School Employees Benefits Board
Meeting Minutes

August 30, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 4:30 p.m.

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

Member Absent:
Katy Henry

SEB Board Legal Counsel:
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 9:02 a.m. Sufficient members were present to allow a quorum. Board introductions followed.

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

Approval of March 15, 2018 Meeting Minutes
Lou McDermott: Pete Cutler found a typo on page 5 in his first comment, last sentence. PEBB should be SEBB. The correction was made in the Briefing Book you have in front of you, but not on the version sent electronically.

Terri House moved and Pete Cutler seconded a motion to approve the March 15, 2018 minutes as amended. Minutes approved by unanimous vote.

Approval of April 30, 2018 Meeting Minutes
Alison Poulsen moved and Patty Estes seconded a motion to approve the April 30, 2018 minutes as written. Minutes approved by unanimous vote.

July 30, 2018 Board Meeting Follow-up

Dave Iseminger, Director, Employees and Retirees Benefits Division. At the June Board Meeting, Pete asked for information about the PEBB Program Uniform Medical Plan (UMP) cost internationally versus domestic.

Slide 2 is a chart that provides a visual of the numbers regarding international and domestic claims.

Pete Cutler: Thank you very much.

Dave Iseminger: The Health Care Authority (HCA) completed both procurements it was undergoing since the last meeting. We completed the separate vision benefit plan and announced three separate apparently successful bidders. They were Davis, EyeMed, and MetLife. We are proceeding to contract negotiations. Lauren will provide more information about that procurement at the end of the meeting.

HCA also completed the fully insured medical procurement. On Monday, we announced six apparently successful bidders. In alphabetical order, they are: Aetna, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of Washington Options (their PPO product line), Kaiser Foundation Health Plan of the Northwest, Premera, and Providence. We are proceeding with negotiations on those contracts. We'll discuss the ongoing contract negotiations in Executive Session.

We have gone through the branding exercise for the self-insured plan names. The name selected for the plan that correlates to Policy Resolution SEBB 2018-21 is UMP Achieve One, which was roughly 82% actuarial value (AV) plan. UMP Achieve Two correlates to Policy Resolution SEBB 2018-20, which was the approximate 88% AV plan.

Policy Resolution SEBB 2018-22 is the high deductible plan, which we are naming UMP High Deductible. It will contrast with, on the PEBB side, the UMP Consumer Directed Health Plan (CDHP).

Policy Resolution 2018-23 is UMP Plus. We brought information back about the different treatment limitations. We talked to the networks and this is a multi-contract situation. There are different parties which makes it more complicated than the other UMP Plans. We've come to the conclusion that, if the Board wants to make changes on different benefit designs, there would be the ability to do that within UMP Achieve One, UMP Achieve Two, and UMP High Deductible. For UMP Plus, because of the multi-plan contracts, it would be much more complicated and challenging to make revisions within the benefit design. Therefore, that plan name can continue to be called UMP Plus. Those are the plan names for the self-insured portfolio.

K-12 Data Support for Decision Making

John Bowden, Manager, School Employees Benefits Section**,** and **Kayla Hammer**, Fiscal Information and Data Analyst, SEBB Finance. We are presenting information on data available to HCA to assist in answering questions in preparation for creating the School Employees Benefits Board Program.

Slide 3 – Five K-12 Data Sources. These data sources, or sets, describe what types of data elements are contained within those data sets. They were not necessarily collected for the purposes we're using them for now. They are data around school employees and the benefits they currently receive. They are rich with data, but the original intent was not for starting this program. We have K-12 staffing data, Office of the Insurance Commissioner data collection results, K-12 groups currently in the PEBB Program, HCA legislated data request, and fully insured medical data received from a Request for Information (RFI).

Slide 12 - K-12 Staffing Report. The Office of the Superintendent of Public Instruction collects this data twice a year from school districts, ESDs, and charter schools. Data is collected early in the school year and again later in the year because there are changes in staffing that occur. There is a preliminary report and a final report.

This data set, the S-275 Personnel Report, contains information about most employees, but not all of them. Substitute teachers for the most part are not included. A few are included when they reach a certain number of days that they sub. The most recent report is from the 2016-17 school year. The data includes: employee name, demographic information, gender, race, ethnicity, age, job title, job duties, and FTE worked. It does not contain hours worked. It has a percentage of FTE. It also contains compensation information, their salary or wages. For each employee, there are typically multiple lines for each type of compensation they receive.

Slide 5 lists some of the sample questions used in this data set: how many employees are potentially eligible; what types of jobs do these employees have, comparing certificated and classified, part-time and full-time employees. I showed you a report showing school employees are predominately female, some of the urban/rural divisions, and east/west. This was important because we had employees asking us not to forget them. On the east side, we don't have the same kind of access. We can use some of the demographics in the K-12 workforce to compare to other populations, such as the state employees in PEBB.

As I mentioned, there are limitations with the S-275 report. There isn’t really information about substitute teachers. When we talk about substitute teachers being eligible, if they work 630 hours or more, this is a large segment with no information. It also does not include information about independents. We don't know how many children, spouse, or state-registered domestic partners there might be. A very important piece on the FTE is it’s a percentage. An employee, a teacher, for instance, who works 80% in one district may not work the same number of hours as a teacher in another district who is also listed as working 80%. For teachers, that's not a big problem, but for classified, some of those differences become a little bigger.

Slide 6 – OIC K-12 Data. This slide is the Office of the Insurance Commissioner data collected over a five-year period, school years 2012-13 through 2016-17. It was collected to look at whether school employees should be consolidated into a single benefit program. That was very relevant for what you are doing here. It contains employee, district, and carrier data. It has information about the planned benefits, the medical and dental premiums paid, and in some places, information about vision. But, the emphasis is medical.

There is some employee demographic information about what plans or tier levels the employees have selected and about dependents. Most of what we know about dependents from these data sets is by the tier. About half of the districts were able to supply information about dependents, but not in all cases so it's incomplete. There is also information about what the employees' contribution is to the medical plans they selected. There are some large claims by diagnostic categories. These are employees that have claims over $100,000 in total.

Slide 7 has sample questions providing answers to what types of plans and benefits employees selected, and what the individual employee contribution is. A limitation is that it is only the school districts and no information about the educational service districts or the charter schools. In many cases, particularly in the claims area, it's aggregated data, not individual and focused on the medical coverage. The data is about three years old.

Kayla Hammer: Slide 8 – K-12 Groups in PEBB Program, is another data source. It comes from HCA's vendors and contractors. HCA provides the eligibility and enrollment data, and the carriers provide the claims data. It is then aggregated, matched up, and blinded for use by our contractors. The data contains enrollment and claims data over multiple years, including partial 2018. It contains data on both health and dental plans, and data for approximately 3,600 employees from 71 school districts, 5 ESDs, and approximately 4,700 dependents. Slide 9 has sample questions like: how does K-12 enrollment within the PEBB Program compare to the broader PEBB Program enrollment, and what areas of the state are current K-12 groups participating in the PEBB Program? I think the major limitation with this data source is that it's not a large enough sample for standalone estimates or projections. As I said on the previous slide, 3,600 compared to the total population that will exist in SEBB is not a lot.

Slide 10 – HCA Legislated Data Request. Data was collected from current K-12 carriers in March and April 2018 and aggregated by HCA contractors. This data was authorized in HB2242 in 2017. ESSB6241 adjusted the timeline slightly in 2018. It contains data from all different types of benefit offerings currently offered to K-12. It includes profiles and benefit package information, claims of limited demographics, diagnosis and procedure codes, total cost and employee cost-sharing, and information.

Slide 11 has examples of questions, like how does the cost per service vary by region and compare between carriers, and what is the relative morbidity of the population? Limitations with this data is that it's difficult to standardize. Each carrier submitted data that wasn't necessarily comparable. Some provided different plan year information, varying plan designs between carriers, and highly variable descriptions of benefits and features. It wasn't representative of future eligibility. Those enrolled previously are not the same that will enroll in the future. As we know, eligibility is different now as it will be under the SEBB Program. Another example of that is we estimate there is a 20% waiver rate that currently exists in K-12. We don't anticipate that being the same under the SEBB Program. There's limited dependent information.

Dave Iseminger: There's one other piece that was brought to my attention. I've talked before about this data set because this is the April carrier data that was received. I described it as being 85%-90% of the data. What I've learned is that it's very heavy on

medical and dental. It has a fair amount of life and LTD but it is not as robust a set on life and LTD benefits. As we try to do some comparison to give information from this data set, it has limited predictive aspects with regards to life insurance and disability. It is much more robust for medical and dental.

Kayla Hammer: Slide 12 – Request for Information Data. In April 2017, we sent out a request for information to the K-12 fully insured medical carriers. This data contains fully insured medical plan data. We only received data from carriers that were potentially interested in responding to a future RFP. It had demographics and distribution data, possible plan design information, and non-binding rates.

Slide 13 has examples of questions like what are possible plan designs that would be offered? What counties are carriers proposing to cover? What is the range of potential bid rates for the program? Some limitations to this data are the ability for the comparison of the non-binding rates. The rates that we received were based on population variable and we only received age and gender, and area information. We're missing some bits that would make it a clearer picture.

We also asked them to build the non-binding rates, based on what they projected the entire population to look like. Not all K-12 carriers responded, so we are missing some bits of information. The rates are non-binding and not representative of the K-12 population that will exist under the SEBB Program.

John Bowden: Slide 14 – Takeaways on Using Data. None of these data sets were collected with the express purpose of consolidation, although the OIC data was collected with that possible use. In many cases we're trying to answer questions for you that go beyond the original intent of the data set. Not all the data sets are complete, pointing out substitute teachers in particular. We don't know about their needs. We don't even know how many substitute teachers would be eligible. We can't tie data sets together. There isn't a unique identifier in these five that we can tie one employee's demographic information in the S-275 to any claims data that might be for that particular individual. The claims data are services that employees have received.

It's important to remember it's based on what was offered to them, and what they selected in terms of a medical plan. With SEBB Program changes, the plans offered and what they might be able to select could be very different than what they have selected and used in the past. Within those plans, there would be differences, potentially, in their design. The types of services covered and the treatment limits, for instance, could be changed. What we have in terms of claims data is representative of what the member pays and what was available to them. If you make changes in copays, deductibles, or the coinsurance, their share of the payment, the patterns of usage may change as well.

I think it goes without saying that the available data are historical, so when you do future what-if's, you have to keep in mind things do change. We don't have anything to project what possibly might come in the future. But, keep in mind that there are changes. Some changes for consideration are the 630-hour threshold to be fully eligible. That's a lower eligibility than exists for many of the districts now. Although it is different in many places, an important piece is that for the employees' share there's no more prorating.

The 630 hours is fully eligible. All employees will be paying the same for the same plan in the same tier, across the state. We won't see differences in the employees' contribution, other than by the plan and tier selected.

The employees' premium share depends on the number of people they have included. A big piece is the three to one ratio that now exists, so that employees that have a spouse, state-registered domestic partner, and children will pay no more than three times as much as an individual would pay. We'll find employees that have previously waived, the 20% Kayla mentioned, that's a big part of the reason we expect lower waive rates. We'll have employees that haven't been there before. A few other things may change, such as employees or dependents currently Medicaid-eligible where they might receive benefits. There's a number of factors we can't predict right now that will influence the utilization.

Patty Estes: You keep saying substitute teachers are not included in the data. What about substitute classified employees? Are they not included as well?

John Bowden: My guess is they would not be. I haven't seen anything in the S-275 that suggests they are substitutes. In the job classification, there is substitute teachers specifically listed as one of the groups. I haven't seen substitute classification.

