School Employees Benefits Board
Meeting Minutes
Approved January 24, 2019

June 13, 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
Sean Corry
Patty Estes
Wayne Leonard
Pete Cutler

Members Via Phone:
Terri House
Katy Henry

Member Absent:
Alison Poulsen

SEB Board Counsel:
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 1:37 p.m. Mr. McDermott said that pursuant to RCW 42.30.110(1)(L), the Board met this afternoon in executive session to consider proprietary or confidential non-published information related to development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session began at 12:00 p.m. and concluded at 1:27 p.m. No final action, as defined by RCW 42.30.020(3), was taken during Executive Session.

Sufficient members were present to allow a quorum. Board and audience self-introductions followed.

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

Prior Meeting Follow-up Questions

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division. Answers to some of your questions from the May meeting are in presentations throughout the day.

Sean Corry asked a question related to neurodevelopmental therapies and the number of visits offered. Shawna Lang said individuals have five visits available to them. Then Sean asked what codes were used for neurodevelopmental therapies. Slide 2 is the full coding that exists under the ICD diagnosis codes for under neurodevelopmental therapies.

I want to highlight where that number five came from because it doesn't quite mean what we all thought. At the bottom right corner of the Slide 2 you'll see the number that's roughly 20,000 and a number that's roughly 4,000. If you divide those numbers, you get five, but that's not really an average. The value that's more important is the total number of visits. It was five visits per unique members, which is not a very useful utilization standard for the Board to understand. We are now giving you the total visits by the neurodevelopmental therapy codes. That's what this information is, and the context of that number five.

Sean Corry: And ABA therapy is excluded?

Dave Iseminger: Correct. ABA therapy is a different benefit in the self-insured plan that has unlimited visits. ABA is not included within the neurodevelopmental code in the state's self-insured plan.

Slide 3 relates to a theme of questions that have come up. It wasn't a direct question from the Board, but it felt relevant to some of the questions you've asked over past meetings. You've asked about member experience and feedback in these plans.

This is the CAHPS (Consumer Assessment of Healthcare Providers and System) survey results for the PEBB Program's UMP Classic and UMP CDHP plans from 2016 and 2017. There is no data for the UMP Plus plan because it's important to have two years of CAHPS data to be able to start getting trend lines and there isn't two years' worth of data that exists yet. We will be able to provide that type of information once the current plan year ends and the CAHPS survey results are available in 2019.

We've included the benchmark used and both plan years. What's also important is the percentile in the 2017 columns because depending on where the plans in the survey fall, an 89% doesn't mean the same thing on each of the measures. It's important where the plan ranks with regards to all the other plans in the survey. I want to highlight a couple different features because we could spend an entire meeting talking about CAHPS surveys. If you want more granular CAHPS survey data, we can work on providing that. This is a high-level piece, from a member perspective, and information that might interest you.

In the "Getting to Need Care" row you see, in UMP Classic in 2017, it's the 72nd percentile across the participating plans and contained within the survey. There are always improvements that can be made with any health plan. For example, one of the reasons the 72 percentile is lower in the percentile band for getting care is the 30th percentile for the subset of specialists and being able to get needed care from specialists in a quick manner. The component that focused on specialist access and getting needed care was ranked lower by members. That's an area the plan has been trying to improve on and an area we've identified from the CAHPS surveys that we've been working with our TPA on improving.

Another example is in the "Customer Service" row for UMP Classic, it's the 78th percentile. There's a phenomenon that happens in call centers and we experience it here at the Health Care Authority with the retiree customer service we provide. When answering a question about whether you're getting the information and help you want, sometimes the responder answers no. You got information, but you didn't get what you wanted. There was a drop of a couple percentages from 2016, but although people were concerned about what information they were getting, it was still at a high level and they had a 98.7% response indicating they were treated with courtesy and respect along the entire process. Even if they felt they weren't getting the answer they wanted or their question answered, they felt respected during that call.

I want to highlight the rating of the UMP Classic health plan. The benchmark is 59.4% and the respondents for Classic from the PEBB Program rank it an 80.5%, which is the 99th percentile. Overall there is a high satisfaction and rating of this self-insured plan by members in the PEBB Program.

On the CDHP side, the rating is the 38th percentile. One of the things we've learned about CDHPs, as people go further into the experience of the CDHP, they learn that more of their cost obligations are out of pocket and they need to meet a high deductible before they get more coverage by the plan. That shows up in this particular metric. We think some of the results on that piece are reflective of the design of a high deductible health plan and are inherent to the nature of that plan.

Slide 4 answers a question by Pete Cutler of how many members are outside of the country. For the PEBB Program there are 78 members outside of the country. A little more than half are employees and a little less than half are retirees. They are in 35 countries, but predominantly in Canada.

Pete Cutler: Thanks, Dave. I'd be curious to know if the average claims costs for folks outside of the United States differs from the average claims costs for those in the United States.

Dave Iseminger: We'll bring that back to you at the next meeting.

Slide 5 – Pharmacy Benefits. After our Assistant Chief Pharmacy Officer, Ryan Pistoresi's, presentation in May, Patty Estes asked what a transition period could look like regarding pharmacy benefits. We have a question that's part of the fully insured

procurement that asks how carriers would manage the situation of transitioning from one formulary to another. We were also thinking we would work with our current self-insured TPAs for the pharmacy benefit to be able to promote and answer how the transition would happen. I'm talking about having tools available that promote drug pricing and coverage to help people understand what their new coverage is. Robust pharmacy literacy, essentially, is that part of it. Also being clear and direct in member communications. Possibly targeted communications for individuals whose claims experience shows that they're about to hit a refill and explain what their situation would look like and how they can navigate this new plan. We'll work with the self-insured TPAs on any prior authorization steps that might be waived for a period of time to get people understanding their new benefit. It's still in the very early stages.

We think it will also be helpful to understand what our fully insured carriers are proposing.

SEBB Program Timeline

John Bowden, SEB Section Manager, Employees and Retirees Benefits (ERB) Division. Slide 2 starts with the first SEB Board Meeting in October 2017. As you move across you see the different things the Health Care Authority is currently working on. Benefit Options. We've presented to you information about the types of benefits employees have selected and the types of benefits they currently have offered to them. We also shared information about employee demographics, which included whether they're classified or certificated, the age of the employee, the gender of the employee, whether they're full time or part time. This gave you an understanding of the employees who will be part of the SEBB Program. When you look at benefits and what to offer, it's important to know the types of jobs employees have and whether they're part time or full time. It impacts the affordability, the age and gender, and the jobs, the types of benefits they may need.

Procurement and Contracting. We currently have procurement and contracting underway. You've heard about the RFI (Request for Information) for the fully insured medical and that we got responses from seven different carriers. We released the RFP (Request for Proposal) which is due the beginning of August. Then we start the negotiation and contracting period.

We've been working on eligibility and enrollment based on Senate Bill 6241. We are calling the employers SEBB Organizations and looking at what they might offer locally in terms of employees below the 630-hour threshold. All of these decisions go into rule making.

We are working on a system of record so employees can make their selections. We gather the information necessary to send to carriers, we know what invoices need to go to the SEBB Organizations.

If you go backwards toward the left side, the Enrollment and Claims Data Collection was something under Senate Bill 6241 we were given access to five years of data that the Office of the Insurance Commissioner gathered from school districts. That's been an

important part of understanding the claims made through the years and what the areas of need have been. We also were given authority to ask the carriers for claims data. We had specific claims level data for school employees and all of that was an important part of being able to do the procurement. We are working with WSIPC (Washington School Information Processing Cooperative) to gather information because many school districts, ESDs, and charter schools use WSIPC now. When the system of record is ready to go, we'll hopefully have insurance tracking available to all of the SEBB Organizations.

One thing we do know with this change is that some of the entities providing the online open enrollment disappear, and we need to provide the employers and employees a way of making those selections. That needs to be done in time for WSIPC staff and HCA staff to provide the necessary training so people understand the eligibility and enrollment rules, what plans are available, and what other benefits besides medical are available. We need that information in order to do all of the outreach and training for an open enrollment that will start in the October/November 2019 time period.

There is overlap in all of these tasks. Some tasks have a deadline to ensure we meet the timeline. We're trying to maintain good stakeholdering and member communications throughout the process.

Pete Cutler: On the enrollment claims data collection, has the Health Care Authority, and specifically, its actuaries -- do they believe they've gotten all the data needed to be able to do analysis?

John Bowden: Yes, we've done an estimate on how much of the data we've received. It's a little difficult because we don't know what the data looks like, so we're estimating. It's at least 90% between the OIC data, the claims data received, and information from the PEBB Program for school districts and ESDs. Some of the areas missing we believe is due to prorating and tier structuring. We don’t know about some dependents. We've tried to get some information through the dental and vision piece. We have a better sense of who the dependents are for those benefits than we do medical.

Pete Cutler: Thank you. If I understand you correctly, I want to confirm, it sounds like "system of record" is a term you're using for the automated systems that will deal with the enrollment process and transmitting of information back and forth from school districts to the SEBB Program, Health Care Authority, and back. Is that correct?

John Bowden: Correct. It's the data system for eligibility and enrollment. We talked about it with a front end and a back end, and the conversations with WSIPC have been to help us in doing the front end, which is the open enrollment and employee selections. HCA intends to do the back end, which will be invoicing the SEBB Organizations and making payments to the carriers.

Dave Iseminger: Pete, the system of record also refers to the system that we use to feed eligibility to the carriers so they know who enrolled in their plans. The system of

record really is the system that maintains who is eligible, what plan they're in, and housed at the Health Care Authority.

Pete Cutler: Are those automated systems?

Dave Iseminger: We're doing our best to be the least dependent on paper as possible on the open enrollment piece; but, no assurances that there won't be some paper in this large of a system.

Pete Cutler. Right. Great. Thank you**.**

SEBB Procurement Summary: Group Vision

Lauren Johnston, SEBB Procurement and Account Manager, SEB Section, ERB Division. First, I want to respond to a question from Pete Cutler from our May 30 meeting. Pete asked a question regarding compliance with the Administrative Simplification Act. My understanding of that is in regards to the Affordable Care Act. Is that correct?

