employee's next opportunity to enroll the dependent based on the Cafeteria Plan design would be at the next annual open enrollment, or a special open enrollment if one occurs earlier than the annual open enrollment.

On this particular policy, policies seem to vary by district, but employers seem to require dependent verification for at least some types of insurance. The proposed policy resolution before you is the same policy used for the PEBB Program. The only guardrail that staff have indicated has to do with those irrevocable elections under the Cafeteria Plan. Once an election is made, an employee couldn't change it unless there was a special open enrollment or prior to the next plan year during the open enrollment.

Dave Iseminger: Barb will send these proposed policy resolutions out to stakeholders. We will ask you to take action on Proposed Policy Resolution SEBB 2018-12 at the next meeting, but none of the others until July 30.

Public Comment

Julie Salvi: Good afternoon. I'm Julie Salvi, representing the Washington Education Association. I had a few things I wanted to share this afternoon. Back long ago when you were talking about the various policies on the self-insured plans, and that was the beginning of a lot of discussion this afternoon, which I appreciate all of the input from the Board Members. I was concerned that two of the options that were presented around UMP Classic was essentially one that would model UMP Classic and one that will be a lesser value plan. I will have to say very clearly right now that my members have no interest in being pushed into a plan because that is how they are viewing the SEBB system, a plan that would be a lesser value than what is out there for state employees. I understand and I appreciate the agency's interest in giving options, but the fact that options are what we have today, and less, rather than giving an array that

would be greater than and less than, was something that I just felt I needed to push back on.

It was also the beginning of an afternoon filled with questions from many Board Members. I am hoping that the agency will take that input, and my sense in the audience was there were a great number of Members who are frustrated and/or angry about feeling really pressured to make decisions when they didn't have the data they needed and didn't feel fully vested in understanding these policies.

Two other points. On the prescription drug Value Formulary, I feel like the PEBB has done a lot of work on that and they're midway through a process. And so my caution would be, they have done a bit of a deeper dive than the SEBB Board and I wouldn't have any interest in the SEBB Board acting until at least the PEB Board made some decision on that, or that you get the same level of detail.

And then finally, on the RFP that's going to go out possibly before your next Board Meeting, the main question I have is what policy decisions may be embedded in there that may bind this Board in future decisions. Because I think that was a consistent caution and concern that I heard this afternoon.

Fred Yancey: Good afternoon. I'm Fred Yancy, on behalf of the Washington Association of School Administrators today. I just have a few points. At least for my members, when Mr. Corry raised the question about -- well, he didn't raise this question but it raised this question in my mind, which is what choices does the committee have in terms of making changes in program design? It would be nice to share with my members as an example, if I asked that question, a nice little sheet that puts this information together where you have columns that lists what you can change. As an example, in response to Mr. Corry's remarks, limitations, David said deductions, coinsurance amounts, exclusions. I mean, there is, you know, what can be changed and still make it substantially the same? It would be nice to have a chart where you have, you know, here's what can be changed. Here's what UMP does for it. Here's what Kaiser does for it. Here's what SEBB is proposing to do for it. And then the committee members and my members could look and say, "Well, boy, I need more chiropractic visits," or, "I would like a higher deductible." So it's just a question of trying to get information and feedback from my members as to what they'd like to see changed.

And then it begs the question as to whether the Health Care Authority or ERB has done surveys of members to find out what parts of benefits they may be unsatisfied with. Just because there are a few exclusions for, say, the ten chiropractic treatments, I know in my case and many other cases, if my insurance limits me to ten chiropractic visits, guess how many I take. Ten. If I'm not healed, I'm not taking number 11. I'm not taking number 12 because I can't afford that as a school teacher. So I'll take my ten. Would I like more? Well, has anybody asked? And I don't know if there is data for that. I'm interested to see the data, the premium effect of the dual coverage, because indeed, that is an issue that members have. And at least from a school teacher perspective,

every dollar saved is one that they can apply towards paying off their college loans. So it's not a luxury dollar.

On page seven, on the issue of employer contribution where the example was given where an employee is anticipated to work greater than 630 hours. Her first working day will be August 27 so she can get her classroom ready. I assume that should read her first contracted working day. If it isn't, then a teacher can just start qualifying whenever he or she wants by saying, "Well, I've got to get my classroom ready." I would take all of August to prepare my classroom if I knew I could start my coverage. So I think that's just a wording issue.

And that's really all I have. I thank you for your work and I appreciate the staff work as well. I didn't get this until this morning, electronically. I did find it yesterday. It was posted. And I found it very overwhelming looking at it just cold online. So I appreciate the clarification and discussion that both you had and the staff presentations to help me make better sense of it. So, thank you.

Dave Iseminger: I want to comment about the long weekend and when materials came out, our standard practice is not to release to the public the information on the morning of the meeting. It is the day before typically. A lot of it was the long weekend and when we finished up the materials on Friday night. I do apologize to the public that the materials didn't get on our website until late last night, early this morning, the Gov Delivery message goes out. That's not our standard practice. It was the calendar quirk. I did want to acknowledge that that's not our standard practice.

Lou McDermott: The next meeting of the SEB Board is June 13 from 1:00 – 5:00 p.m. in the same location.

Preview of June 13, 2018 SEB Board Meeting

Dave Iseminger: We will bring back self-insured resolutions and Policy Resolution SEBB 2018-12. We hope to bring more data so you can take action on Policy Resolution SEBB 2018-15. There will be a presentation about the Centers of Excellence Program, which is the bundled payment program. Right now it is for hip and knee replacements. We will talk with you about that as a potential benefit offering overlay of the self-insured plans should you enact the self-insured plans.

Lou McDermott: Thanks to you and your staff. I really appreciate it and thanks to the Board Members. This is tough stuff and it's a lot to grind through. So thank you.

Meeting adjourned at 5:02 p.m.