Patty Estes: It would be varied, like bus drivers, food service, all of that...

John Bowden: If they are in there, and I don't believe they are, we wouldn't be able to tell that they are substitutes.

Patty Estes: Okay. Thank you.

Wayne Leonard: I think you are referring to the S-275 report where that data is, and based on my knowledge, that report would not include classified subs. The only certificated subs I think it contains is certificated subs in a long-term sub position. It doesn't include very much information on the day-to-day substitutes.

John Bowden: I think the last time I looked , I seem to recall about 60 substitute teachers in any given school year that are in the S-275 statewide, and we know there are considerably more than sixty.

Dave Iseminger: That is an example of the limitation of the data set.

Pete Cutler: Has HCA prepared, or are they going to prepare, something that provides a more detailed written description of the data elements of each of these written sources? This is useful for giving a general idea, but I'd be very curious to know at a much more granular level, what the elements are that are collected by the different reports.

Dave Iseminger: Certainly, Pete, we can work to make that available to the Board. We didn't want to go through that granular level here, but we can certainly put together the data elements and a brief description of them.

John Bowden: I started preparing that as an appendices to this presentation, and I think I got up to about 22 pages. It'll be rather large.

Pete Cutler: I understand.

Dave Iseminger: It's in the works already and we'll complete it and make it available.

Kayla Hammer. I had a follow-up, not an agenda item. As a follow up to this presentation, in regard to the discussion that's been taking place with possible impacts on increasing the benefit limit for the CAM and therapies, (chiropractic, acupuncture, and massage). As I'm sure you remember, Kim Wallace in previous presentations has presented a table and it looked at UMP Classic active employees, non-Medicare. Looking at possible magnitude of the different levels, increments of increasing the limit, and what the possible paid per subscriber per month (PSPM) impact would be. We were asked if we could do the same thing with the K-12 data that we have.

It turns out that, based on the differences in underlying the population that we have for the K-12 and what was used in the analysis of the UMP Classic, we are unable to populate that table with K-12 information. We did some other analysis and I think I have information that would be beneficial to share with you today.

Our review of historical experience suggests that the amount spent in calendar year 2017 per subscriber on CAM and therapies for the currently covered K-12 population is 40% lower than that for UMP Classic non-Medicare state active in 2017.

Lou McDermott: Dollars, utilization, or both?

Kayla Hammer: Dollars. The PSPM paid on CAM and therapies. There are three components needed to estimate the cost of benefits or benefits change. Percentage of members who are claimants, average visits per claimant, and the average cost per service. In looking at the experience data, we found that the percentage of members who are claimants, and the average visit per claimant, were both lower in the current K-12 population than the UMP Classic. Just a note that the average visit per claimant for both of the populations does not meet the current PEBB UMP Classic visit limitation.

Sean Corry: Excuse me. What you just said meant that in general the benefits available in school districts plans have lower limits than what's available in the state plan that you were using as a comparator?

Kayla Hammer: No. That's not what I was saying. I was saying the average visit per claimant that happens for everybody. In K-12, on average, the claimant doesn't use the benefit limit. They use much less than that, like five days. Five visits, I believe. I have to look at my numbers again. I just have notes.

Sean Corry: So, you're suggesting it's not a function of lower limits themselves?

Kayla Hammer: Yes, it's just the benefits utilization behavior.

Lou McDermott: Let me understand this. Is the behavior of the K-12 system less than PEBB's current limits?

Kayla Hammer: Yes, that's what we've seen.

Lou McDermott: So, they're less than their limits and it's also less than our limits?

Kayla Hammer: They have varying benefit limit offerings.

Lou McDermott: In general.

Kayla Hammer: In general, yes. But most of them on average used lower than the 16 visit limit in PEBB UMP Classic.

Terri House: Kayla, is it possible that we get a paper copy of what you just said?

Kayla Hammer: Yes. And, lastly, the average cost per service actually varied quite a bit by service type between UMP and K-12. One wasn't necessarily higher than the other as far as the average cost per service. The average cost per service for acupuncture might have been somewhat more expensive and there was variability between those. The first two items really can impact overall cost. The percent of members who were actually claimants and the average visit per claimant was lower in the current K-12 covered population.

Pete Cutler: Not to beat a dead horse, but by average, you mean the average number of visits in a year by the claimant?

Kayla Hammer: Yes.

Pete Cutler: Great. And in terms of the average cost paid for whether it was acupuncture –

Kayla Hammer: Service.

Pete Cutler: Service that varied sometimes higher, sometimes lower, so, no distinct pattern.

Kayla Hammer: Yes. And, there's some regional variability, I imagine. There's a lot of variables that come into play with the cost per visit.

Sean Corry: I have a question, because what you've been telling us makes me think of the presentation that Kim did for us last time, which, by the way, I followed up with a question and we had some correspondence back and forth about whether the pricing, as you go into more and more visits, makes sense. The pricing provided by Milliman, apparently. There was follow-up from Kim that effectively argued that this is the reason those numbers make sense. As an aside, her answer didn't make sense to me. But, in any case, what I'm really getting to is that now that we have an understanding that the actual utilization among school districts generally is lower, or considerably lower, how

does that tie into what seemed to be a rather large prediction of utilization and cost for those therapies that Kim was talking about?

Kayla Hammer: Are you asking about increased benefit limit and increased utilization as a result of that?

Sean Corry: My vague memory of this was it was increased utilization that came at a cost. There was pricing associated with it. There was a fairly large jump in pricing at the last increase of benefit availability. It was a downward slope and then at the end a big jump. In my words, it's just that once it became a free-for-all, everybody would jump in. Putting aside my continued disagreement with that pricing, what you're telling me now is new information, which is that at Seattle Public Schools, school districts generally, and I think at Seattle, too, utilization of those benefits is relatively low. Having available benefits currently that are not being used makes me think that there won't be a rush to take up additional services, and therefore, it doesn't help me understand the big jump in pricing that Kim talked about.

Megan Atkinson HCA Chief Financial Officer. I'm going to interrupt here. On the phone is Ben Diederich, one of our actuaries from Milliman. Ben, as always, if I start describing things incorrectly, jump in and help correct us.

Sean, I want to help tie these things together. For the Board Members, you'll recall Kim presented some analysis on the CAM and the therapies around this discussion of benefit limits. Benefit limits differing across the different K-12 plans, generally having benefit limits different than what we have seen in our PEBB UMP plan, and then trying to understand if you have benefit limits that are higher or lower and how that either drives or doesn't drive over all plan cost. Kim started the conversation. We had follow-up questions and in the follow-up questions, Milliman undertook the analysis that Kayla was describing. I want to put a bow on what Kayla was describing first.

I think the urban myth around a utilization difference that, again, the mythology was in the K-12 population, a higher utilization of CAM and therapies. We have been told anecdotally as we were setting up the SEBB Program, the K-12 population really uses these benefits. They're important to the population and they are high users of the benefit. The analysis Kayla was describing as comparing the utilization from the data we have available to us, the utilization we see in the K-12 population wasn't comparing the utilization in K-12 to the K-12 current limits because those limits vary across the different K-12 plans. We have the entire UMP population in one plan with one set of limits. In the analysis, we did see that the K-12 population had lower utilization than compared to the PEBB UMP population. That's what Kayla was describing. Lower utilization and, I believe, lower cost per service?

Kayla Hammer: Varying costs per service.

Megan Atkinson: Varying cost per service. I want to put a bow on that because that's different than, again, the urban myth that we had around the K-12 population of these limits.

I want to pivot over, Sean, to your questions. Yes, we have an ongoing conversation around the cost estimates we were presenting and showing you if you set these CAM and therapy limits at a higher level versus a lower level. Milliman costed out two sets of behaviors when they did the analysis. They were costing out the current users increasing their use of these benefits. So, somebody getting a massage every other month, and then scheduling and getting a massage every month. Someone getting a chiropractic adjustment? I've had these instances in my own health where I schedule, one every other month or one every two months. Those current users using more.

There was a second behavior of people who aren't currently coming in and using. I believe in the last response, Kim and Milliman were trying to pull those behaviors apart because you were raising good questions about what would we expect in the behavior. I want to also provide the caveat that there's not a set algorithm to use. There's not a body of research you can point to and say, “this definitively is how people respond when you have” (when you change benefit limit”). It's essentially knowledgeable, informed experts getting together and asking what we think would happen. That is what was in the analysis we were presenting. With that sort of preface, I believe the question you are asking today is: does the information we've seen now that we've gone in and pulled apart the K-12 utilization, see that they actually use less than UMP? I'm speaking for you, so, correct me if I'm wrong. Essentially, would that change or adjust the information we had presented previously? Is that where you are now?

Sean Corry: That's just fine.

Megan Atkinson: Ben, I'm going to send it over to you and see if you want to weigh in to help Sean and the Board understand, as we're looking at costing out differences in these benefit limits, how to think about this and how to move forward in looking at this analysis.

Lou McDermott: Is there one more variable in that mix? The two variables were new people coming in and how behavior changes in the existing population. Does provider behavior change? The providers are usually familiar with your benefit levels, what plan you're at, and how much you can do. I'm wondering if there's any thought of whether or not the providers actually change their behaviors. If they know you only have twelve, one a month sounds great because it's a plan year. If it's 24, twice a month might seem reasonable. I don't know if that's true. Is that part of the calculus?

Kayla Hammer: I believe it is. I will go back and re-read what I read, but I do believe that was taken into consideration because, you're right. People know their benefit limits. If they have fifty, they can go every other week and it would be better for you to go every other week.

Sean Corry: To interject, I want to first agree that would be a variable worth considering. But, given the behavior that you've told us is occurring within school districts, I would guess the impact of that variable would be very small, since very few people are reaching maximums now, relatively speaking in the K-12 population.

Megan Atkinson: Ben, can you weigh in and help us with this conversation now?

Ben Diederich, Milliman. Everything that's been said up to this point, I agree with. Especially, Kayla, your last point about the discussion that provider behavior definitely comes into the calculus. The biggest piece that I don't know if enough emphasis was placed in the discussion, is that the population currently covered under K-12 is very different than the population that's likely to be covered under SEBB because of the change in the employee contributions. We're going to get a great deal more of dependent spouses covered under the population. When we presented the analysis originally, we were presenting PEBB results. That was making the grand assumption that the eventual SEBB Program population will look more like the PEBB Program population than what it looks like currently today. We're circling back with the results of what the current K-12 utilization is looking like. That utilization is different. It is lower, like Kayla was talking about. But, that's going to change when we get to 2020 and implement the SEBB Program. I think the big unknown is modeling what the future benefits are going to cost under the future program. That's the piece that we're trained to give estimates around on the initial presentation.

Megan Atkinson: I think what we're struggling with, and the reason we hadn't brought this up on the tail end of John and Kayla's presentation today, is these data limitations and trying to predict and model future behavior with a population that could be significantly different. We're expecting significantly different than the population we have right now. I understand this is a hard conversation because we're asking you, in a separate work stream, to decide on benefit limits. I'm not certain we're going to be able to get data and definitive costing in a way that we can do anything more than give you a different costing and say we're still uncertain. This is one of those areas where we look at the benefit design and the overall benefit package, rather than think we're getting overly precise, think of it in terms of magnitude of the total benefit package. In all honesty, possibly just a comfort level that you individually or collectively have with knowing what the K-12 employees are experiencing now, the options that they have now in their benefit packages, information that we can give you about how much they truly are utilizing based on the information we have. Again, a comfort level with a decision around a benefit limit. We're not going to be able to get you definitive costing on that.