Pete Cutler: No, in 2009, the Legislature passed a number of sections put in the state insurance code that had the Insurance Commissioner set up work groups to require, or to promote, standardization of administrative processes related to claims processing and prior authorization, a number of different areas. The work of that was supposed to lead to, as much as possible, uniformity in those processes to reduce burden primarily on the medical clinics, hospitals, medical providers. Out of that there were standards adopted. I know there was some contract. I guess it was a Medicaid contract that had reference to them as a requirement for the carriers who were selected to be the managed care organizations to comply with and implement those standardization provisions that had been adopted through the Insurance Commissioner's Office. So I'm wondering whether that same kind of provision was put into the RFP for the fully insured plans for SEBB. We can talk about it offline or later, but that's just the general area.

Lauren Johnston: My research did yield that, also. It's through One Health Port. There is language in the RFP that addresses One Health Port and having to submit claims data to it. I think we're covered on both sides then.

Pete Cutler: Great. All that work was actually done through One Health Port, so if everything that they're doing is part of the requirements that the carriers have to follow, then that would seem to address it. Thank you.

Lauren Johnston: I also wanted to let you know that the fully insured medical RFP was released on Friday, June 8, and the proposals are due back on August 2. The scoring of the RFP will mainly focus on administration and operational services and responsibilities of the contractors, as well as their clinical programs. Although we are asking bidders to submit a number of plan designs, they will not be scored.

Dave Iseminger: We're bringing that information to you because your authority is with regards to benefit design. We've tried to focus the scoring pieces that the agency is

responsible for on administrative aspects. The RFP specifically asks carriers to bid plans that are at a 76% AV (Actuarial Value) or higher. There is no cap on what that AV can be, but it does set the minimum of 76%.

Lauren Johnston: Group Vision Plan(s) Procurement Update. Slide 2 is information on the release of the RFI. On March 15, 2018, the SEB Board adopted a resolution to procure for stand-alone group vision benefits. We released a request for information on March 27 with responses due back on April 24. The redacted versions are available on the HCA's Bids and Contracts web page. I want to mention that, unlike the fully insured medical RFI, this RFI did not require a response to the RFI in order to respond to the RFP.

Slide 3 – RFI Objectives. Since the PEBB Program does not have a stand-alone vision benefit, we released an RFI to ensure we had an understanding of how these plans operate and the kind of benefits they offer. We also wanted to learn more about the different provider types the carriers contract with, as well as their adequacy throughout Washington State counties, Idaho, and Oregon. This will assist us in creating the RFP, and the market is now aware that we are procuring for a group vision plan. There were ten respondents to the RFI, listed on Slide 4, some of who currently offer vision benefits to school employees.

Slide 5 – RFI Response Highlights. All of the plans that responded have self-insured and fully insured plans. Most are customizable. The different provider types covered are ophthalmologists, optometrists, opticians, and independent and retail vision hardware stores. The majority of their benefits included the same core benefits -- comprehensive eye exams, prescription lenses, frames, and contact lenses. They also have additional options, such as different coatings, which include UV coating, anti-scratch, anti-reflective tint, as well as Lasik surgery and the option to purchase additional glasses at a discounted rate. Members can purchase vision hardware in person or online, and they have customer service available seven days a week.

Slide 6 – Ophthalmologist/Optometrist 101. An ophthalmologist is an eye medical doctor. They can treat and diagnose all eye diseases, as well as perform surgeries, prescribe and fit eyeglasses and lenses. Optometrists are health care professionals, doctors of optometry, not medical doctors. They perform eye exams and can detect defects in vision and other vision problems. They can prescribe eyeglasses and contact lenses, as well as medications for certain eye diseases and visual therapy. If they detect something that needs treated, they will refer that patient for additional medical treatment.

Slide 7 – Provider Access Key Takeaways. There is widespread availability throughout the state of Washington for the different provider types. However, Garfield and Columbia counties have no access to ophthalmologists or optometrists regardless of carrier. This includes Regence, as well, within the UMP plan. Even just doing a simple Google search shows that there are no ophthalmologists or optometrists in those two counties available. Of all the respondents and the contracted providers in Washington,

half of them said they have less than 999 providers in Washington. Three have 1,000 to 1,999, and one has over 2,000.

Slides 8 and 9 – Components in Upcoming RFP. The upcoming procurement RFP is for a fully insured Group Vision Plan. This could be one or more plans that provide provider access throughout the state of Washington. It could be one carrier who has a lot of contracted providers throughout the state, or it could be a few different carriers in order to get enough provider access throughout the state. We don't know where the providers overlap. Some providers may contract with the same carriers. The RFP also requests online hardware purchasing capabilities for convenience and access to rural communities. The RFP requests that a microsite allow members one-stop-shopping for viewing and accessing all benefit information. This includes certificates of coverage, explanation of benefits, claims lookup, provider searches, etc.

We're also requesting they cover prescription lenses, frames, and contact lenses at different price points for member choice. It will ask the bidders to submit different plan designs and rates for HCA to evaluate. Later we may negotiate and use that information to determine a final cost analysis. HCA recommends a maximum of two to three carriers, however, we would like SEB Board input on that number.

The RFP is also asking bidders to submit costs in two different ways: 1) to account for dual coverage, which would include full coordination of benefits; and 2) which accounts for no dual coverage.

Dave Iseminger: We were thinking it would be a price point or information we could share in Executive Session related to the dual enrollment piece and get more information on Resolution SEBB-2018-15.

Lauren Johnston: Slide 10 – Looking Forward. The SEB Board will vote on both the fully insured medical and vision plan design resolutions. At that time, you will make a decision on whether to keep vision benefits embedded in the medical plans, or as a separate group vision plan.

Dave Iseminger: Lauren, correct me if I get this wrong, but the way we've released the RFP for the medical plans we've asked them to account for both an embedded and a carved-out vision plan. The Board will have that information to make a single decision. We've kept up on all the flexible options, and are gathering information in the multiple procurements to be able to present you with a choice and the impacts of having an embedded vision versus a stand-alone vision plan.

Lauren Johnston: We are asking to see what the plan design of embedded vision looks like. But because we are not asking for rates within the fully insured medical RFP, we won't have that information until later in the process, not by November.

Dave Iseminger: Part of this presentation is to ask the Board if there are other pieces for the RFP. At the last meeting, there were several pieces brought up for medical that we were able to take back and incorporate in the final document before its release. I

want to make sure we leave open the opportunity for things you're thinking of related to these benefits that we can take back and refine the RFP. In particular, the recommendation of two to three carriers maximum in this procurement, because we are asking for cost information, we will ultimately have to announce a set number of apparently successful bidders. That is a key part of releasing the procurement. In this instance, with that cost piece, we really need to make that decision at this point and put it in the procurement document. We're curious about the Board's thoughts around capping it at two to three. That doesn't mean you would have to accept and offer all of them, but it would severely ratchet up the competitive pressure of the procurement and get the best results for the program.

Sean Corry: I have a question about self-insured vision because many of the school districts across the state currently have a self-insured vision plan. Could you help us understand why we're looking only at fully insured?

Lauren Johnston: The RFI responses seem to point in the direction that the majority of employer groups choose a fully insured. It ranges between whether or not enrollment is higher in a self-insured or a fully insured. In regards to knowing what costs are up front, a fully insured might be a better way to go, but it just depends. We don't have to limit it. We could ask them for both and see what they come back with. Do you want us to keep it open and ask them to submit plan designs for both fully insured and self-insured?

Sean Corry: Sure. Generally you had a set of reasons for this. I'm not sure I heard all of them for me to say go for self-funded as well. If we're going to leave it at this, and it's an easy thing for you to do, I would say yes, please. I don't know if any other Board members have an opinion about this.

Dave Iseminger: I think what Lauren was saying is that the recommendation for fully insured was really born from the overall suite of information received in the RFI process. It seemed like that the market was signaling fully insured was the way to go, but we can certainly ask and leave that option open. At the same time, we will have to discuss with the Board when you make the decision to have an embedded vision benefit or have a separate group vision benefit, how that would relate to any self-insured plans. The resolutions that are before you later today include an embedded vision benefit. If you make the decision later to have a stand-alone group vision benefit, we'd need to write a resolution to refine and move that out of a self-insured plan. We could also evaluate if we have the contractual measures to be able to have a stand-alone benefit and immediately create that separate self-insured vision plan. We'll explore options to be able to keep it open and as flexible as we can.

Pete Cutler: One specific piece of data I'd be interested in if it's easy to collect would be to check with the insurers that responded already as being interested in offering a fully insured plan, to find which of them would also be willing to act as an administrator (TPA) for a self-funded plan arrangement. We could get a sense how common it is to have organizations where you can purchase into their network, their framework, and their communication structure.

Lauren Johnston: They all do offer either. You can pick for any of the carriers.

Pete Cutler: You already know the answer. That's great.

Policy Resolution

Barb Scott, Manager, ERB Division's Policy, Rules, and Compliance Section. There is one resolution to vote on today. I've included the examples from the last meeting. Example #3 was modified based on feedback from Mr. Yancey. He suggested the word "contract" be included because in this particular example, we used a circumstance where it said "teacher whose first day of work will be August 27." Mr. Yancey felt we should make it clear that we were talking about a contracted or paid working day for this teacher in this scenario. You'll see the word "contracted" added.

We also had feedback requesting an extra example, which is #4. This is an example of a new employee anticipated to work 630 hours or more during the school year. Her first working day is October 1 and her district's first day of school is September the 9. In this example, coverage begins first of the month following, November 1, 2020.

In these meetings, I summarize stakeholder feedback received because we're using a number of different methods to ensure we're getting stakeholder feedback. The resolutions are sent to stakeholders after each meeting. I've been sending resolutions related to eligibility and enrollment. I have not been sending resolutions related to benefit decisions this Board is asked to make. Going forward, I will send both to stakeholders.

Dave Iseminger: This was a miscommunication between the expectations for what resolutions would go out, and some stakeholders pointed out that they felt they weren't getting all of the resolutions. We're going to make sure that all resolutions go through the same stakeholder process. Barb's team will be the central point for all feedback on all resolutions.