Sean Corry: Thank you for that. Two things. One, it was a good email conversation I had with Kim about this and if any Board Members individually want to see that, I'd be happy to pass it on. But, what I'm hearing here is, “this is our best guess,” and not hearing that you have a high probability of being right. Which, for me, puts money on the table if for conversations about other tweaks to benefits. Maximums in other areas, copay changes, changes in the cost of the life insurance, for example, which we're going to start talking about today. I see that as all in the mix.

Megan Atkinson: Sean, as we move forward on looking at life insurance, other benefit limits, and everything, the best kind of metaphor/parallel I can give you all is, if you go on your weekly grocery shopping and you have a list. You have a general idea of how much you spend each week as you go. But, as you move through the grocery store, you routinely select the more expensive bottle of wine, the more expensive cut of meat, the more expensive, the more expensive. Then, overall, you're going to get to the checkout and you’ve driven the cost higher than what you thought you were going to when you walked in the store doors. This is an area where we put together the benefit

package and provide you options regarding disability, life, and other benefits. Even if we can't definitively cost each and every one of those for you, what we will be coming back and trying to help you keep track of is, "you went high here, you went high here, you went low here." You know, that. We can't definitively cost the total benefit package for you and what it's going to cost in 2020, but we can keep track of and help you understand the decisions you're making consistently pushing cost. Or, are they staying around neutral, are they coming in a little frugal?

Sean Corry: And lastly, I appreciate that because that is the way I have been thinking about it. The only other comment I want to make is that when we have this discussion about benefit changes here or there within a medical plan or across a range of benefits, there is uncertain money on the table here and there. But, what also is not fixed yet is the dollar amount that will be funded by the Legislature. If we knew that number, it would be much easier for us because we would have certain pennies on the table. Now, we don't. I'm saying that not to say that we should be cautious. What I'm saying is that gives us an opportunity, as a Board, to make decisions about the benefits we would recommend for the population of school districts. If it causes costs to go up somewhat and I'm putting a reasonableness aspect into it, that would be the ask from the Legislature. It's not a fixed dollar amount yet.

With that in mind, I think these kinds of conversations are very helpful to us as we drill into these different benefits, and the level of benefits that will change for school district members and whether it's okay from our point of view, on whether it's different from what PEBB has now. I'm looking forward to those conversations.

Dave Iseminger: I want to say one piece related to this concept. Although the Legislature has not set a fixed dollar amount, we do know, and Megan's described before to the Board, that just getting over the FTE to head count piece is going to be a significant amount of money that has to be addressed in the system. There are multiple places where there is already a significant amount of money that needs to be addressed by the Legislature related to launching this program. There is a cautionary tale, there are already major components to bring the SEBB Program into alignment with how the state has addressed state employees. There are significant areas where hurdles need to be crossed. The more that is requested on other parts will continue to raise the entire cost of the program.

Wayne Leonard: I had a follow-up question to some of Sean's questions. This assumption that the population is going to change significantly, is that based on an actuarial guess, or is that based on the limited data of the K-12 groups that have moved to PEBB?

Megan Atkinson: It's both, but, the data behind it is what we've seen as K-12s move into the PEBB Program. They add dependents, spouses, and children and look like our PEBB population.

Ben Diederich: We're also modeling the employee base that’s within the current K-12 system, who’s eligible for benefits, and what their associated dependents would be if all of them have the PEBB broad demographics. These are two large populations within the -- [audio cut off]

Lou McDermott: We lost you, Ben.

Ben Diederich: All right. There's static on the line. I don't think I can get through it.

Megan Atkinson: Okay.

Pete Cutler: First of all, I want to reinforce your point that I think there is going to be some significant sticker shock on the cost of providing full funding on a head count basis of the K-12 employees.

Another point I want to make is that I assume as we go forward, for every cost estimate given for any of the different options in front of the Board, it'll be based on the agency's best analysis, which will be heavily contributed to by the actuaries and their data access sources. It seems to me that this latest information is just one more piece to fine tune when we get down to actually making decisions. Maybe it'll tweak that estimate we got. I'm not sure. But, at least they'll be able, if it doesn't, indicate why they don't think it should.

And, last but not least, as I understand it, collective bargaining statutes say that before our Board Meeting in October, we should have a collective bargaining agreement (CBA) that includes an exact number that all employee organizations that are part of that coalition, and the Governor's office are going to say, "This is the funding level that is appropriate. We support going forward for the next biennium." In my mind, at that point we'll know the size of the box that we're working within and that's when I'm looking forward to where the rubber meets the road in terms of what are the tradeoffs.

Dave Iseminger: To that point, assuming there is a ratified tentative agreement of a CBA. We'll plan to talk about it at the October meeting.

Alison Poulsen: I think I wanted to add on to what Pete said about appetite in the Legislature to move this when there are a number of other health related things that I think are going to be in front of the Legislature and we should be aware in general of that type of spending.

Dave Iseminger: The other piece I wanted to add is, as you think about the head count FTE piece, that's unique to SEBB in bringing up the SEBB Program. When you start to talk about potential increases on other benefits, life insurance, disability, there will be a natural question for the sister program of, if there's money to pay for SEBB to push a benefit up, do we have double the amount of money for that request to bring both programs up? There is an extra layer of consideration in the legislative process for the implications of what this Board thinks about and what your sister Board would think. That is another factor for consideration.

Centers of Excellence

Marty Thies, Account Manager for the Centers of Excellence Program. Today's purpose is to inform the Board about the Centers of Excellence Program (COE). This is currently a benefit option available to UMP Classic and Consumer Directed Health Plan (CDHP) members. Three things. For serious procedures members might need, they

can opt to use the Centers of Excellence Program for that procedure, or they can use their existing benefits with UMP. Secondly, the program is about quality. We incentivize members to use the Centers of Excellence. Cost savings are a secondary consideration and quality is first. And third, the SEB Board can choose to adopt this COE Program to overlay on selected SEBB self-insured plans.

Slide 3 – Centers of Excellence Program. There's a national movement toward a focus on quality rather than quantity of care. This is true especially for procedures and services that have a wide variation in cost and outcomes. Slide 4 – Washington State. Washington has been a leader in this area. In 2014, the Legislature gave HCA the directive to increase value-based purchasing and increase access to high quality, high value care. Two years later, the PEB Board approved a resolution to establish the Centers of Excellence Program. There are three main components to the Program. First, there's procurement, issuing a Request for Proposal (RFP) requesting the potential Centers of Excellence abide by the Bree criteria. We incentivize members to use the Centers of Excellence. All this is to improve access to health care quality. Regarding cost, the idea is to bundle together a standard set of services associated with a procedure, and then pay an agreed-upon contractual price for that episode of care.

Dave Iseminger: This is a prospective case rate; an episodic case rate that's determined. It is not a look back at claims and a retroactive bundling of services and then saying we're only reimbursing you for this. This is actually a prospective payment model.

Marty Thies: Yes, what we pay is a matter of contract. Slide 5 – Standards and Best Practices. I believe you've heard about the Bree Collaborative and the Bree Criteria from our former Chief Medical Officer, Dr. Dan Lessler. The next few slides provide a brief update of the Bree Collaborative, established in 2011 by the Legislature to address issues of variation in cost and outcomes, and working toward better health trends in Washington State. The deliverables of the collaborative were to identify best practices to establish methods to collect, report, use, and improve access to health data, and increase the use of evidence-based practices.

Slide 6 – Bree Collaborative. This slide is procedures and health conditions the Bree Collaborative has addressed over the years. Total knee and hip replacement is where the Health Care Authority started with its Centers of Excellence Program because of high utilization in the PEBB Program self-insured plans. Slide 7 – Total Joint Replacement. Utilization for 2014, 2015, and 2016 was approximately 650 total hip and knee joint replacements each year. We saw high variability in cost in the data. It could be as low as $20,000; a replacement with complications could approach $100,000. We wanted to address that.

Bree also focuses on specific standards for total joint replacement: appropriateness, fitness, surgeons who have performed fifty plus surgeries a year and begin surgery before 5 p.m., and recovery.

Slide 8 – Total Joint Replacement: Design. The design of the total joint replacement bundle is voluntary participation. Members do not have to use the Centers of

Excellence available to Classic and CDHP members. The primary incentive is low to no out-of-pocket cost to members. The bundle includes the surgery, their inpatient stay, the implant itself, any durable medical equipment post-op, case management from the time they call to the time they leave with their new hip or knee, and even transportation and accommodations for both the patient and a care companion that joins the patient during the procedure. This is a prospective payment. There is no reconciliation after the fact, and we have a 90-day warranty with our Centers of Excellence for certain complications. Seven, 30, 90 days out, if there is an issue, the Center of Excellence will cover it.

Dave Iseminger: We are describing the design as it relates to how the PEB Board has implemented it in their self-insured plans, and highlighting UMP Classic and CDHP. That means the question before this Board will be if you want to adopt this program, do you want to adopt it in UMP Achieve One, UMP Achieve Two, and UMP High Deductible? It does not currently overlay within the UMP Plus plan on the PEBB side. We are still working on if there are ways to integrate those payment models represented in that plan. But, the question before the Board at a subsequent point will be whether you want to adopt this type of program for the UMP Achieve One, Two, and High Deductible plans.

Lou McDermott: I was involved in the procurement of this plan. We were looking to have something that was statewide and not centrally located on the west side because we knew traveling was going to be difficult. When we went through the responses to the RFP, I couldn't believe some of the numbers we saw on readmissions. A facility in the local area applied and they had a 15% readmission rate out of every hundred people. Fifteen people wound up back in the hospital for infections or secondary issues. The successful bidder had a readmission rate of 0.2 - two out of a thousand. When we say the price difference and the quality difference was variable, we mean incredibly variable. I like to point that out because I thought we were going to see some variation, but not that much variation! These numbers they reported to us, it wasn't us trying to glean it together from the data. They thought they were doing a great job. That was the other part. When we were doing orals and the site visits, they were very proud of their numbers and statistics, and had no idea where they were on the scale.

Marty Thies: Perfect segue, Lou. Slide 9 - The Centers of Excellence Total Joint Replacement Team is Virginia Mason Medical Center. Lou just described their complication rate. They have been involved with the Bree Collaborative, I believe, since its inception and have certainly adopted Bree criteria in their clinical practice. The third-party administrator is Premera Blue Cross. They do an enormous amount of work starting the moment the member calls to ask about the benefit to the survey 30 days after surgery. We call it concierge case management, holding hands, pulling medical records together, preparing referral to the Center of Excellence, handing off the member, and the surveys at the end.

Slide 10 – Calendar 2017 COE-TJR. This slide is a snapshot of our experience with the total joint replacement bundle in the first year. Premera prepared and sent 122 referrals to the Center of Excellence. In 2017, 95 of those referrals had surgery. Another sixteen of the 122 were in the pipeline toward a surgery. Eleven did not result in surgery for

various reasons. The Center of Excellence is in Seattle. People are coming from all over the state to take advantage of this program.

Slide 11 – Summary: Quality and Costs. There have been zero readmissions for members undergoing a joint replacement at the Center of Excellence and no complications reported resulting from these surgeries. There has been great savings to participating members, unless they have a CDHP and they, by IRS rules, must use their deductible. They are not paying out-of-pocket. (Data shows the average out-of-pocket cost, depending on the facility you select, is about $900-1,000.) For the UMP population, these surgeries at the Centers of Excellence, with this high quality, were less expensive than the surgeries outside of the Centers of Excellence.

Pete Cutler: Just to confirm that less expensive is to the Uniform Medical Plan, as opposed to the prior bullet being for the participants.

Dave Iseminger: There is both savings to the member and savings to the plan.

Pete Cutler: First bullet point seemed to hit the one, just wanted to make sure the second one was not just stating that first bullet a second way, but was in fact dealing with the overall plan cost.

Lou McDermott: I think one of the intangibles was readmissions. Readmissions aren't cheap, and even if there were to be a readmission, it would be under warranty and neither the state or member would be charged.

Marty Thies: Correct, within the warranty timeframe. There is a seven-day warranty, a 30-day warranty, and a 90-day warranty for complications. What we've done is use those codes to look at Regence data to see if people have been going elsewhere to address complications and did not find anything in their data.

Emily Transue, Associate Medical Director, HCA. Those conditions and timelines essentially match a consequence of a surgery. If you have pneumonia within seven days, it had to do with a surgery. If you have pneumonia two and a half months later, it's probably independent.

Marty Thies: Slide 12 – Comments from Members. Premera sends out surveys to those who undergo surgery at the Center of Excellence. There is an opportunity for participants to give narrative comments about their experience. Slide 12 highlights some of their comments, all favorable.

There have been other comments, too. Someone didn’t like the hotel. It took longer than they anticipated to gather medical records to prepare the referral. Others said the opposite. "Boy, we just zipped right in there." Sometimes, there were issues with care companions and not having someone available to accompany them for several days.

Slide 13 – PEBB Program Participant Surveys. We try to address issues we can to make the program better. We have quantitative data that reflects this. There are sixteen survey questions. Six questions highlighted on this slide and scored one

through ten. Of the 16 questions, five were between eight and nine. The other eleven were nine and above. The lowest was eight and there was one of those.

Dave Iseminger: I think it was actually 8.3. It's not even eight.

Lou McDermott: What was the question?

Marty Thies: "After I sent my information, I received my recommendation in the expected time frame." I mentioned that we got an 8.3. The highest were: "If I have another joint replacement, I'll use the COE again" -- 9.7; "I'd recommend the program to family and friends" -- 9.7. Extremely strong member response and a response rate of 69%.

Dave Iseminger: One other piece is the travel benefit applies for anybody who is outside of 60 miles of the Center of Excellence. If you're outside of 60 miles of Virginia Mason, you're eligible for the travel benefit.

Marty Thies: Slide 15 – Benefit Design. That was the first bundle of the Centers of Excellence Program. We are implementing a second bundle for spinal fusion. Over-utilization is an issue when it comes to spinal fusion. If a member is found to be a fit or appropriate candidate for spinal fusion, there is a comprehensive evaluation that is provided. We hope that, in itself, will decrease utilization appropriately. The benefit design for the spinal fusion bundle is much the same as the joint replacement; Bree criteria, little to no out-of-pocket, travel expenses, etc.

Slide 16 – Spinal Fusion Centers of Excellence Procurement Timeline. The timeframe for implementing this bundle is quite aggressive. The RFP was released in February and two apparently successful bidders were selected in July. Virginia Mason will be one of the Centers of Excellence, and Capital Medical Center, with a relationship with Olympia Orthopedics, is the second Centers of Excellence for the Spinal Fusion Program. We will implement the program on January 1, 2019.

Slide 17 – Next Steps. There will be a follow-up presentation to the Board at the October 4 Board Meeting. I will bring a resolution for your consideration to include the Centers of Excellence Program benefit in the SEBB Program. The anticipation is the Board would take action at the November Board Meeting.

Alison Poulsen: Are there other COE proposals on the table for the future for either the SEB Board or the PEB Board that we might see coming forward? I think this is really exciting when you actually talk about the triple aim. I'm going to imagine even the quadruple aim, you might see some improved job satisfaction from providers in that way. I'm just curious if we would imagine more of this happening as we try and meet those needs.

Emily Transue: I think someday, yes. We don't currently have a pipeline on what that would look like.

Dave Iseminger: The best marker for things that could potentially be part of a Centers of Excellence Program would be some of the other topics rooted in Bree criteria. That is the starting point. If you look around nationally, other areas some employers have gone forward with are things like bariatric surgery and coronary artery bypass graft (CABG). There are Bree criteria related to those, so they might be logical next areas for review, but we're in the very early stages of a potential third bundle.

Alison Poulsen: I was specifically interested in the maternity side.

Dave Iseminger: That is an area we're also in the early stages of pursuing.

Policy Resolutions

Barb Scott, Manager, Policy, Rules, and Compliance Section, ERB Division. There are three policy resolutions for action today. Policy Resolution SEBB 2018-28 was introduced in May; Policy Resolutions SEBB 2018-33 and SEBB 2018-34 were introduced in July. We continue to work on Policy Resolution SEBB 2018-32, mid-year hires for positions anticipated to work 630 hours in the next school year, and plan to bring it back to you for action at a future meeting. Changes have been made to the resolution titles and language, so we've included the original language as they were introduced in the appendix.

Slide 4 – Policy Resolution SEBB 2018-28 Eligibility for the Employer Contribution Based on Stacking of Hours. This resolution ensures all hours worked by a school employee are counted towards determining eligibility. It will address cases where a school employee fills more than one position. We are recommending the Board authorize stacking within a single SEBB Organization. This resolution would not prohibit the Board from expanding this policy in the future. As far as stakeholder feedback, most stakeholders supported the policy as written. However, one stakeholder suggested we allow stacking across SEBB Organizations with premiums prorated across SEBB Organizations. They are looking at the PEBB eligibility for faculty within the higher education institutions, where stacking is allowed across organizations, and where there is a proration of premiums across those higher education institutions. This is very specific to just faculty and faculty hours. We will continue to evaluate cross-district employment situations and bring information to the Board at a future meeting.

On the slide before you, we removed the word "only" from the end of the sentence where it says, "within one SEBB Organization." The original resolution said, "within only one SEBB Organization." Passing this resolution will reassure school employees who are working multiple positions within a single SEBB Organization today.

Lou McDermott: **Policy Resolution SEBB 2018-28. Eligibility for the Employer Contribution Based on Stacking of Hours.**

Resolved that, a school employee may establish eligibility for the employer contribution toward SEBB benefits based on stacking of hours within one SEBB Organization.

Alison Poulsen moved and Patty Estes seconded a motion to approve.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-28 passes

Barb Scott: Policy Resolution SEBB 2018-33 would allow a school employee who has already established eligibility for the employer contribution towards SEBB benefits to have uninterrupted coverage if the employee is returning to the same SEBB Organization, and is anticipated to work at least 630 hours. Without this policy, a returning employee would have a gap if they return on September 5, the first day of school for their SEBB Organization based on paragraph number one of SEBB 2018-12 as adopted, which identifies when coverage begins. School year ends August 31, and for some employees, their first day the next year is going to be September 5. What we're trying to accomplish is to have uninterrupted coverage for that employee who is going from one year to the next. This policy is intended to prevent that gap.

Most of the stakeholders supported the resolution with some minor edits. We've incorporated those into this version. One stakeholder would like us to put forward a policy that would presume eligibility rather than coverage. We will be introducing a separate policy to support presumed eligibility later in this meeting. There were some changes to the body of the resolution. We removed the word "eligibility" from this policy because we wanted to focus on removing that gap in coverage that could exist for some employees.

Lou McDermott: **Policy Resolution SEBB 2018-33. Returning School Employees with Uninterrupted Coverage.**

Resolved that, a school employee returning to the same SEBB Organization who is anticipated to work at least 630 hours in the coming school year, and who was receiving the employer contribution in August of the prior school year, will receive uninterrupted coverage from one school year to the next.

Dan Gossett moved and Terri House seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-33 passes.

Barb Scott: Policy Resolution SEBB 2018-34 – Eligibility When Moving Between SEBB Organizations. This resolution is intended to remove the eligibility and coverage gap that would otherwise occur for an employee who moves from one SEBB Organization to another within the same month or a consecutive month. The employee must be eligible for the employer contribution toward SEBB benefits in the position that they're leaving, and anticipated to be eligible for the employer contribution toward SEBB benefits in the position they are moving to.

Most stakeholders supported the policy resolution with one edit replacing the word "transferring" to "moving." The introductory clause was also rewritten in order to address a question where an employee had a gap of many months, or maybe went a year between employment. We addressed that by including, "within the same month or a consecutive month," so you could see they're moving from one spot to the next.

Dave Iseminger: That change also aligns with all the examples provided to the Board at the prior meeting. The examples all conveyed same or consecutive month examples. When the question came up we knew it needed to be made clearer.

Lou McDermott: **Policy Resolution SEBB 2018-34. Eligibility When Moving Between SEBB Organizations.**

Resolved that, a school employee will have uninterrupted coverage when moving from one SEBB Organization to another within the same month or a consecutive month if the following conditions are satisfied:

- The employee was eligible for the employer contribution toward SEBB benefits in the position they are leaving; and
- The employee is anticipated to be eligible for the employer contribution toward SEBB benefits in their new position.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-34 passes.

Barb Scott: The next steps will be to incorporate these resolutions into SEBB Program rules.

Ethics Training

Kate Reynolds, Executive Director, Executive Ethics Board. This presentation today is more of an introduction and it may create more questions. Contact information is on the last slide in your materials.

The Ethics Act is a 1995 Act largely driven by the need to bring various pieces of ethics into one statute that would cover all state employees. The Ethics in Public Service Act covers all state employees. It covers the Executive branch employees, Judicial, and Legislative branch. Each one has their own ethics board that governs the Act for that particular branch. It's to hold us accountable to the public.

First consideration is access to confidential information and protecting state employees. Then there is the use of public equipment and the use of technology. Everything that you use is the property of the state, and we need to be good stewards of that. We also

need to be accountable for how we use our time when we're in our role as state employees. We need to make sure we are using our time for the good of the people of the state.

Who is the Executive Ethics Board? It's a five member Board appointed by the Governor for a five-year term. Two are state employees, one classified employee and one exempt employee, which is important to ensure you have the state employee perspective. They cannot take personnel actions, but they can issue a civil penalty of up to $5,000 per violation to an individual state employee. The Board has a few statutory missions. One is to interpret the law, and they do that through enforcement actions and through publishing Advisory Opinions.

Advisory Opinions are when someone writes into the Board with a particular set of facts asking if it would be a violation, not a violation, or how do I avoid violating the Act with this particular set of facts? The response is published. All of those are on our web page. You can search on topic, year, agency. There's numerous search provisions. It's a great place to start if you have a question.

The Ethics Board also adjudicates complaints. The Board's jurisdiction is roughly over 60,000 state employees and the Executive Branch.

Complaints come to us from the public, agencies, boards, commissions, colleges, etc. They can refer matters to us for investigation. Sometimes, they do that before a personnel action. We also work closely with the State Auditor's Office with whistleblower investigations. They do the investigations and if there's an Ethics Act component, they forward it to us for further proceedings under the Act.

Most of our complaints come from co-workers. If there is a violation under the Ethics Act, we open an investigation. Our investigators take charge at that point. There is an opportunity for the respondent to reply, provide evidence to the investigators, and be part of the process. It comes to me for review to see if it's eligible for an Executive Director dismissal. If it's not, it's passed to the Board for a finding of either a reasonable cause or for a dismissal, as well. At that point, if they find reasonable cause it goes through a normal administrative process. The respondent can request a hearing before the Board and would have an opportunity to present witnesses and evidence. The Board would make a determination on whether there is a violation. If the respondent is not happy with the outcome, which does happen, they can appeal to Superior Court.

The first section of the Act people come into problems with are conflicts of interest. It's about 20% of our cases. We get calls with potential conflicts of interest or actual conflicts of interest and they want to know how they can mitigate the issues that are going on, or even avoid the conflicts of interest. It has to do with the concepts of benefit and bias. How you deal with those because you wear two hats. You wear your state employee hat when you're sitting on the Board and you wear your private hat. What we're looking for is the intersection of when your private interests and your interests with your official duties are not going to align. When they start to butt heads, that's where the conflict of interest comes in.