Barb Scott: We use different stakeholder activities to ensure we're talking to a number of different people and collecting information so we can bring informed decisions back to you. Some of those communications are in written format. We send resolutions within a couple of days after introducing them to the Board asking for feedback from stakeholders through that method. Typically, the response comes in writing. Sometimes we have phone conversations afterwards to ensure we understand their concerns.

We also have a standing meeting with the Washington Association of School Business Officials (WASBO) following each Board Meeting. The meetings are typically three hours or more and difficult as far as note taking. We're engaging WASBO members across the state. We'll share those notes with you, too.

I have also received direct feedback. We've tried to make sure we're getting a broad understanding. I'll continue to summarize at our meetings; but going forward, in addition to that, when we get written feedback, we'll prepare a packet for the Board.

Dave Iseminger: We will give you all the written documentation we receive, but it isn't comprehensive of all the feedback because we also receive feedback verbally and in one-on-one meetings. Stakeholder groups are offered the opportunity to respond verbally. Stakeholders respond in different ways and we do our best to provide what we receive to you in order to be as transparent as possible about the feedback received.

Pete Cutler: First of all, thanks for forwarding what written information or feedback comes in. I think that's great. I fully understand that the verbal kind of interactions can be extremely time consuming to try and catch, but at least where something is put into writing and submitted to you in written form, it would be great as a Board Member to be able to see those comments or suggestions. Also, I hope things are very quiet in the PEBB world because I know you have both hats. I can see the communications and working with the school employees is going to be taking up a lot of your time. As well it should, at this stage. I just hope the rest of the PEBB world cooperates by staying very quiet and peaceful.

Barb Scott: It is not. We have that next week or the week after. I haven't tracked that yet. We worked with stakeholders on Resolution SEBB 2018-12 – Effective Date of Coverage for School Employees Eligible for the Employer Contribution. It was changed significantly during the stakeholder process. We had several stakeholders who sent notes indicating they were in support of the resolution as you see it today. I have not made changes since it was reintroduced to you at the last Board Meeting.

We received recent feedback from one stakeholder suggesting that in the second paragraph, the effective date of coverage, the language be overlaid with the PEBB eligibility standard. I wanted to talk to you about what the PEBB eligibility standard would look like. We considered this standard as we were preparing to reintroduce this to you and came across a number of different concerns.

In the PEBB world, most employees work a Monday through Friday workweek. Most employees in the state system start on either the first or sixteenth of the month. Also in the PEBB world, the first working day of the month has been described through a chart that includes every month of the calendar year and what the first available working day is on a Monday through Friday workweek, with, on occasion, a holiday occurring on a Monday. That is a complex standard administered across a large system, the PEBB System, and it's complicated enough that we've had to use a chart in order to help staff get it right. Our staff still answer a number of questions related to that. In looking at the resolution before you, I've not added that. You could decide to do that. It would land in the second paragraph.

Resolution SEBB 2018-12, as it stands today, is consistent with some of the PEBB eligibility in that PEBB eligibility typically starts the first day of the following month, except in cases where the employee's first working day falls between the first day of the month, the first calendar day, and the PEBB first working day, which is the first available weekday based on that calendar month. For example, July 1 is on a Sunday. For July of this year, the first working day in the PEBB world is July 2. If an employee's hire date or their eligibility date for the employer contribution in PEBB was July 1 -- because

typically we hire on July 1 or July 16 -- then employee benefits would start on July 1, if the employee happened to work on Sunday, and at some of our hospitals that occurs. If the employee truly is an employee who works a position like I do, their real first working day is going to be on July 2. PEBB eligibility for me would start on July 2. That works in the PEBB world, because most folks in that population work a Monday through Friday workweek. When we looked at that within the SEBB population, our concern was around months where they may not actually have schools opened on the first or the second of a month, and so the month that staff gave me as an example was in April, when there are spring breaks. Sometimes, depending on where spring break falls for a given district, it may be that spring break occurs the April 1 through April 6, and the first day that school doors would be back open for some employees might not be until later in the month. For that, it became much more complicated once we looked at this within the SEBB population and in that environment.

The Board could choose to go that direction. Another option for the Board would be if a person really does start on the first calendar day of the month, that coverage begins on the first day. I didn't modify the policy before you, because of that complexity. That's why we brought back the policy as it was written before.

Patty Estes: I know in our school district our employees, both certificated and classified, are hired and voted on by the School Board at a School Board Meeting. The date of that meeting is actually their hire date and goes into their employee record. How would that work? Those can be, and have been, pushed back months because there wasn't enough room on the meeting agenda. So as far as eligibility goes, with the policy written like this, would that start on the day they were hired and started working versus when the School Board voted them as an employee?

Barb Scott: I'm going to say it back so I can make sure I understand. The first working day for the employee is the day the Board votes them -- is the hire date the Board uses as it votes them in?

Patty Estes: No. Their School Board Meeting date where they approve the list of employees normally on their agenda, they approve people that are getting hired for whatever positions. That goes into their personnel file.

Lou McDermott: Could someone start work on September 1 and get voted in on September 20?

Patty Estes: Yes, or October or November. It depends.

Lou McDermott: It comes down to what the official start date is versus their official first day of actually being in the office?

Patty Estes: Well, to my understanding, the way my school district has done it in the past is they don't necessarily become a school employee until the School Board votes them in. But, they are working before that as a sub or whatever they deem, whatever. It's really wishy-washy on how they're doing it.

Lou McDermott: Are they getting paid?

Patty Estes: They are getting paid.

Barb Scott: In the resolution before you today, we have tied it to their first working day. So, in that case, if their first working day was September 1, then they would fall into this first paragraph of the resolution, which would be "…and whose first day of work is on or after September 1, but not later than the first day of school for the current school year, as established by the SEBB Organization." I don't know what yours is for your district, the effective date of coverage would be the first day of work. And so in this case, September 1.

Patty Estes: Regardless of what the School Board had voted?

Barb Scott: Because it fell in September.

Patty Estes: But what if it's in a different month? Say they get hired in February?

Barb Scott: Then as the proposal is before you today, it would be first of the following month.

Patty Estes: Of when they worked?

Barb Scott: If you said first of November is when they worked, then it would be first of the following month.

Patty Estes: I just want to make sure.

Barb Scott: This is where the Board has room to say since it's November 1, that's the date you want coverage effective. If it is the first calendar day of the month, then you want it to begin that day.

That's not how the resolution is written, so we would have to modify it today and have you vote on the modification. That is within your authority to make that decision.
Patty Estes: Okay, I think I understand.

Sean Corry: This is a good time for me to ask this broader question. This particular circumstance is new to me. Some of us got thoughts submitted to us just recently on other changes that are being suggested, which I don't know that we're going to talk about them today, but what I'm really getting to is recognition that this is complicated because of so many districts doing things in so many different ways. I suspect not only will we continue to learn about new circumstances, but we'll come to circumstances in which we will have already passed resolutions we'll want to revisit. The question I have has to do with what's the practical timeline, and how do we go about revisiting resolutions we've already passed?

Dave Iseminger: I've said before in the eligibility process that PEBB has gone through for 35 years, they did not create 40 pages of eligibility rules on day one. It is an iterative process over time; and you are right, Sean, that we are going to learn things as we go along. If something comes up after the Board passes a resolution and we learn about an unintended consequence, or we learn from a district they're applying it differently in a way that was not intended. We are going to bring that information back to the Board informing you of what we've learned about a rule that was passed and ask you to make a decision on how to proceed.

We are not guaranteeing that every circumstance in all 295 districts is going to be captured in 20 resolutions over the course of the next year. It is going to definitely be an iterative process, and there are going to be things we don't know yet. We're going to learn and where issues arise, we'll gather information, stakeholder, and bring it back to the Board and tell you what your discretion is to address that situation for all employees.

You do have to start somewhere, and create a rule you think covers a wide variety of situations and then work to refine it over years. Nothing you do in the entire build of this Program says you're done today and you're not talking about it ever again.

The reason there is a complex numbering system for resolutions is we've foreshadowed that we will have to bring resolutions to you at some point in the future that says "amending Resolution 2018-12 in the following ways." We'll be able to track over time.

Just as we don't know everything, I don't think all of you know everything, either. We're all learning about this, and working lockstep together to build something that we think is manageable to start with, knowing that it is going to have to be refined over time. Did that answer the question, Sean?

Sean Corry: Mostly, thanks.

Dave Iseminger: Did I miss something in that? Because I don't like to only mostly answer questions.

Sean Cory: We're good. Thank you.

Katy Henry: I want to follow up. Is there a window of time before the implementation in 2020 that we can no longer make changes to the resolutions before the implementation, or do we have to wait to make any changes to the resolutions after the implementation? I don't think you quite answered that.

Barb Scott: Rob Parkman of my staff is working on the actual rule drafting. Within the next couple of months, Rob will come the Board and tell you where we are in the process with the resolutions, procurements, looking at what's required under federal law in a number of different other sources, then putting together draft rules in order to be able to have phase one of rulemaking complete. Remember, there will be two phases of rulemaking.

Phase one rules will go out for broader stakeholder feedback, out for public comment, and then hold a public hearing. We expect to wrap up phase one in 2018. At the same time, we will continue to bring resolutions to you for input because there's a lot to get done before implementation. We'll need to start working on phase two of rulemaking. Once these policy decisions are in draft rules and sent to stakeholders, we may get further feedback, and we expect we will.

If that causes the need to come back and revisit a resolution, we could do that during phase two. With the PEB Board, we revisit resolutions every year during rulemaking. You will have another opportunity before go-live in order to address anything that comes back from broader stakeholder review.

Dave Iseminger: To summarize, today is not the last day of rules before the 2020 launch. The official rulemaking process required under the state's Administrative Procedures Act is the piece Barb's describing as the broader stakeholdering and the public hearing. It's a state requirement for making rules, and we need the policy decisions to be wrapped up into rules to have better force of law defensibility of the program in legal settings. At the point where we begin the second official rulemaking process in 2019, that will be the point at which there is an inability to influence things for the 2020 launch. We are not at that point yet. We are trying to get a core set of rules that can go through the official process in the first two phases. Some of the most important ones are when coverage begins, when coverage ends, how long you have to turn in your forms, or make your election requirements. We expect to discover this information in this iterative process so we have a chance to clean that up with the Board in rulemaking two, which is the final set of rules before going forward for 2020.