There are a couple different places where we see this a lot. One of them is you own a private business. As an example, you own a private business, and you supervise individuals in your state job that may need some extra money and you decide to hire them during the summer to help with your painting business or whatever it may be. That would be a conflict of interest because your official duties as a supervisor and your private interest as a business owner are not aligning.

Another example is you work at an agency that does permitting processes and you're in charge of the permitting process. You send out all the RFPs, you review all the RFPs that come in, you decide who gets the grant money, and you administer that grant money. Let's say you go out and you start a non-profit in this area of work and you apply for that grant money. You review your own application for your non-profit's application. You decide to grant the money to your non-profit. You administer the money of your nonprofit. There is a conflict of interest there and that's a problem.

What we see a lot with board and commission work is that you volunteer on a board or commission and because a lot of them are volunteer, you get a small stipend. But then, in your personal life, you also run a business or have other interests that may not align at some point with your official duties on the board or commission. This is where we do a lot of our advice pieces. People call us and ask for advice. They may have accepted a position on a board and they own a business where people come before the board that might be competitors or they might have a personal interest in contracts that they review. The Ethics Board will look at a few things.

There are two gold standard advisory opinions on this, 9609 and 9609A. They're on our web page. They lay out what the Board expects when you come into a conflict of interest situation. 9609A are model rules the Board has proposed could be used by boards and commissions. For example, you have a written procedure for conflicts of interest issues that board members may come across. The first thing that the Board is going to expect you to do is abstain. They're always going to expect you to just remove yourself from the situation, abstain from putting yourself in a situation where there may be a conflict of interest. We realize that's not always the most practical way to go. What are you expected to do? The second thing is disclose. Start the conversation with both sides. Start the conversation with the boards or commission, with your employer, if you think there might be a problem. Then, look for those written procedures. Some agencies have written procedures in terms of what happens with conflicts of interest. Or, they have forms that you need to fill out that will help the agency identify conflicts of interest. Look to see if there are already written procedures in place.

Lastly, I think this is an underutilized tool, largely because it's more of a legal concept, is a screening memo. It basically identifies a potential conflict of interest, or even an active conflict of interest and addresses how it will be solved. It helps so people don’t panic when the situation comes up. You have a plan and a process in place. Also, if there is a complaint, you can send that into the Ethics Board and let them know the potential issue was already identified and this is how we dealt with it. Everyone understood what was expected, we have this memo. It's very helpful for both sides, to get out in front of it.

The second section of the Act that we have a lot of questions on and not a lot of cases is actually the gift section. Gifts are broadly defined under the Act. It can be anything of economical value. It can be a gift, a gratuity, or a favor. And, basically, the baseline in the Act is that you can't accept anything if it's reasonably expected to influence the performance or nonperformance of your duties. I call this the Lamborghini rule. If someone drops the keys on your desk to a Lamborghini, they wink at you and they say, "You know what you're supposed to do, right?" Obviously, they're trying to influence you. So, don't take the keys to the Lamborghini. That's the baseline to the rule.

Now we chip away from that baseline because not everything is meant to influence your performance. It's not always that obvious. Before you accept a gift, ask yourself two questions. Depending on the answers to those questions, you may or may not be able to accept the gift. The first question is what is the gift worth? The second question is who is giving me the gift?

What is the gift worth? The Act says a state officer may accept a gift with a value of less than $50 from a single source, or from multiple sources with a cumulative value of $50 per year. There are certain things under the Act that are excluded from that $50 gift rule. It's either by a definitional section or by the other more involved section of the gift act. Basically, it's items from your family members. We don't get involved with what you got for your birthday from your mom. Gifts between co-workers are excluded from the definition of gift. For example, when you have a shower of some sort or you have a retirement party, those are they type of things contemplated under there. Also, promotional items. If it comes in a box of 300, you can have it. So, all of those pillow mints, those pens that break when you click them the first time, those post-it notes, like those visors, you can keep those types of things. Also tokens of appreciation. Those acrylic stars that say, "You're a rock star 2018!" You can keep all of those, as well. Food at a hosted reception, which we'll talk about, what a hosted reception is.

For the second question, you need to determine whether or not you’re a Section 4 employee. That is really about who is giving you the gift. Section 4 refers to the section of the act. That’s important because Section 4 employees are limited on what gifts they can accept. The $50 gift rule does not apply for them and they can only accept things delineated in Section 4 of the Act. There are three questions for determining Section 4 employees. Each time someone tries to give you a gift, you need to go through this analysis to determine whether it's permissible or not. Question 1, are you employed by a regulatory agency or an agency that seeks to acquire goods or services? The word “agency” can be replaced with board, commission, whichever kind of body you sit on. This would also drill down to the divisional level. It's not necessarily your agency. If you work in the contracting section of your particular agency then you would have to answer "yes."

Question 2, does your agency regulate or contract with the person giving you the gift? This is also future. If you know in the future they're going to be seeking a contract or some other type of agreement with you, then you would have to answer "yes."

Question 3, did you participate in the regulatory or contractual matters with that person? If you're going to be reviewing their proposal, application, or permit whatever it may be, then you need to answer "yes."

If you answer yes to all of those questions, then you are a Section 4 employee. As I mentioned, the $50 gift rule goes out the window. Stricter restrictions apply to the types of gifts you may accept. You cannot accept flowers or plants, travel expenses. If you get into that situation, feel free to give us a call. It's based on the facts and where you're sitting in relation to that particular entity and whether you're in Section 4.

Food and beverage could be an issue. You're allowed to go to a hosted reception, which the Ethics Board has defined as: You walk into a room and there's approximately 300 people. You know some of them and don't know some of them. They may be state employees, maybe not. Some may be from an industry. There are tables on either side with food. That's the general rule. If you're sitting down, there's silverware, salt and pepper, linens, and people are bringing you your food, it's no longer a hosted reception.

There's a limited exception in the Act for meals in the course of your ordinary business that are infrequent. Let's say you're invited to a working lunch, where lunch is going to be provided, but it's part of a working lunch. You're there in your official duties and it happens maybe once a year. It may fall under Section 5. Section 4 employees can still accept all those promotional items, the pillow mints and all that stuff.

Slide 10 – Use of State Resources. 33% of our cases come under this section. You cannot use state resources for your private benefit or gain. The resources are given to you by the state to do your job. We're able to see what Facebook pages you've been on, what you commented on, what you posted, which bills you paid, where all your banking institutions are, what you printed, how long you took editing things, what printer you printed things to. We get a comprehensive snapshot of how you've been using the resources that were given to you.

Pete Cutler: Just to be clear, that's only for state supplied computers. It's not your home computer.

Kate Reynolds: Correct. There is a de minimis use rule. It has to meet all the following criteria: occurs infrequently, use is brief, little or no cost to the state, no interference with official duties not done to support an outside organization, does not support a private business, does not compromise the security or integrity of state property, information, or software. If any of the above are knocked out, it's no longer considered de minimis use under the rule.

De minimis use is brief and infrequent. It could be making a medical appointment, sending a brief email to a significant other or your child because maybe they got out early and you just want to make sure they got home safely. Or, if you don't have a fancy smart phone and you're going someplace after work that you don't know how to get there, go ahead and MapQuest it and get there safely. Those are some examples of brief and infrequent.

Lou McDermott: If somebody from the Board has a question, are they to ask Dave? Are they to ask Katy Hatfield? Are they to ask you?

Kate Reynolds: You could ask anybody. We're considered the subject matter experts so if it's easier, come directly to us. We are more than happy to do that. It also depends on how things are set up, because there are some agencies that have a chain of command for questions. You're not prohibited from coming directly to us.

Lou McDermott: Dave, some guidance on that for the Board Members. For me, we have an agency ethics advisor, and I would go and talk to that person. But, for others on the Board, if there's multiple paths for them, what are their options?

Dave Iseminger: Board Members can go directly to Katy Hatfield. It could be to me. We can provide insight from our experiences in the agency. I'd be interested, if there's something Kate's giving advice on, if it's something that the agency can learn from as well. But, Kate said you're not prohibited, and you can certainly go directly to Kate. If there are things you're comfortable sharing, I can be part of the conversation so that the agency can also learn. I think that there's value to that, too.

Kate Reynolds: Sometimes we get emails where the ethics advisor or the AAG are copied on, as well, because they want everyone in on the conversation. That's always an option. Every agency is required under the Act to have an ethics advisor. They are a great resource because they are our first line of defense in terms of asking questions. They know the agency players and the specifics that we might not. If they don't know the answer, they will come to us.

Katy Hatfield: I was hoping that you could explain for the Board a little bit about how Section 4 might interact with their specific roles in terms of that they are not in the contracts unit at HCA, they are not sending out the RFPs, they're not reviewing the actual bids that Kaiser, Regence, and Premera are sending back. But, yet they still have a role in voting on final products that will be provided, and they also provide feedback during the contracting process. Can you talk about how that works in real life?

Kate Reynolds: Any time you're in that relationship where you're approving, disapproving, providing feedback, can make discretionary decisions - any of those things -- you're most likely in a Section 4 relationship with that entity/individual who is coming before you. In an abundance of caution, depending on what they're approving, too. We would need facts like where are you in the process? What is your role in the process? In an abundance of caution, I would say, safely, if someone's coming before you to seek approval on something, then you're most likely in a Section 4 relationship with them, and you should not be accepting gifts from them. That's a good baseline to start from. If you have specific questions, because the relationship with the individuals coming before you is a little murky, whether it would fit under that, then call us and we can start asking questions to see which line you're on.

Dave Iseminger: I can provide more clarity. We will often, in the contracts, the agency will bring forward the plan designs, although there are obviously carriers behind that. We're presenting the recommendations around the plan designs for your approval. All the contracts have clauses that are subject to Board approval, which means if the Board doesn't approve that plan, we would terminate the contract. That is a direct relationship

that is probably a key factor that might help people feel more comfortable, that the assumption should be that they're Section 4 employees.

Kate Reynolds: I would totally agree with that. The other thing, too, I should note, is that sometimes people will come and drop a plate of cookies for the Board Members as a thank you for all the hard work you do. With those guidelines sometimes I say, you know, it's best to just put that out in a general area where everyone can eat the cookies, and not put them all in your pocket and go home with them.

Dave Iseminger: Everyone's looking at the food HCA put out because we had them here since 9 a.m. for eight hours.

Kate Reynolds: The agency is not in a Section 4 relationship with the Board. It's okay to eat the muffin.

You cannot use state resources for political campaigns. There's no de minimis use under this. It doesn't mean you can't be politically active. You just have to do it on your own time, with your own resources. You have to do it as a private citizen. You're passionate about environmental issues and believe everyone must get involved. You bring a copy of the environmental ballot initiative petition to the Board Meeting and ask all of the Board Members to sign it. That's a violation.

Sean Corry: On Slide 17, it's a violation if that petition or ballot measure is brought to work and time is spent soliciting signatures. But, it's not a violation if I were to do it with my neighbor who happens to work with me at the same agency.

Kate Reynolds: As long as you do it after hours and not on facilities. If you say to your coworker, "Meet me in this neighborhood and we'll go doorbelling for an hour after work," and take off your HCA sweatshirt, you'd be fine.

If you're asked by a local politician for your support in their upcoming campaign and they want to use your name and commission title, they come to the commission headquarters, take a picture of you standing in front of the commission, use it in their flyers and on Facebook, you need to be really careful with this. There's actually an advisory opinion on this that you can use your title, but you have to use a disclaimer. You have to say, "I'm not speaking on behalf of my agency, board, or commission. I'm speaking as an individual." I would be very careful with that because it looks like you or the agency itself is endorsing, or commission itself, and not just you. You need to be mindful of that.

What this boils down to is public trust. The public is trusting you with all the resources and the time to do the job that you've been appointed to do, you have to keep that in mind, it's about that public trust and being good stewards of the trust that they've put in you.

We have a 90-minute online training. We also have tons of materials online, our enforcement and final orders or stipulations, the advisory opinions, and FAQs.

Dave Iseminger: Kate, if they email you a question with a lot of sensitive information, how does your advice interact with the Public Records Act?

Kate Reynolds: You do not have attorney-client privilege with me. I am not anyone's attorney. I don't give privileged advice. Anything you send to me would be subject to the Public Records Act. We get a lot of phone calls. There are a few things I prefer to do in writing. Just because it's so factually intensive and it really depends on one fact or another. That's post-state employment advice. I will always push it on to email. And some conflicts of interest. If they're really complicated and there are a lot of different players and a lot of different roles, then I will ask you also to put that in writing so I can really take a look at it. Other than that, you can call us.

Lou McDermott: Thanks, Kate. The Board will meet in Executive Session during the lunch period, pursuant to RCW 42.30.110(1)(d), to review negotiations on the performance of publicly bid contracts when public knowledge regarding such consideration would cause a likelihood of increased costs; and pursuant to RCW 43.30.110(1)(l), to consider proprietary or confidential non-published information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026. The Executive Session will conclude no later than 1:30 p.m. The public portion of the meeting will resume no earlier than 1:30 p.m.

Group Vision Plan(s) Procurement Update

Lauren Johnston, SEBB Procurement Manager. Slide 2 – Status. Eight proposals were received in response to the group vision plan procurement. Three apparently successful bidders (ASB) will move to the next phase. They are Davis Vision, EyeMed, and MetLife. MetLife will negotiate to offer only a fully insured plan as they did not submit a bid for a self-insured plan. We will be asking the Board to take action on Policy Resolution 2018-35, which will establish a separate group vision plan. We will also be going into contract negotiations with all three ASBs, as well as working on plan designs and rates.

Slide 3 – ASB Response Highlights. Based on their responses, the ASBs cover the comprehensive eye exam, as well as prescription lenses, frames, contact lenses, and other lens options (ultraviolet coating, transition lenses, tinting, anti-scratch, etc.). There will also be the option to have online or in-person purchasing of hardware. All three ASBs offer a one-year warranty for prescription lenses and/or frames and customer service seven days a week.

Slide 4 – ASB Network Key Takeaways. Some of the ASB's takeaways have to do with geographical coverage, which include the potential for vision provider coverage in 37 Washington counties. Garfield and Columbia Counties have no optometrists or ophthalmologists located in those counties. There are none to contract with.

Provider coverage is available in the other 49 states, as well as Washington, D.C., Guam, Puerto Rico, and the U.S. Virgin Islands. Out-of-network coverage is accessible outside of the United States. If a member receives services while traveling abroad, they could receive services and submit a form for reimbursement. On the provider contracting side, these are credentialed providers. Some of the credentialing is done

based on their work experience, things like member complaints, criminal history, litigation, etc. We are also increasing rural access for members through provider contracting and the option to purchase hardware online. Some optical retailers that are potentially included are Costco, Pearl Vision, America's Best, and Lens Crafters.

Slide 5 - ASB Proposed Provider Locations. This map provides you with the number of providers in each county. It combines the three ASBs. It's a local overview of what it would look like in Washington, and the border counties in Idaho and Oregon.

Sean Corry: I have a question on the "combined." Picking on King County with 1,043 providers, is that 1,043 providers that are in common with all three of the vendors, or is it in every single one, whether that provider's contracted with one or three?

Lauren Johnston: It's combined. One might have 500 of the 1,043, another might have 200, another might have 300.

Sean Corry: So, if we had all three plans in place, we'd have that number of providers?

Lauren Johnston: Yes.

Pete Cutler: Does that mean you have accounted for duplication so that, if the same provider signed up for all three they are not showing up as three providers, they're just showing up as one?

Lauren Johnston: That is my understanding, yes.

Dave Iseminger: I do want to be clear that we're entering the contract negotiation stage. None of this is final in any way, shape, or form. Obviously, nothing's finalized until contracts are signed and the Board has approved benefit design.

Lauren Johnston: Slide 6 – Considerations. I wanted to provide you some considerations to assist you in making your decision of whether or not to approve a separate group vision plan. Considerations on the left are for a separate group vision plan. Carriers who specialize in providing group vision benefits, as well as the option to purchase hardware online using in-network benefits, possible set copays or co-insurance for benefit options after the allowance is met. Instead of paying 100% after an allowance is met, there might be some copays or coinsurances that are set for the member that they would be aware of. Many school employees are already familiar with separate vision plans. There are more purchasing options without the member having to submit a reimbursement form. If I purchase hardware online and I use an in-network provider, I wouldn't have to submit a reimbursement form to my vision carrier. If it's an in-network provider, the claim would go through to the network carrier and they would pay the claim on my behalf instead of me having to submit a reimbursement form. There's also higher visibility into plan costs and utilization, so more transparency for the member. It could potentially mitigate the future Cadillac tax responsibilities under existing federal law.

Dave Iseminger: And, for that last one, just as a reminder, the current iteration of the Cadillac tax is supposed to hit starting in 2022. It's been pushed out by Congress several times, but it is still on the books and could hit. There are very few ways in which an employer with a high-value plan can mitigate their Cadillac tax liability. One of the interesting quirks of the IRS regulations in the law is that vision benefits count if they're embedded, but they don't enter the calculation if they're outside. That's, I believe, a 40% excise tax above a certain threshold. It is a significant tax.

Lauren Johnston: Considerations to continue to keep the vision benefits embedded within the medical plans is that regardless of the type of service that a member were to receive, the provider bills one carrier for all services. That would be their hardware, exams, any other kind of eye medical services they would receive. It would all go to the medical carrier. There is the potential for more contracted providers, based on the carrier that might end up being the final contracted group vision plans. Eye health services are more likely to be integrated and managed with medical services. Right now, there might be a disconnect between providers talking to one another, or the medical plan talking to the primary care provider or the eye doctor if there were to be some sort of an eye health problem that the member was facing.

Slide 7 – Proposed Policy Resolution SEBB 2018-35. Group Vision Plan(s). The proposal is to offer a group vision plan(s) beginning January 1, 2020 that is separate from the medical plans. By passing this resolution, the Board's intent would be no vision benefit coverage under the medical plans, except when required by law. Or in other certain situations, if a child was receiving a well child visit, the pediatrician was doing part of their well child exam, and the visual acuity exam work to be done in that visit. That's just one example.

Dave Iseminger: For clarity, this is the proposed resolution we're teeing up this time. We will push it into stakeholder review, but we are going to ask the Board to take action on this at the September 17 special meeting to help eliminate some of the variables as we move into the fully insured medical plan proposals that we'll bring to you in October.

Life and AD&D Insurance

Beth Heston, PEBB Procurement Manager. Our objectives today are to provide additional information about the proposed basic and accidental death and dismemberment insurance benefits and to take action on Policy Resolution 2018-31. We received a lot of stakeholder feedback.

On July 30, we talked about the basic life and AD&D insurance. We recommended a $35,000 basic life insurance plan, with a $5,000 basic AD&D. The Health Care Authority recommended benefit levels align with the current funding assumptions. The Board asked about pricing and increasing the basic benefit.

Dave Iseminger: The last bullet, “an increase or decrease of $10,000 in basic life insurance is estimated as ~$1 per subscriber per month (PSPM). I verbally committed to putting it in writing for your slides. That approximate, what does $10,000 or $1 in PSPM equal? We'll continue to provide this type of metric as we're providing recommendations on other benefits so you can see the types of relationship you could do to trade between different benefits. We'll try to put it in the context of a dollar PSPM.

Sean Corry: I don't mean this facetiously, but it's in this case about a buck per subscriber, but what are the parameters. Is it within ten cents? Or is it within fifty cents? What I'm saying, you've rounded it to the nearest dollar.

Dave Iseminger: Sean, when I say a dollar, I'm talking within a penny or so. We've asked the carriers to identify what a dollar equals? It happened to be $10,000. If it was $6,975, then it would be $6,975 as $1 PSPM. We're trying to benchmark it to a dollar.

Beth Heston: Slide 4 – Stakeholder Feedback and Responses. The first item of stakeholder feedback had to do with the increased coverage amounts. We wanted to put on the record and make everyone aware that amounts of basic life insurance over $50,000 have tax implications for employees under the IRS code. It's perceived as taxable income. Taxes have to be paid on those amounts. It's an imputed salary and it's based on an IRS table that we've included in the appendix of this presentation. It becomes a calculation of what it's aligned with.

Dave Iseminger: The important thing here is we're highlighting that there's extra impact on employees of having an amount that's imputed into their tax returns as an amount that they then owe federal income tax on. It's just for the education of the Board that once you hit that $50,000 threshold, there's imputed income for the value above $50,000. We put one illustrative example, to give you a sense as to what that imputed taxable income is. It's not something the Health Care Authority has done at this point. We do have an understanding from WASBO officials that some payroll processes in school districts currently have the ability to handle this. We haven't been able to confirm that as widespread, but, there is this assertion that there is this ability and some employees currently do this imputed income. We want the Board to be aware of that implication on an employee's taxable income.

Sean Corry: I was about to say, essentially, that you just said, that is routinely done by many school districts already. It's a payroll function that's in their system that's fairly easy to do and being done.

Beth Heston: We also wanted to talk about benchmarking insights. We looked at 2018 carrier data. We asked for the employer and employee paid data be separated. What we got was mainly combined funding sources. Despite these limitations, looking at the overall limited data, the suggestion is that employer-paid life insurance benefits do not currently exceed the $50,000 cap for the majority of school districts.

Dave Iseminger: Let me paraphrase a bit. Earlier today I talked about the April carrier data the agency got and there are some limitations, particularly when it comes to life insurance and disability. That was my breadcrumb to pick up and reinforce that there are a lot of limitations when it comes to life insurance because we had roughly about half of the school district data that was provided as part of that carrier request. When we talked to our actuaries at Milliman, there were a lot of concerns about being able to draw specific conclusions. What they could tell in a general brushstroke from what they received is it seemed that, generally speaking, most school districts had a benefit that was under $50,000 as a basic employer paid. We know there are definitely examples against that. What we saw in the carrier data provided, again acknowledging that it has

some limitations, was that of roughly half of the school districts represented in that claims pool, it was suggested that it was below $50,000.

Sean Corry: That's a different measure than counting heads who are enjoying that higher level of benefit. I think the larger districts generally have a higher benefit than $50,000. Which means, I think the majority of employees have the better benefit.

Dave Iseminger: We're providing the examples of data that we do have, acknowledging its limitations. Back in December, we did a comparator in Seattle, Spokane, Lynden, and WEA. We know there are instances where they are higher, and it's not on a head count basis that we're providing this. We're giving you the information we do have.

Beth Heston: There are ten school districts currently insured by our carrier, MetLife. They're non-PEBB participants. In that group, the average benefit for employer paid is $14,200. One district has $50,000 and the most common benefit is $10,000 employer paid. We can also compare that to the federal employees' group life insurance.

Lou McDermott: Beth. Total lives?

Beth Heston: I don't have that number.

Dave Iseminger: Total lives in the $10,000? We can follow up with that.

Lou McDermott: I was curious if it's 100 people or 1,000.