If there are things that are unintended, we'll be able to bring that back to the Board in rulemaking two over the next several months, until we hit that official administrative procedure act filing in the early part of 2019, the drop dead point.

If you're concerned that we're going to learn something, we've built that into the process. There is time and a way for us to learn, respond to that, and bring those issues to you as we move forward. But, in order to identify those, we need to start the process.

Pete Cutler: I wanted to make sure you could explain how, after the Resolution, there's a process for rulemaking under the Administrative Procedures Act. There will be a hearing. There will be an opportunity before, at least by some point in 2019, if any one of these resolutions we come to the conclusion we'd like to fine tune in some way. So, thank you.

Wayne Leonard: I know that I listened in on some of your WASBO meetings. They probably could have gone five or six hours if you had the time to stay because it is a lot. There are a lot of questions and there's history in every district about how they do things with what bargaining group, and it's different from district to district. I know how Patty was describing in her district. In my district that's not how it works. There's a hire date, a start date, and the first start date. But, this is a slight change in terms of what's

currently the practice of an employee has to work usually a month before they become eligible for benefits. I don't have a problem with having them be eligible the first working day, but operationally, payroll departments haven't had time to process their paperwork. If an employee goes to the doctor and says I'm covered but there's no information in the system, they don't have a benefits card, there is no indication they've enrolled anywhere, then they're denied coverage. Then they then end up in my office. So how does that work for those employees?

Lou McDermott: Wayne, can I clarify something when you say "and then they're denied coverage."

Wayne Leonard: If there's no record in the system that they're eligible for benefits because they haven't worked. Or their enrollment form hasn't been put into the system and they have a doctor's appointment.

Barb Scott: In that case, in the PEBB world, our staff typically end up calling that eligibility into the carrier. For example, things aren't put into the systems as early as people would sometimes like. It takes time to process paperwork or enrollments. HCA transmits eligibility files daily to our carriers. However, if they don't have the eligibility showing in their system, an employee tries to access services, they can contact their payroll person. Payroll persons have a contact at HCA (our Outreach and Training Unit), who collects that information through a couple of different ways, phone calls included. They would have the ability to call information into the carrier. That's what we do today. If I am at the emergency room and need services, I'm going to get services. If I need to fill a prescription and I don't appear on record, then I contact my payroll. My payroll says HCA's Outreach and Training is their source and they call that eligibility into the carrier at that point, so that I can get services.

Lou McDermott: If this all happened, if you went to the emergency room or something and you didn't have your card yet, it takes a little while to clean up, but your eligibility is still retroactive. It may not be ideal, but it does get resolved. It may take a little time, especially if it is something unexpected like an ER visit.

Barb Scott: And if it were on a weekend. We don't have staff here on a weekend that would call that in. But typically we do have staff, who if it's something that needs to be escalated, there's a path for a payroll person to escalate it.

Lou McDermott: Resolution SEBB 2018-12 – Effective Date of Coverage for School Employees Eligible for the Employer Contribution:

Resolved that, for September each year, a school employee who is establishing eligibility for the employer contribution towards SEBB benefits, and whose first day of work is on or after September 1 but not later than the first day of school for the current year as established by the SEBB Organization, the effective date of coverage is the first day of work.

For a school employee who is establishing eligibility and whose first day of work is at any other time during the school year, the effective date of coverage is the first day of the month following the day the school employee establishes eligibility for the employer contribution toward SEBB benefits.

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

Julie Salvi, representing the Washington Education Association. I just want to point out that I have remaining questions about the issue that Patty raised. And while I think on the words on the page, this resolution -- the eligibility would start when they start working -- when you layer it with the eligibility about anticipated to work 630 hours, I am not sure that would hold true. So, I think it's a valid question to raise from the employees' point of view and for the Board to keep considering. I don't have magic words to offer today of how to address that, but I think that is a valid question.

Brian Simms, representing WASDA. I have a similar question, or perhaps a suggestion, that this resolution could be independent from a different resolution that says that the anticipation of 630 plus can occur after the first day of work, but prior to the first day of eligibility. So, somebody gets hired on October 1. They're not eligible until November 1, but the district starts to figure out who this person is, how much they can work, as a bus driver realizes they can work 630 and that might happen by October 20. So, that document goes into a file to confirm that anticipation. That wouldn't mean that there's a delay in the eligibility. So, I see this policy as independent from the confirmation that the anticipated 630 is met. I'm looking for nods.

Patty Estes: Are you talking about establishing the eligibility as anticipating to work 630 hours or more being a separate resolution than this?

Brian Simms: Yes, that this could allow for that. Otherwise, this would have to be the anticipation of 630 happens prior to the first day at work, and I'm not sure that that's practical for districts.

Patty Estes: No. Especially when we start layering substitutes and other school employees.
Pete Cutler: I share the view that the issue is a separate issue that not only could be, but should be addressed separately. Although I will, frankly, if Barb leapt up and said, "no, they have to be in the same one," I would tend to show her great deference. [laughter] But without the benefit of her input, I think it should be a different resolution.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Resolution SEBB 2018-12 passes.

Self-insured Plan Information
Marcia Peterson, Manager, Benefits Strategy and Design Section Manager, **Shawna Lang,** UMP Account Manager, and **Kim Wallace,** SEBB Finance Manager, Financial

Services Division. We are here to answer some of your questions from the last Board Meeting about the self-insured medical plans. Very specifically, answer questions about what can be customized within the self-insured plans, what it would take to administer a new self-insured plan should you decide to go that direction, and address issues around fiscal impacts of that potential customization.

In November we talked about the types of employer-sponsored plans that were typically offered. We talked about fully insured and self-insured plans. As a reminder, fully insured plans, in those situations, an employer will contract essentially with a carrier to provide coverage over claims costs and also administrative costs for their employees. In this situation, the carrier holds the financial risk for the claims costs for that population. The employer is paying something like a premium per month, whatever the arrangement is, to cover those costs. Again, the carrier is at risk.

In the self-insured plans, which a lot of large employers tend to offer, sometimes in addition to fully insured plans, sometimes exclusively, the employer carries the risk. Essentially, they pool all of the risk of their employees and pay for the claims costs directly. The employer bears the risk for those claims costs. Because most employers don't have the capability or the operations to take care of billing and network administration, they often contract with a third party administrator to carry out those operational tasks. One of the advantages with these employer sponsored self-insured plans is that the employer may be able to save administrative costs. Because remember, those are built into the fully insured rates.

Another benefit that employers sometimes see with a self-insured plan is that they have greater ability to control what those benefits look like in terms of what's covered, what's not covered, the coinsurance, copays, etc. That gives you some background as we talk about these topics.

Slide 4 is a history of the State's self-insured Uniform Medical Plan which was established in 1988 by the Legislature. Prior to that, there was a fully insured plan administered through Blue Cross of Washington Alaska. Fiscal crisis occurred. The state wanted to have control over premium costs and the costs employees were experiencing, so this is when they created the self-insured Uniform Medical Plan and Uniform Dental Plan. Some of the goals of the self-insured plan were to increase the efficiency of providing incentives, of sharing risks with providers, increasing access to care by providing plan choice in every region of the state and encouraging new providers to participate. We sometimes use the Uniform Medical Plan as an experimental laboratory for innovative programs and payment approaches. It allows us to provide other options, benefits, and plan designs that may not be available in the private sector as well. UMP can provide coverage to members while out of state.

Slide 5 – Ways to Leverage Efficient Purchasing with the State's Self-Insured Third Party Administrator (TPA). In the SEBB legislation 2422, the SEB Board is advised to leverage the PEB Board benefits around efficient purchasing to gain health care services. One option is the ability of the SEB Board to access the preferred contract rates negotiated by Regence, the TPA, through their statewide provider network. Their

network has worldwide coverage and utilizes over 13,000 providers within Washington State. It also allows the SEB Program to provide some pressure on pricing, making rates more affordable overall for their members. It provides some competition for rates. In addition, it also allows the SEB Program to design, to some extent, their own benefits, particularly around coinsurance, the types of services, the numbers of visits and so on.

Slide 6 – SEBB Procurement Timeline. This slide is a diagram to give you an idea of how that competitive aspect works. It shows the different phases we'll go through in the procurement for the fully insured plan. We are now in phase one. On Friday, we released the RFP for the fully insured procurement. They will come back in August and evaluated through November. Phase two begins with looking at the bid rates from February to June. Then in July, the Board will be finalizing those employee premiums. Meanwhile, if there's a self-insured plan available during phase two, there is the possibility to create some additional competitive pressure on those fully insured plan rates by the fully insured plans better understanding what the bench marks are with those self-insured plans. In July 2019, we will bring premiums to the Board for your review and approval.

Pete Cutler: I want to clarify that for the self-insured plans we talk about phase two bid rates. As I understand, you're not really bidding, but developing numbers that, I guess if you were an insurance company, you'd put out as your bid rates. They show the costs that you would expect the plan to have.

Kim Wallace: Yes, that's correct. It's rate development, essentially.

Dave Iseminger: I was looking at that bottom left box - phase one, plan design, June – thinking how that squares up with the ability to make refinements over the next couple of meetings. I want to reassure you that the box really should say June to November, just like the blue box above it. Asking you to make those major steps today with the subsequent resolutions, but if you have refinements along the way, finalizing them in November. The word "November" should be in that bottom left box, too.

Marcia Peterson: Slide 7 – Customizing the SEBB Self-Insured Plan(s). To address the question of customization, it turns out quite a bit. It includes things like the point of service cost sharing, the ability to modify dollar amounts, limits on cost sharing, the deductibles, copays, out-of-network costs, service limitations, including the number of visits, etc.

Slide 8 – What Cannot be Customized for the SEBB Self-Insured Plan(s). There a few examples, such as state and federal mandated requirements like the Affordable Care Act requirements, the Health Technology Clinical Committee's (HTCC) evidence-based coverage determinations, and statutory requirements for certain services such as screenings, contraceptive coverage, etc. In addition, there's a nuance here that I want to make you aware of. When you look at many plans and certificates of coverage, which we've done, you begin to realize that they combine some things like physical therapy, occupational therapy, speech therapy, neurodevelopmental therapy

(PT/OT/ST/NDT), massage, chiropractic, acupuncture in different ways, depending on the plan. For Regence, our third party administrator, they have combined PT/OT/ST/NDT in one annual visit limit. That is an operational issue more than anything. The limits themselves can be customized.

Dave Iseminger: To be clear, the grouping of them can't be broken up. You couldn't separate PT out and have it as a separate number. But, you could change the treatment limitation for the bucket.

Sean Corry: There are a number of state mandated insurance benefits that affect the state provided carriers, or the state-based carriers. The plans that are here. Are there any mandated benefits provided by the insured carriers currently that are not provided by the PEBB?

Dave Iseminger: There's a lot of different combinations of the overlay of self-insured and fully insured and what rules apply. Most of the time when a state mandated benefit is put into the insurance code, either it's referenced in health care purchase statutes that are applicable to state self-insured plans. When we go through the legislative process, we will respond to the Legislature through fiscal notes and pieces saying, "it's not clear whether you intended this to apply to the self-insured plan or just the fully insured market. In case you were asking it to be in the self-insured plan, here's what the fiscal impact of it is." Typically that works itself out, where there's direction from the Legislature as to whether it applies. Shawna, can you think of any examples where it's not the case? Typically the Legislature, who also is a recipient of PEBB benefits, has taken the mindset of "if we're applying it to the market we apply it to ourselves." So, typically, things that apply as mandates in the fully insured are applied to the state self-insured plan.

Shawna Lang: We try to stay in alignment with OIC standards and fully insured programs as much as possible. When we implemented transgender services across HCA PEBB benefits, we did it both for fully insured and our self-insured at the same time. USPSTF standards are another one that are mandated for fully insured, but we also make sure that self-insured also follow those standards. We do our best to always make sure there is parity between both plans, as far as what's covered in both fully insured and self-insured.

Dave Iseminger: Sean, was there a specific benefit you were thinking about?

Sean Corry: No, I didn't have anything in mind. I know that self-funded plans, whether it's the state's self-funded plan or Boeing's, are generally not subject to state mandates. So, I wondered if there was some disparity between the Kaiser plans for example, and what's required coverage and what's not.

Shawna Lang: I will point out the one disparity is the HTCC decisions determinations. Those have to be followed by self-insured. Fully insured do not have to abide by those.

Dave Iseminger: It's the opposite of direction.

Sean Corry: Yes, understood.

Dave Iseminger: There's a pressure relief on the fully insured side that's not on the self-insured side. You are correct that most of the time, state mandated benefits don't apply to the Boeings, Amazons of the world. But what I said was, they usually apply it to the self-insured plan because it's applied to themselves. Sometimes in the initial legislation it might not be as apparent, but as the process ultimately works out and a benefit is mandated, it's clear by the end of the process that it's applying to the state's self-insured plan. We'll come back to the Board if there's anything we identify in that discrepancy. But, there's nothing that's coming to mind as a disparity.

Shawna Lang: We do a nine-month process on our certificates of coverage every year and we go through them with a fine-tooth comb just to make sure we haven't missed anything between the fully insured and the self-insured.

Wayne Leonard: You said HDCC services. What is that?

Shawna Lang: Health Technology Clinical Committee. HTCC.

Wayne Leonard: Oh, HTCC.

Shawna Lang: Slide 9 – Costs and Timeline of Procuring a Self-Insured TPA. In the 2017-2019 biennial budget, we had $4.9 million put in for this particular UMP TPA procurement. We spent that on project management, actuarial services, and subject matter expert consultants.

Slide 10 - It took nearly a year of just trying to figure out what the planning and funding was going to be for this particular project, and about a year of writing. That was the majority of October 2015 - November 2016. We had about six different RFP versions that were reviewed by about 40 employees of HCA and our consultants to make sure we didn't miss anything. It was an iterative process. Our RFP release was from November 2016 to April 2017, and the scoring started. Response writing took about three months and our finalist's presentation took about another three months, a time span of April until August. Our best and final round went from August of 2017 to January of 2018. We went through negotiations and signed the final contract in February 2018.

We've started implementation and are in the alignment phase now. We are going into our definition and implementation phases. As we have 14 work streams that are currently being implemented, all of those are being scoped, have individual implementation plans that are now feeding into an overall implementation plan.

Lou McDermott: We've been with Regence for eight years. Can you talk about why there's a big implementation plan and why it's going to take so long?

Shawna Lang: In the overall procurement, we've added certain services and refined others. Over the previous eight years, we started with UMP Classic and added CDHP

in 2012. We then added UMP Plus in 2016. It's been this iterative process of building these plans out. In that process, sometimes you only have six months to stand up a plan. There are things you're still running to catch up on. So, part of it is to reestablish, make sure our data feeds are where they need to be. We also added 25 clinical programs that Regence offers as their book of business that are now offered in their per subscriber per month (PSPM) to us. They're not buy up programs; they're part of the base PSPM. We added clinical performance guarantees (PG) and a value-based payments PG. We have an overall medical trend PG that creates utilization and unit cost.

Pete Cutler: PG is performance guarantee.

Shawna Lang: Yes. Performance guarantee.

We added 6,000 work order hours that are also built into the PSPM so we can use those for additional things that maybe we didn't think of in the contract. Those are built into the PSPM so we don't have to ask for more funds for those types of things.

Dave Iseminger: PSPM -- think of that as the monthly admin fee.

Shawna Lang: We also have a guarantee over the ten years of how much that PSPM can increase over time. There are limits on exactly how much we'll be paying over the next ten years as well. Those were the major parts and it's really making sure that we're starting from the ground up and looking at all these plans, how they interact, and making sure those data feeds and everything else is as solid as we can. Because we've now had two years of experience with the UMP Plus, we're making some upgrades in how we do data management there. The data flows, how we get data back to the providers. We're doing all of that as part of this implementation.

Marcia Peterson: This was really an answer to a question of "could we do our own?" The answer is "yes." The SEB Board can do their own TPA. We, at the Health Care Authority, are not recommending it because you can see by the timeline it won't be complete by the time we go live in January 1, 2020 for the SEB Board. We won't have that ability to benchmark against those fully insured plans, providing that competitive pressure, and a number of the other issues that we talked about before. Yes, you can customize. Yes, you can do this yourself. We recommend the Board consider customization and what areas to customize? June is not the only time, as Dave talked about. There is a window here to discuss. We don't recommend going forward and pursuing a self-insured TPA yourself.

Kim Wallace: Slide 12 – Customizing Member Cost sharing. The purpose of the next few slides is to show that there are two flavors of customization to consider. One has to do with member cost sharing, and the other has to do with customizing benefit limits, the actual number of visits or days associated with a particular service that will be covered. Slide 12 highlights the opportunity to customize member cost sharing. There are two primary ways or outcomes associated with changing cost sharing. We have talked in previous meetings about changing the actuarial value (AV) of a plan. We

talked about the types of member cost sharing -- deductibles, out-of-pocket maximums, a coinsurance percentage, or copay dollar amount that's owed at the time of service. We've talked with you about the UMP Plan design which has a federal AV of 88%.

The column under 88% are the cost shares are associated with the UMP Classic. We also shared with you an 82% AV plan. We put tht forth to you to show the opportunity to have a plan with covered services and a design or structure of cost sharing that was very, very similar to UMP Classic, but with the dollar values and percentages being just a bit different. Obviously if you change the level of the annual deductible, the level of out-of-pocket maximum, etc., you do impact the AV. As a reminder, the AV is that percentage a typical member can expect the plan will pay for them in a year. It's a percentage, or a proportion. It's not really talking about the exact dollar amount the plan will pay or the exact dollar amount a member will pay when they seek services, it's the share.

The bottom bullet, not changing actuarial value, indicates you can actually make trade-offs between types of member cost sharing and keep that AV the same. By that I mean you could trade off, for example, a lower deductible amount for a higher percent coinsurance. A person would meet their annual deductible sooner, but after they do so and they actually seek services, they would owe a bit more when they actually get care. The point we're making here is that we have presented and recommended a certain structure based on UMP Classic. But the opportunity does exist to explore some trade-offs. You could achieve an 88% federal AV plan that would actually have different numbers and percentages listed for the different types of cost sharing.

Pete Cutler: The key point that really isn't mentioned here, if I understand correctly, if you have the 88% AV, so the plan’s picking up more of the cost of the services that all of the members under that plan access, that's going to cost more as a premium than the 82%. That's where the trade-off is. You can't pursue both low member monthly premium costs and as high a number as possible for the actuarial valuation, the AV.

Kim Wallace: Yes, exactly. I didn't make that clear. The very definition of the AV is the percent of the cost the plan will pay. From the state's perspective, from the purchasers, local districts perhaps, they're going to be interested in watching and vigilant about the AV percentages of the plans. I believe we've talked about the benefits of considering AVs in a range. There could be individuals who would have reasons to select a high deductible plan. There would be individuals who would prefer a lower deductible plan, based on their intentions or their guesstimates about how much care they're going to use. Your point about plan costs is important and well put, thank you.

Patty Estes: Can you remind me of the AV for the CDHP and the Plus?

Kim Wallace: Yes. The UMP CDHP, I don't know the decimal point, I believe is 88%. And the UMP Plus is 89%.

Pete Cutler: Just for the record, I was thinking that consumer directed health plan number sounded very high and then I remembered it includes the value of the health savings account contributions.

Kim Wallace: Employer contribution to the HSA, exactly. That's an important point to make. When people think of a high deductible health plan, a plan where the deductible is $1,200, $1,400 or more, and the UMP CDHP deductible is $1,400 per year, that seems like a lot of money to pay out before your plan coverage kicks in. That seems like it would be kind of a cheap plan. The point that you're making, though, is the state, in the PEBB UMP CDHP, contributes to the members' health savings account every month. Those are real dollars and that is taken into account in the AV.