Beth Heston: The federal life insurance benefit is 1/3 paid by the government, the other 2/3 paid by the employee. That benefit is one times salary, rounded up to the next $1,000 - plus $2,000 on top of that. The average benefit for federal employees is about $83,000. But, again, they're paying 2/3 of that themselves.

We also looked at the public sector of other states. In nine states, there is no employer-paid life insurance. Five states have $10,000 or less. Five states are in the $15,000-$25,000 range. Two states have $25,000 - $50,000. And then, six states have one times salary. No states that we reviewed, in the total of 27 states, included spouse or child life coverage in employer-paid benefit.

Dave Iseminger: With that piece, we were trying to find additional benchmarks to provide you. The public sector, it's very hard to determine exactly when school teachers are included, or if it's other public sector pieces. We're trying to give you a sense in the public sector from what we can see, different pieces of information about different ways there is employer-paid life insurance coverage.

Lou McDermott: Sean, do you have experience with whether or not dependents are covered with basic? Or, is it usually just the employee?

Sean Corry: Both. It is usually just the employee. But in some cases, there is a small amount of dependent life that comes with the basic package.

Beth Heston: I'm going to talk about that now because one of the other pieces of feedback we got was that some school districts' medical plans have embedded life coverage for the employee, spouse, and dependents. Our comment on that would be under PEBB. Under SEBB, we believe the employee medical premium contributions will be taken as pre-tax deductions. When the benefit is paid, the beneficiaries have the tax burden. If you choose $50,000 of coverage and you pay with pre-tax dollars, when the $50,000 is paid, it won't be $50,000. The tax burden is subtracted from that. It makes the true value of the death claim a little less definite. As I said, depending on the given tax situation, the amount could be different.

Dave Iseminger: The other pieces harken back to the conversation about the cafeteria plan that Tristin Leppa-Sullivan provided last April. We were envisioning under the plan that medical would be taken pre-tax and save those payroll tax deductions, or lower taxable income on that piece. Life insurance would be on a post-tax basis. That way, an individual would have assurances that whatever amount they elected truly was free and clear under IRS rules at the time the benefit was taken. We wanted to make sure that, although there was the stakeholder feedback about this, there wasn't a specific request to have life insurance embedded, but, we wanted to make sure we explained to the Board what the assumption was about how those premiums would be paid and the reason for that recommendation.

Beth Heston: The other thing about including dependents, whether they're spouse or children, in the risk pool is that the employees seem to be relatively healthy because they're actively at work. When they subscribe, when spouses, state-registered domestic partners, and other dependents are included, there's no assumptions to be made about their health. That causes us to get higher risk scores because they don't know who they're getting. Higher risk scores generally mean higher rates. That's another drawback of having it embedded.

We had questions about whether employees' current insurance amount above the new proposed plan's guaranteed issue could be grandfathered. We are discussing the possible transition opportunity related to honoring some existing coverage amounts. It's still under discussion; and of course, our goal is to minimize disruption to the members as they come over. The next point brought up was that some school districts use a higher employer-paid life insurance coverage as a recruitment tool. We want to emphasize that, under the statewide risk pool, we can't offer varying amounts to different employees. That speaks directly to the equity of benefits. There was talk about that putting a district at a recruiting disadvantage, but when everyone's getting the same amount, no one has any advantage or disadvantage.

Dave Iseminger: Remember that this Board has the exclusive jurisdiction with regards to this benefit. The local school districts, ESDs, and charter schools don't have the ability to offer competing or additional supplemental plans beyond what this Board authorizes.

Slide 8 – Proposed Resolution SEBB 2018-30. Basic Term Life Insurance and Accidental Death and Dismemberment Insurance. We're not asking the Board to take action on this proposed resolution today. I want to highlight one small change that was

made to this resolution based on the discussion the Board had at the last meeting. At the end there is an extra clause that says, "unless modified in a subsequent resolution by the Board." This is true of all resolutions. I've tried to describe the iterative process that the Board can revisit different pieces, then some resolutions don't need to be amended. The policy idea is a separate stand-alone resolution. I felt the Board wanted extra assurances in this particular instance, so I did want to say that it would be true, regardless of whether those words were there, but I felt that the Board really wanted those words written in. We've added them in the current proposed version. We will ask the Board to take action on Policy Resolution SEBB 2018-30 at the October 4 meeting. We believe there will be even more context about the entire benefits package at that point.

Pete Cutler: As I wrestle with this, I think I mentioned prior in a Board Meeting, I'm a big fan of the life insurance benefit and the basic life insurance term benefit. In my mind, the accidental death and dismemberment insurance is roughly equivalent to having employer funds pay for lottery tickets. It's a benefit with no real basis in policy. I was wondering, would it be possible to split this into two separate resolutions, so when it comes time to vote, I can robustly endorse one and not have to go on record as endorsing the other?

Dave Iseminger: We'll take that under advisement; but, you can always put on the record, if there is any subset of a resolution that you're uncomfortable with, ultimately say yes or no, and describe all aspects of a resolution and your concerns about any part of any resolution. I will say that when the resolutions went out for stakeholder feedback, there was not a request to eliminate the AD&D benefit. The request was to increase the AD&D basic employer benefit. Apparently people want more lottery tickets. I'll remind you that, when you look at the total premium that's paid, for example, on the PEBB side, we spent somewhere between $6,500,000 per year on the basic benefit to the carrier. For the AD&D, the $5,000 benefit on the PEBB side, it's about $100,000. The cost of that, if you wanted to horse trade the money related to AD&D, it's such a small amount that there really wouldn't be much you could trade that for. That's another related factor.

Pete Cutler: I thought it couldn't hurt to ask. Secondly, if they are split, I will not feel bad at all if it's an eight to one vote; however, we have many members on the Board. I understand it's not particularly material in terms of the overall package of benefits, but there's just some part of me, my past life as a budget analyst, what I consider a rational benefit policy for an employer-paid benefit of this type, I prefer not to be on record in support of it. So, thank you. Whatever the Board or the agency decides, I'm fine with. Thank you.

Dave Iseminger: I think this record may be adequate enough to describe your lack of appreciation and support of that benefit. I think it will also be in the July minutes. So it can be in July, August, and October's, if you'd like.

Beth Heston: Slide 9 – Basic Benefit – Next Steps. We'll ask the Board to take action on the policy resolution at the October 4 meeting. If the basic life benefit exceeds $45,000, rates for both the basic and the optional coverage will be re-evaluated. But,

the optional benefit design would not need to be reconsidered because if we raise the amount of the basic benefit, we could have what we generally call "adverse selection."

Dave Iseminger: At the last Board Meeting, there were some questions. Could you take action on the supplemental benefit, because, if you ended up changing the basic benefit, what's the relationship there? That's the transition point to the rest of the presentation, which is asking for action on the supplemental life insurance benefit because the benefit design would not need to be revisited. We will go through the rates that go with the supplemental benefit design in the slide deck. If the Board were to consider a different benefit design, we would also try to describe to you the potential impact on the supplemental rates at the same time. But, they are sufficiently divorced from each other. We felt the Board could proceed with the benefit design on the supplemental benefit.

Beth Heston: Slide 10 – Recommended Supplemental Life Insurance Plan. This is the layout of the supplemental life insurance design, up to a guaranteed issue, with no evidence of insurability, no need to take a health test. The amounts over $500,000 would require evidence of insurability. That's for employees. And then, up to 50% of the employee's supplemental, with $100,000 for the spouse or state-registered domestic partner. A supplemental dependent term life of $10,000 - $20,000 in $5,000 increments. That is all guaranteed issue. And, lastly, the supplemental spouse, employee, and child AD&D, those are guaranteed issue, no need for -- can't medically underwrite an accident.

I spoke to MetLife just before the meeting to make sure I had the most recent statistics. When people sign up for the supplemental life insurance, if they choose to do EOI, they are asked to fill out the evidence of insurability questions online. Statistics are that 60% of people pass immediately and are approved for higher amounts. The evidence of insurability is not elaborate in that case.

Slide 11 – Supplemental Employee and Spouse Rates The rates listed are per $1,000 of insurance. You take the amount of life insurance in thousands, multiply it by these rates, and that will give you the monthly payment. All rates are guaranteed for five years.

Slide 12 – Supplemental Child and AD&D Rates. These rates are guaranteed through 2024.

Dave Iseminger: I want to talk about subsidization. I want to remind the Board that there are no premium reserves that can be used to subsidize any rates. If you take these rates and compare them to the PEBB population, you'll see that the PEBB Program population is paying less right now. As the PEBB Program transitions to MetLife, there are some premium reserves that needed to be spent down so there's a subsidy on some of those rates. Yours are comparable rates, when you take out the subsidization on the PEBB side. I did want to make sure that you were aware of that. Here, there are no subsidies or no premium reserves to use to lower these rates, even in a short-term period.

Beth Heston: The reason for that is it will be a non-participating plan.

Dave Iseminger: It's also because we're starting a plan and there's no money when you start a plan.

Beth Heston: The next few slides are examples of supplemental premium calculations. Slide 13 is for a smoker, 35 years old with $200,000 on himself and $100,000 on their spouse. They'll be paying $18 a month for their employee coverage and $9 a month for their spouse coverage. The example of the 50-year old non-smoker who chooses a $150,000 supplemental employee coverage, and $75,000 for the spouse, which is 50% of the employee's coverage. The rate is $28.50 per month. And $14.25 for the spouse. Slide 14 is child life with $20,000 of supplemental child life at $2.48 per month. Supplemental employee and spouse AD&D for $250,000 in coverage would be $4.75. $25,000 in supplemental child AD&D would be $0.40.

Slide 15 – Policy Resolution SEBB 2018-31. Supplemental Term Life Insurance Plans.

Dave Iseminger: When we went through stakeholder feedback earlier in the presentation, the stakeholder feedback was all about basic life insurance. There were no specific concerns related to the supplemental benefit we provided. There was one question, I believe sub-bullets 2, 4, 5, and 6 didn't have a reference to guaranteed issue. A few people thought there would be clarity at the resolution itself on guaranteed issue. The only change made was one piece of feedback clarifying guaranteed issue. GI was added to the end of all of the bullets, to provide clarity to the stakeholder response.

Katy Henry: Beth, can you confirm for me that it doesn't matter what the age or the smoking status of the spouse is?

Beth Heston: It's all dependent on the enrollee, the subscriber owns the account. So, it would be the employee themselves.

Lou McDermott: They're going to pay the smoking rate for the spouse, even though the spouse is a nonsmoker for the insurance? That's what we're saying, it all keys off the subscriber? If the subscriber is a non-smoker and the spouse is a smoker, we're paying the non-smoker rate for supplemental insurance for the spouse?

Beth Heston: Yes, because the way our plans work, the plan actually belongs to the employee, so, their status is what's most important.

Lou McDermott: For rates.

Beth Heston: For rates. Also, the age is based on the last day of the tax year.

Lou McDermott: **Policy Resolution SEBB 2018-31. Supplemental Term Life Insurance.**

Resolved that, beginning January 1, 2020, the voluntary employee paid supplemental life benefit will include:

- An employee supplemental death from any cause life insurance benefit of $500,000 guaranteed issue (GI), up to a maximum of $1,000,000 with medical underwriting for amounts over $500,000;
- An employee supplemental AD&D benefit of $30,000 up to $250,000 GI;
- A spouse or state-registered domestic partner death from any cause life insurance benefit of up to 50% of the employee supplemental elected amount with $100,000 GI and amounts over $100,000 with medical underwriting;
- A spouse or state-registered domestic partner AD&D benefit of $30,000 up to $250,000 GI;
- A child death from any cause life insurance benefit of $10,000 up to $20,000 GI; and
- a child AD&D benefit of $10,000 up to $25,000 GI.