Lou McDermott: Kim, in a nutshell, higher AV means more out-of-pocket for the plan, which translates into higher premiums for the member, lower cost share at the point of service. For lower AVs, the plan is paying less, less of a premium impact, but at the same time higher cost share at the point of service.

Kim Wallace: Potential exists for the member, yes. What's good or bad for people, of course, is very much driven by their needs, the type of health care, and the amount of health care that they and their family members are going to need. It's nice to have a portfolio, or a menu, of options to offer.

Slide 14 – Medical Services Limitations Comparison. There are lots of boxes, numbers, and rows on this slide. It shows ranges of visit limits for services you've asked about that exist in K-12 plans. The headings, UMP Classic, Lynden School District, Seattle, Spokane, and the WEA Select Plans, are the same headings we've used before. The purpose of this table is to show how these comparator school district plans compare with the UMP Classic benefit limits on certain services. It's important to remember that there are multiple, different plans represented in each column. Our challenge was to provide this at a glance, easy to reference, information about the number of visits allowed currently when we're trying to report on multiple plans per school district. From left to right, the top row, the first category of service is physical therapy, occupational therapy, speech therapy, and neurodevelopmental therapy (PT/OT/ST/NDT). Listed for each group is the maximum number of visits per year. It's important to note that services listed vary by school district. The visit limit applies to all of those services as a group.

Lou McDermott: Kim, was there any delineation on timeframe? We know that sometimes people count units, and I think we're counting a massage as one unit, no matter how long you go. Did you get into that?

Kim Wallace: We did not get to that layer of detail. That is a good way of highlighting the many nuances and details in the variations that exist in benefits coverage. It's very challenging to compare exactly the coverage. If you have particular details that are very important to you, we can go to the source information documents and find that detail. But it takes time, and it's difficult to certainly depict in a single slide.

Lou McDermott: I didn't mean to throw you under the bus. I was trying to point out that just because there's a number, that doesn't mean it's apples to apples. Even if it's saying "this is massage," there are nuances in there that people just need to be aware of, as we're making decisions. Sorry about that. That was unplanned.

Dave Iseminger: The other piece is we're just showing you raw information. We're not opining as to the benefit or not benefit of how you bundle the sticks together. But do remember the limitation you have in your customization is you must keep the buckets on the left-hand side. You can manipulate the numbers in the second column, however. That's just the realities of being able to leverage HCA's existing contract.

Marcia Peterson: Can I also mention that "in limitation" should also be in quotes because one of the things in some of these services is that if you max out, you can get an authorization and go beyond the limits.

Lou McDermott: Does that come down to medical necessity? If you have X number of visits and you need additional visits per your prescribing physician, then you need to demonstrate medical necessity to the satisfaction of Regence?

Shawna Lang: It comes down to medical necessity. But it's a group level exception because we're self-insured. It comes to our clinical group.

Lou McDermott: Our clinical group, though, is using the criteria of medical necessity to make the determination.

Shawna Lang: From Regence, yes.

Sean Corry: I have a quick question, in anticipation of the next slide. For example, the WEA Select Plans for PT, OT, etc., have a range of visit limits of 15-80, right? Because they have a variety of plans offered. So, whenever there is a set of numbers, that's the range of the plans offered at that district, or through that program?

Kim Wallace: Correct.

Dave Iseminger: Obviously, there's a lot of complexity, and this is just a treatment limit number. When you look at a range such as 15-45 or 15-80, the coinsurance and the point-of-service cost payment varies in such a way that sometimes the plan that has the highest number of treatment limits also comes with a higher cost share. Or vice versa. There's a wide range. To Pete's point earlier, it's not necessarily the most at the lowest cost. There is a relationship with the cost point-of-service payments.

Lou McDermott: So you can have 100 visits, but you're going to pay 60% of each visit, versus you're going to have 40 visits where you pay 5%.

Dave Iseminger: Correct. And I'm not trying to opine that's exactly what is in each of these, but there is a relationship. I wanted to make sure the Board had that variable and concept in mind as well.

Kim Wallace: A good example of that, actually, is in the chiropractic benefit row. You'll see the abbreviation for unlimited there. We wanted to note for you that the unlimited number does come with the member paying a specialist copay. Specialty provider coinsurance or copays tend to be higher than the level required for primary care. So, that's a case in point. The black square doesn't have number for NDT in the UMP Classic row because it's in the grouping above.

Slide 15 – Fiscal Impact of Increasing Services. This slide shows the analysis we've done with respect to some selected services, chiropractic, acupuncture, massage services, and the therapies. This table shows, left to right, what would be the cost impact on paid claims. How much more in paid claims would there be if SEBB self-insured medical plan chose to increase the chiropractic visit limit from the 10 that's in UMP Classic under PEBB to 52, acupuncture from 16 to 52, and massage from 16 to 80.

Dave Iseminger: Kim, will you clarify the same cost shares that exist in UMP Classic, as well. Same coinsurance levels.

Kim Wallace: Coinsurance, yes. In the Percentage Change column, there is a .2% increase in paid claims. In a dollar amount, that's approximately $2 million per year. It's interesting and important to note that that $2 million per year increase is on a total paid claims of approximately $1 billion. The analysis was based on the PEBB UMP population in 2017. We don't know if the SEBB covered population will utilize these services at the same rate, but, we don't know that they won't. We want to make it clear to you that this was based on the PEBB data that we have to give you order of magnitude and a general sense for the type of cost increase that would be associated with this benefit change.

Sean Corry: Now, to my second question. This seems a little incomplete and also could be described as exaggerating. I mean, the SEBB numbers are 52, 52, and 80 are the top end, which is one plan - at districts, for example, one plan of many. So, the average costs across that spectrum is going to be way less for each of these categories than what you've drawn out to be a $2 million dollar expense for these three types of coverage. So, the $2 million, it seems as if the $2 million in this example is the highest end possible difference in cost?

Kim Wallace: Actually, the analysis we had done specifically said what would the increase in paid claims be, using the PEBB population data, if the benefit limits were actually increased to 52, 52, 80. What I think you're getting at is, we don't know how many of the 52 visits would actually be used. But if the actuaries assessed that given the utilization rate and the number of visits sought by the PEBB population, they extrapolated that giving a 52, 52, 80 would lead to this much. You saying that it seems like the $2 million is a soft number. Tell me a little bit more what you meant by exaggerated.

Sean Corry: With the spectrum of plans offered at districts, some of the plans have limitations that people come up against because it's a lower number. And so, the actual

cost of having that spectrum would not include those claims that don't exist, because they weren't submitted because people have reached their max. I don't know that anybody here would have anticipated a set of benefits for the entire population of 52 visits, for example, which would allow practically everybody to go as many times as they wanted to. That's what that $2 million --

Lou McDermott: I want to verify this. What I'm hearing, Kim, is that our actuaries used their magic black box and anticipated what the change in utilization would be. They didn't go max value on the analysis. They didn't say everyone's going 52, 52, or 80. They basically said, "this is what we think the utilization will increase to and our best guesstimate."

Kim Wallace: Yes. I want to say two things. One is, I will verify in more exact terms exactly the structure of the analysis and what was assumed in the analysis. But I do feel confident in saying that we did not assume that every covered individual would use 52 visits of chiropractic, 52 visits of acupuncture, and 80 visits of massage per year.

Sean Corry: Nor did I. But, with the spectrum of plans which have various limitations, for those plans they have lower numbers of visits available for coverage. Some of the people in those plans will run up against that limit and not submit any more claims or go to the chiropractor again. But if everybody had 52, everyone would go to the chiropractor as much as they wanted to, up to 52 visits. I'm not saying that everybody does that. I'm saying that it covers the entire range of numbers of visits; and therefore, I think, compared to the spectrum of limitations that are in a school district, set of benefits, set of plans, that's going to be higher than what actually occurs, because of that spectrum, because lots of people are cut off by the plan that they've chosen. And, they would have gotten more, but they don't.

Kim Wallace: Yes, actually, I think the challenge is the comparison between the PEBB population and the claims data from PEBB that this is based on and then applying it to the SEBB population that has, currently, a wide variation in the benefits visits available to them. And then, in trying to understand what their utilization and costs would be under this SEBB 52, 52, 80. We are only saying the $1 billion number and the $2 million number that I gave of course are PEBB numbers. UMP Classic numbers. It's just to give you an order of magnitude. I don't want to say that if you increase the benefit limits to 52, 52, 80, the SEBB self-insured medical plan would pay $2 million more per year for chiropractic, acupuncture, and massage (CAM) services. That's not what this is saying. This is anchored to the PEBB data and it's giving you an order of magnitude between total paid claims for a population, and the amount of money spent on CAM services, the difference between a relatively limited number of visits and a much higher set of visit limits. Does that help?

Pete Cutler: Just quickly, as a Board member, while I appreciate the estimate for what seemed to be a pretty high end in terms of the limit, I would like something in between, like 24, have that be the maximum. Twice a month you could go for chiropractor, acupuncture, or massage services. What would be the estimated impact is kind of a middle ground between the two examples here. Also, could they convert that into a per

subscriber per month number so we have a sense of how it would relate to the premiums that people would be expecting for the plan.

Megan Atkinson, HCA Chief Financial Officer. I want to weigh in here on a couple of things. I want to reiterate that we're using PEBB information on this analysis. I think there's some better understanding we need to glean from you, Sean, on exactly your concern. Because I thought I was following, and then I'm not certain I completely followed your concern. We did not take somebody who in the PEBB population used zero chiro, and then assumed they went up to the 52. We took the people who were maxing out, and assumed they continued to go up. But, let's set that kind of offline. I think there's some additional detail we can figure out with our actuaries and then have a conversation with you to make sure we're understanding the analysis you'd like.

To underscore one of Kim's points, what we were trying to do here with this example is show you orders of magnitude. These issues, the chiro, acupuncture, massage, and then the therapies come up in a lot of conversations. They've come up in a lot of conversations when we've talked about SEBB. They come up in a lot of conversations around PEBB, as well. And, really what we wanted to show you here is picking up on the idea of what can you customize, what can you not customize, and what are the impacts of customization. Showing you some of these things that have a lot of value to a member wouldn't necessarily be large cost drivers for you. That's really the bottom line here. But, definitely, we're happy to talk more about the detail analysis on how the actuaries got to the numbers.

To Pete's point, yes. We can pull this into a different per-unit analysis. But, the real take away for this is, that in these areas that have high value to members, they're not large cost drivers.

Lou McDermott: That was one point. Sean, were you thinking that was a lot of money?

Sean Corry: For some people, $2 million is a lot of money.

Lou McDermott: I understand.

Sean Corry: And that's the reason earlier today I questioned the use of the millions of dollars, or lots of money, kind of conversation, without it getting to a PMPM basis. Because, that puts it into a better perspective than just millions of dollars.

Lou McDermott: It does. Again, I think the point was to demonstrate the fairly small impact on the overall expenditures. I think that was the point.

Dave Iseminger: Yes, we had the analysis done and saw a cost of $2 million. In the context of a billion dollar program, it's the perspective of that. You could slice it much smaller. We gave you the order of magnitude and it can only get smaller from there. That was the illustration. This concept was generated because of the questions this Board was asking last month and trying to scope out different pieces. We could

certainly give additional information. This was really to scope the widest part of the bread box potential with what we were seeing and the comparison that we produced. It gets smaller from there.

Kim Wallace: I will make one other remark, just to be complete. On the bottom row of the table, something similar is shown if the visits per calendar year were increased in the SEBB self-insured plan from 60 visits per calendar year to 80. No change essentially means nominal or minimal change. Now, that might seem counter-intuitive, but you remember, of course, that increasing a visit limit does not generate cost unless people use the visits. For the PEBB population that was used for these numbers, the number of people who would pursue more visits under a 80 visit per year limit than a 60 visit per year limit would be minimal and would generate essentially no change. Not saying there is zero cost to more visits, but, the benefit limit itself does not create more costs.

Slide 16 – Appendix – Links to Benefit Summaries. This identifies links to source documentation that you may want to reference.

Self-insured Medical Plan Resolutions

Dave Iseminger: As a reminder, we will not ask you to take action on Resolution SEBB 2018-24 value formulary components today. I do want to level set as to what the pharmacy benefit would be under Resolutions SEBB 2018-20 through SEBB 2018-23, without taking action on SEBB 2018-24. Currently, in the state self-insured medical plan, there is the pharmacy benefit that Ryan brought as a presentation at the last meeting, that went over the open formulary concept with five tiers: the Preventive Tier, Value Tier, Tier 1, Tier 2, Tier 3 that has a non-preferred/preferred drug aspect to that formulary. That formulary is embedded within the benefit design in Resolutions SEBB 2018-20, SEBB 2018-21, SEBB 2018-22, and SEBB 2018-23. At a future meeting, you would potentially take an affirmative step to change that formulary piece to incorporate the value-based formulary principles if you wanted to enact Resolution SEBB 2018-24.

One of the reasons that we're not asking you to take action on Resolution 2018-24 is because when I was looking at the agendas for the May 30 and June 13 Board Meetings, I recognized that I wasn't sure when the PEB Board was going to take action on a similar value formulary resolution. We have had significant, ongoing conversation for this entire PEB Board season. It started last season with the PEB Board, and we think it would be informative to this Board as to the deliberation that has gone on with the PEB Board. There's still time to answer this question. We can provide you more information, both on what the PEB Board decides to do with this policy idea and then additional information beyond the May 30 meeting.

I also want to highlight for the Board that there have been questions about why the agency has put forward and recommended the four separate plans. If you go through those four AV plans, Resolution SEBB 2018-20 is the 88% AV plan that is similar to UMP Classic, Resolution SEBB 2018-21 is the 82% AV plan that is similar to UMP Classic, Resolution SEBB 2018-22 is the 88% CDHP. Resolution SEBB 2018-23 is the 89% Accountable Care Plan option that is also the same AV in the PEBB Plan.

We're only talking to you today about the self-insured piece of the puzzle. When you look at the PEBB portfolio and their medical plans and account for both the fully insured and the self-insured plan, the suite of portfolio benefits covers the entire range of the 80%s of AVs. It goes from the 80% to the 89% area. We don't yet have before you the pieces of the puzzle on what the fully insured plans will come back with from the procurement. We've allowed carriers in the current procurement document to bid anything above a 76% AV plan. We simply wanted to put forward resolutions that fit the portfolio we currently manage. It also takes into account that there are unique circumstances to school employees that are going to be in the single risk pool. The single risk pool has to account for all classified and certificated staff. We started to think about an individual who is just at the cusp of eligibility for 630 hours, working the bare minimum of hours, their hourly or annual salary, and the potential cost of insurance premiums, and we wanted to make sure we recommended an affordable and accessible option to a wide range of the SEBB population.

We are interested in seeing the AV of the plans in the responses to the fully insured procurement. A reminder that this is just the self-insured potential part of the portfolio of medical plans that could be on the table at the end of the day.

Barb Scott also described that there was miscommunication and disconnect when asking for stakeholder feedback on the benefits resolutions alongside the eligibility resolutions. Fortunately, how to contact the Health Care Authority is well known. So, despite having had that miscommunication, we did get stakeholder feedback, as did all of you. I wanted to give you some insight on that stakeholder feedback in the same way that Barb has done on the eligibility resolutions.

There was stakeholder feedback that suggested to the Board adding language related to the collective bargaining process. The resolutions put forth by the agency reference “subject to final financing decisions.” There was stakeholder feedback about tying and making a connection and link to the collective bargaining process. Our recommendation is to not link the collective bargaining process within these resolutions based on the bargaining statutes in 41.56.500 and 41.59.105. The sentence that describes bargaining says, "employee bargaining shall be initiated after July 1, 2018 over the dollar amount to be contributed for school employee benefits beginning January 1, 2020 on behalf of each employee for health care benefits." That's the sentence that describes bargaining as passed by the Legislature in House Bill 2242 in 2017.

The additional piece of information is this Board's authority passed by the Legislature in that same bill. In 41.05.740, it says, "The function of the School Employees Benefits Board is to design and approve insurance benefits plans for school employees and to establish eligibility for participation in insurance benefit plans." That essentially shows that the benefit design is the purview of the Board. Our recommendation is not to link your Board powers and responsibilities given to you by statute to the collective bargaining process.

The other stakeholder recommendation was to modify some of the words. You'll notice in the resolutions it says the word “same” quite a bit. "Same clinical policy," "same provider network," and change those to "substantially similar clinical policies," "substantially similar." I'm suspecting that that idea has partly come from the fact we've talked about the word substantially similar to this Board quite a bit in the context of the TPA contract that can be leveraged. This Board, as I've tried to talk about earlier today, really needs to put more lines in the sand and have those tested along the process, and needs to have clear, crisp, descriptive decisions in its Board resolutions. The syntax created, Resolution 2018-21 is a good example of this, is set up in a way that lends itself to easy modification by the Board at subsequent meetings. When you look at the syntax of Resolution 2018-21, it says ‘same,’ ‘same,’ ‘same, except for the following,” and then you create your exception list of the things you want to be unique and customize for your SEBB self-insured plans.

By changing the resolution to say "substantially similar," there would be too many variables when overlaying the resolution onto the “substantially similar” language in the TPA contract. We'd rather work with you to refine the very specific aspects that you're customizing in the syntax of the resolution as it's before you. That's the stakeholder feedback we received, and I wanted to provide some insight as to why we brought forward the same recommendations.

Pete Cutler: I hope we don't even get into this discussion, but I strongly agree with the idea that the collective bargaining process is not intended to deal with employee benefit design at all. That is a purview of this Board. My understanding, and please correct me if I'm wrong, is that if we adopt all these resolutions saying “it’s our intent at this point to have these four different versions of the self-funded Uniform Medical Plan.” Come next spring, when it’s time to actually make the decision of which plans are going to be offered to employees beginning in 2020, that's when the Board really locks in. And, if the Board decides between now and then, for any one of these, we changed our mind. The high deductible plan, we changed our mind. We decided we don't want to do it, statute doesn't require it. It is at that point, really, that the Board locks in this is what we're going to offer to employees.

Dave Iseminger: I would agree with that, Pete, that once the Board is establishing the final premium contributions, if you don't set a premium contribution for a plan, you're effectively saying you don't want that plan to be offered. That's the final point. This puts in motion the ability to price out different scenarios and give more context to the discussion.

Pete Cutler: And certainly a sense of intent, at this point.

Dave Iseminger: Correct.

Sean Corry: A couple of questions, with respect to 2018-21. You pointed out that we have a colon at the end of the first page, and have a list of four bulleted areas of benefit changes that we might be able to make. Back to the some discretion, but not full discretion, is this the limit of our discretion, these four?

Dave Iseminger: No, Sean. It's not the limit. For example, let's just say for Resolution 2018-21, you could add another bullet that talks about a different chiropractic visit limitation, and then put a specific number in there. If the Board is interested in treatment limitations, by saying yes to Resolution SEBB-21 today, for example, we can bring back future Resolution 2018-32 that modifies Resolution 2018-21, and adds a chiropractic bullet, so to speak. We can go back to Resolution 2018-21, add a colon, and start the list. All of these Resolutions can have the iterative process. That's very similar to the iterative process I described for the eligibility pieces.

The analogy I've used is today you do 90% of your homework and we're still going to work with you on the remaining refinement pieces. It sets forward the macro intent piece of what the Board wants for a self-insured part of the SEBB medical portfolio. We can certainly work with you to bring subsequent resolutions to add those extra pieces of customization. You can customize chiropractic, acupuncture, and the combined PT/ST/OT/NTD. As we go forward, you could also get the information from the fully insured medical procurement, if there's an exclusion, that the fully insured medical carriers think should be covered under our SEBB plans we will come back to you with information on the self-insured side and if the Board has discretion to change an exclusion.

We'll give you the play-by-play example of your discretion on the various pieces but we thought that it would be helpful to do that process using the information that comes from the fully insured procurement. You would be able to finish those refinements and revisions to these resolutions through November, when you're also establishing the benefit design on the fully insured plans.

Sean Corry: My second question. In contrast, the other plans that we are going to be asked to approve moving forward don't have a colon and a list of things that could be changed. So, in 2018-22 it will be the same as the UMP CDHP under the PEBB Program. Without a colon. So, I don't understand, does the discretion go across all of these plans, and is just not here on these other resolutions? Or, why is there that difference?

Dave Iseminger: Yes, you can add colons later. You can modify all of these resolutions to add customization. What's been presented to you is the aspect of the “same,” “same,” “same.” All of these can have an exception list. It's just the ones that the agency put forward as your initial recommendation in Resolution 2018-20 and Resolution 2018-22 is exactly the same. But, if you have treatment limitations you want to change, you can change those in Resolutions 2018-20, 2018-21, and 2018-22. We know there's a lot of discretion on the pieces we've given you about customization flexibility for Resolutions 2018-20, 2018-21, and 2018-22. With Resolution 2018-23, in the last two weeks we got a lot done for this meeting, but we didn't get one final piece regarding how much flexibility there is in the UMP Plus-like plan because we have additional contracts that overlay those that we have to work out what the implications are. We know that you have that flexibility with regards to the CDHP and the Classic-type plan. We still have to get back to you about exactly what you can change on the UMP Plus side. We will continue that conversation with you and bring back another

resolution that says, “Resolution SEBB 2018-20 is revised as follows: strike the period, add except for the following and insert -- strike the period, add a comma, and insert the following text.” It's just like the legislative drafting processes, essentially. Just because there's a period there today doesn't mean there's a period there tomorrow.

Sean Corry: Now we all know.

Katy Henry: Is it dependent upon the Board to bring up those options that we want to see in the resolutions or will HCA be bringing forward options to us at a future date?

Dave Iseminger: Given the information we gave in the last presentation, we've already begun drafting language that would fit the syntax of these resolutions, assuming that somebody on the Board was going to ask the agency to bring something forward. We can do it in a couple of different ways, have a blank box and someone can make the motion and insert the number they want; or if they want to work with us in advance to put together specific numbers, it can be done before the Board Meeting. We prefer to work with you to bring forward specific modifications so we can work on language. We spend a lot of time wordsmithing the slides because they are the crux of the resolutions to avoid syntax errors or unintended consequences. We would like to work with any Board Member that wants to work on a specific treatment limitation piece to help streamline the process when we get to the Board Meeting. Just reach out to me.

We typically bring you a proposal at one meeting and ask you to take action at the next meeting. If you are ready to take action on a proposal that adds a treatment limitation at the July Board Meeting, you have that right and ability.

Patty Estes: Do you know the current AV range for the fully insured plans on the PEBB side?

Dave Iseminger: I don't remember the specifics of just the fully insured. I know the whole portfolio, fully insured and self-insured, is between 80% and 89%. We will follow up with that.

Patty Estes: Okay, and the procurement we just sent out, or the RFP, was for 76% and above?

Dave Iseminger: Correct. We chose 76% because of what we saw in the initial benefit survey. If someone wants to put it forward, we should at least let the Board consider it, but we recommended the portfolio for self-insured be 82%, 88%, and 89% and the CDHP at 88%.

Dan Gossett: I'll work with you, if I could just say that right now. And, we'll talk after the meeting.

Dave Iseminger: Perfect.

Lou McDermott: Resolution SEBB 2018-20 – Self-Insured Plan Offering:

Resolved that, beginning January 1, 2020, and subject to financing decisions, the SEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks, and same clinical policies as the Uniform Medical Plan Classic in place for plan year 2020 under the PEBB Program. The cost shares (deductible, out-of-pocket maximums, coinsurance for services, etc.) will be the same as the UMP Classic under the PEBB Program.

Wayne Leonard moved and Sean Corry seconded a motion to adopt.

Fred Yancey, on behalf of the Washington State School Retirees and the Washington Association of School Administrators. I object to this process. I believe that what you've done is you're asking for resolutions to say these are completed products, if you will, and granted there's a timeline. Granted, you have the opportunity to make changes. Today, you're presented, I think the first time, at least I was presented the first time, with a list of actual items I could customize, and actually look at in designing a policy. What these resolutions do is set the insurance plans in place with the guarantee that you have some time in the future you can remember this list and make suggestions and make changes. I would rather have seen a process where you actually start by designing a policy by looking at each of those saying adequate, not adequate, and so forth, and then see what you have, rather than adopting existing programs. Thank you.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Resolution SEBB 2018-20 passes.

Resolution SEBB 2018-21 – Second Self-Insured Plan Offering:

Resolved that, beginning January 1, 2020, and subject to financing decisions, the SEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks, and same clinical policies as the Uniform Medical Plan Classic in place for plan year 2020 under the PEBB Program. The cost shares (deductible, out-of-pocket maximums, coinsurance for services, etc.) will be the same as the UMP Classic under the PEBB Program, except for the following:

- Annual Deductible (medical): $750/$2,250 (single/family)
- Annual Deductible (drug): $250/$750 (single/family)
- Out-of-Pocket Maximum (medical): $3,500/$7,000 (single/family)
- Coinsurances: 20%/80% (member/plan)

Pete Cutler moved and Patty Estes seconded a motion to adopt.

Julie Salvi, Washington Education Association. Good afternoon. I would, and my organization would, recommend that we do not act on this resolution at this time. The process that is talked about where the Board is looking at wanting to tailor some options on the SEBB Plans is being pushed out till the 30th so you can work on some of those visits and possible other changes. This is a list of changes that was predetermined for

the Board, put in front of you by the agency, and we haven't had the same give and take on those items. Are these the things you would change or would you want to change them later? I would recommend that you do this as a whole. That if you're going to look at offering a second option, you do that when you're also looking at all the other options on the table. Thank you.

Sean Corry: I do have a comment I'd like, I guess is a request for affirmation that we have the opportunity to request review of these benefits pretty much at any time in the near term for a good portion of the rest of this year I hear. As we have listed these four items as changes that we're going to adopt, presuming that we do today, that doesn't mean we can't change these in the future. Doesn't mean we can't add items in the future to this plan and other ones? Is that right?

Dave Iseminger: That is correct.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Resolution SEBB 2018-21 passes.

Resolution SEBB 2018-22 – Third Self-Insured Plan Offering:

Resolved that, beginning January 1, 2020, and subject to financing decisions, the SEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks, and same clinical policies as the Uniform Medical Plan Consumer-Directed Health Plan in place for plan year 2020 under the PEBB Program. The cost shares (deductible, out-of-pocket maximums, coinsurance for services, etc.) will be the same as the UMP CDHP under the PEBB Program.

Dan Gossett moved and Pete Cutler seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Resolution SEBB 2018-22 passes.

Resolution SEBB 2018-23 – Fourth Self-Insured Plan Offering:

Resolved that, beginning January 1, 2020, and subject to final financing decisions, the SEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks (either or both of the Puget Sound High Value Network and UW Accountable Care Network), and same clinical policies as the Uniform Medical Plan Plus in place for plan year 2020 under the PEBB Program. The cost shares (deductible, out-of-pocket maximums, coinsurance for services, etc.) will be the same as the UMP Plus.

Pete Cutler moved and Dan Gossett seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Resolution SEBB 2018-23 passes

Public Comment

Doug Nelson: Members of the Board, Doug Nelson, representing Public School Employees of Washington. I really appreciated David's comments about eligibility criteria, because I am being peppered with questions from my staff of the 630 hours and how employees are going to qualify. So, I don't know when we can put together a work group to start developing some rules surrounding the eligibility for employees right on the bubble, or right below the bubble. And so, I just want to encourage you, hopefully, to get something going as soon as possible. Thank you.

Fred Yancey: My name is Fred Yancey, on behalf of the Washington State School Retirees and the Washington State School Administrators. I would just suggest that the statement was made earlier during the meeting that as you increase benefits you, as the AV changes, premiums change. And, it would be nice to have data when you're looking at changes. And, I don't know how to do this. I don't know if you have case studies where you have a high-end user, a middle user, and low-end user to see what the net effect of premiums are. My concern is that, on one hand, you could lower a person's premium, but their out-of-pocket could more than offset what they are saving by the lower premium, and I mean, you need data to see if that's the case. If you can lower premiums and make them save money, as opposed to what they would be paying if they had higher premiums, then I'm all for that.

Lou McDermott: I want to make sure I understand what you're asking. I would imagine that there are software applications and programs you could do where you enter your family medical experience, it looks at the plans you have available to you, and it provides you information on each plan for your circumstance. Is that what you're saying?

Fred Yancey: Exactly.

Lou McDermott: I know I'm speaking out of turn, but I know we are trying to figure out a way people can model their own experience in order to make an informed choice. I don't know where we are on that, but I know that's something we're working on.

Fred Yancy: I thought you were going to tell me there was a software program that did that because we didn't see that when we were looking for health insurance.

Lou McDermott: They are out there and we are looking at them to figure out what would help folks.

Preview of July 30, 2018 SEB Board Meeting

Dave Iseminger: Barb Scott will go over the stakeholder feedback and insight on the eligibility resolutions SEBB 2018-25 through SEBB 2018-29, currently in the stakeholder process.

Staff will provide information on: benefit designs for life insurance and AD&D benefits, including proposed benefit resolutions for action in August; start the conversation about the dental benefit structure; the K-12 Retiree Report; and proposed resolutions on benefit refinements to Resolutions SEBB 2018-20 through SEBB 2018-23, if there are any.

Lou McDermott: Thanks to you and your staff. I really appreciate it and thanks to the Board Members. I know this is extremely difficult, timelines are tight, and there's a lot of work that needs to be done. I don't want the Board to feel like they're getting jammed. We have opportunities to make modifications. There are drop dead dates and we'll continue to share those with you. It's difficult because every single issue is tied to other issues, and if you pull on one, another thing happens. We are in it together. We're going to be here for a long time.

Meeting adjourned at 4:49 p.m.