Alison Poulsen moved and Terri House seconded a motion to approve.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-31 passes.

Dental Benefits

Beth Heston: Slide 2 Policy Resolution SEBB 2018-06 – Fully Insured Dental and Slide 3 – Policy Resolution SEBB 2018-07 – Self-Insured Dental, both passed by the Board on March 15, 2018. These resolutions will leverage features of the Uniform Dental Plan.

Slide 5 – Overview of ERB Dental. The Employees and Retirees Benefits Division has three dental offerings: DeltaCare Dental Plan, which is a managed care restricted network plan with 27,652 members enrolled; Uniform Dental Plan, a wide-ranging preferred dental provider organization administered for HCA by Delta Dental of Washington with ~226,000 members; and Willamette Dental Plan, another managed care plan with roughly 32,000 members. In the managed care plans, you have to see a dentist that belongs to the managed care plan. In a PPO, you can choose the dentist if they accept Uniform Dental. About 96% of dentists in Washington accept Uniform Dental. The majority of PEBB Program members have selected the Uniform Dental (PPO) Plan.

The proposed SEBB Program self-insured dental plan would be administered by Delta Dental of Washington. It would have the advantage of reaching that wide number of contracted providers. It would be like the Uniform Dental Plan, but with claims paid from SEBB funds, subject to financing decisions. The subscribers can see any provider that accepts Uniform Dental Plan. It is the preferred provider organization. It currently covers every county in Washington and some counties in Oregon and Idaho where it's accepted.

Slide 8 – Proposed SEBB Self-Insured PPO Option. We've shown you annual maximums for medical plans. An annual maximum for a medical plan is how much the subscriber has to pay per year. With a dental plan, an annual maximum is how much

the plan must pay during the year. So, they're not equivalent. The current deductible in the Uniform Dental Plan would be $50 for an individual and $150 for a family. I'm told it's a comparable deductible to the WEA plans.

Dave Iseminger: As a reminder for the Board, in the appendix is another recurring theme. We will always include the comparator slides presented at the Board for the various benefits at the December and January meetings. If you want to review the deductible pieces, it's Slide 2 in the Appendix. Any other parts of this benefit design, the other comparator parts, are in the rest of the slides and the Appendix.

Beth Heston: The general office visit, diagnostic, and preventative services are covered at 100%. Fillings and restorative dentistry, including porcelain crowns, is covered at 80%. Implants are not covered at 80%. We are discussing crowns that fit onto dental implants. Those are covered at 50%, but crowns that go on your live tooth are covered at 80%. Root canals are covered at 80%, and routine or surgical extractions are covered at 80%. Local anesthesia is covered at 80%. Dental implants and orthodontia are covered at 50% until the $1,750 maximum is reached.

Dave Iseminger: There's not a lot of orthodontia embedded within a dental plan in the current K-12 system. Where it exists, it exists as a stand-alone. This proposal would include that piece. We are aware there are a variety of different dental benefit designs that exist in the current K-12 world. There's the incentive plan design where, as you access preventive care in successive years, the cost share goes up over time. Part of what we're describing here is putting forward a self-insured option. I know as you read the resolution, you're going to see a lot of the words that say the same. One thing, as you look at a self-insured plan, thinking about the comfort level of taking on that risk, this is a plan design that many people in the state are familiar with the financing and costs associated with it. It will help make people comfortable with taking on that liability, as we've talked about, with the financing decisions that have to be made as this process goes forward. We will bring fully insured dental designs at the October meeting for consideration, and action at the November meeting. We are looking for the best ways to balance the different ideas of plan designs that exist, and see if there is a way to offer a variety of different benefit designs across the portfolio. Today's discussion is just with the self-insured plan.

Beth Heston: Slide 9 – Considerations. One consideration is to have statewide coverage with comparable rates to the PEBB Program self-insured plan. People in the state are used to the way the funding works. Orthodontia coverage is included. And, we believe that, compared to the other plans included in your appendix, we have a competitive benefit structure.

Slide 10 – Proposed Resolution SEBB 2018-37. So, the proposed resolution is SEBB 2018-37. 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 Dental Plan (UDP) 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 UDP benefit under the PEBB Program.

Dave Iseminger: This syntax should look very familiar to you. It's the same syntax used for Resolutions SEBB 2018-20 through 2018-33 about the comparability piece. It's akin to Resolution 2018-20. It is that exact same structure and language. At the beginning, Beth provided copies of Resolutions 2018-06 and 2018-07. For purposes of proceeding with launch, directly leveraging existing contracts and not doing a procurement was a good way to go, considering all of the work on the table. There is a request and commitment through that original resolution to engage in further discussions about dental benefit design in 2020.

Beth Heston. Slide 11 – Next Steps – October. The goal is for the Board to take action on the Policy Resolution 2018-37 in October. There will also be a presentation of the fully insured dental options in October.

Eligibility and Enrollment Policy Development

Barb Scott, Manager, Policy, Rules, and Compliance Section. There is one draft Policy Resolution to discuss today. SEBB 2018-36 - Eligibility Presumed Based on Hours Worked the Previous School Year. This Proposed Policy Resolution would ensure that if a pattern is established, it would be presumed that the employee is anticipated to continue working 630 hours in the current school year if they are returning to the same position or combination of positions with the same SEBB Organization. In order to be clear, we have included examples of position types which is different from what we've done before. If the employee is not anticipated to work 630 hours in the current school year, the SEBB Organization would need to inform the employee in writing and provide the employee with their appeal rights or how to appeal an eligibility decision.

In RCW, the SEBB Organizations will be required to notify employees of their eligibility, which clarifies if this presumption isn't true, then the organization would rebut by putting in writing as to why the employee isn't anticipated to work 630 in the current school year. Employees are always required, based on RCW, to be given the right to an appeal. That information would be included in the notice.

Dave Iseminger: We put in that parenthetical teacher, para-educator, food service worker, etc., to make sure it was clear to the Board and employers that we didn't mean 4th grade teacher of social studies couldn't become a 5th grade teacher of language arts. It was not that granular of a position. It was more at a macro level. We felt that would be an assurance to both the Board, as well as the stakeholder community employers, about what level of position was really met.

Barb Scott: Slide 5 is an example of a part-time custodian not anticipated to work 630 hours or more during the 2020-2021 school year. But, in March of 2021, he actually worked 630 hours and earned eligibility for the remainder of the school year. The question posed is, is the employee eligible for the employer contribution toward SEBB benefits when he returns to work in the same custodian position for 2021-2022 school year? The answer, based on the proposed policy, is yes.

Wayne Leonard: I think for a lot of these positions, to make an estimate or a determination if you think they're going to work 630 hours in a year, is difficult for the certificate in classified substitutes that might become eligible. If they continue, because

the need for substitutes can vary greatly from year to year, depending on illnesses or depending on the amount of training that you put on. That's one area I would have concerns about, not necessarily presuming a substitute would be eligible if they attained eligibility in one year. Not necessarily presuming they would be eligible in the following year.

Barb Scott: In the notice that would go to employees, would you see that being communicated in the notice so it says, "based on what we anticipate in this upcoming school year, we don't anticipate that we'll have need for you in the same capacity as the prior year?" It being communicated to the employee, based on their eligibility change, is required by RCW today. The employee would have the right to an appeal of that decision. We included that language at the bottom part of the resolution to make sure it was clear that, if it isn't anticipated to be the same, if there are differences, then that would be articulated in writing to the employee and they would have that right to appeal.

Wayne Leonard: It's not that we don't anticipate the need for substitutes. We don't necessarily have a good way to anticipate the number of hours they will work.

Dave Iseminger: Wayne, are you expressing that you'd have concerns about how an employer would give specific reasons of not anticipating 630 because that's what this would require in the substitute setting. You're saying as this applies to substitutes, as Barb's describing it, the employer would have to describe in writing why Katy Hatfield, who was a substitute teacher in year one, isn't anticipated to have 630 hours this year and you're concerned about the ability to describe that lack of 630 hours in year two?

Wayne Leonard: Part of it is the way we fill substitutes. It's not necessarily by calling and scheduling them. They can actively go online to most of our online systems and seek positions. They may not want to work as much as they did the prior year. Or, there may not be the same level of opportunities from one year to the next, depending on flu outbreaks or the number of professional development trainings. I don't have any way to anticipate the number of hours they would work in any given year because they're not scheduled. Most of our other employees have a schedule for 180 days, X number of hours a day where substitutes do not.

Dave Iseminger: Wayne, you're expressing concern with the application of the presumption in the first place, in the substitute setting.

Terri House: Just to piggyback on what Wayne said, I read the resolution as employees, so, that's contracted employees within the school district. That would be the teachers, the para-educators, food service workers, custodians, bus drivers, etc. Subs are at-will employees. They can work when they want, like Wayne said. I think there needs to be some delineation between actual school district employees and subs, in that resolution.

Barb Scott: This will show my lack of understanding to some degree, but it has been my understanding that some districts actually have substitutes that would be considered employees of the district where others may not.

Terri House: I can speak a little bit to that. Our district employees, in certain job classifications, are considered "rovers." That's an actual paid contractual job. They may be a roving custodian so they don't have a home base, per se, every day. They may report to a different school. But, they have a job every day. They're expected to be there every single day.

Barb Scott: In some districts?

Wayne Leonard: I would add on to that. They actually have a contract for a certain number of days, whether it's 180 days, whether it's 260 days. They just don't know where they'll be working. They are employees, as opposed to a substitute that, you know, may come once a week, four times a month, or whenever you call them. They may fill in on an at-will basis.

Barb Scott: Are these substitute teachers? Or bus drivers? When we use the word "substitute" are we encompassing many different job classes?

Wayne Leonard: It could be multiple. It could be both classified and certificated staff.

Barb Scott: Was there a specific change to the resolution that you were wanting us to look at making before we send this out to stakeholders?

Terri House: I think the delineation between what is a substitute employee and a contracted employee, an actual employee, is by district.

Patty Estes: I think the issue is the presumption that they're going to work 630 hours because they worked 630 hours the year before. If we put another bullet point in justifying substitutes, there could be something we're getting into whether they're under contract or not, they're still school employees and they're under our umbrella for benefits if they hit 630. We're putting the responsibility of eligibility for those employees on the school district, or on the employers. The employers would have to do some kind of letter because they're not anticipated to work 630 hours in a given school year until they hit that, then they wouldn't be eligible, because there's no way to anticipate whether a substitute classified employee is going to work 630 hours in any given year or not. I think Wayne and Terri both have good points from my perspective. There's really no way to know, from year to year, how many hours a substitute will work, whether it's classified or certificated.

Barb Scott: Am I hearing you want us to include an exception for substitutes that actually presumes they would not be eligible until they actually hit the number of hours?

Patty Estes: I would say something along those lines. My school district gives letters to contracted employees, classified or certificated, at the end of every school year. It's a letter of reassurance for the next school year. Substitutes don't get anything like that. Our substitute classified employees, I speak from experience because I was one before I became a permanent employee, it depends on whether you get that phone call and can go in for that day. Or, you don't get that phone call. There's not a set amount of hours. It goes on a year-by-year basis.

Barb Scott: We will take this away and work with stakeholders.

Wayne Leonard: When I went back and looked back at my certificated substitute roster, for example, we have somewhere between 250 and 300 certificated substitutes on our list at various grade levels and various subject matters they're qualified to substitute in. When I looked at how many hours they've actually worked in the year, I came up with an estimate that probably 70 of them would become eligible in that year. But, whether in the following year, the same 70 would become eligible, or a different group would become eligible, I would not have any way to know. Some may become eligible again. Some probably wouldn't. I wouldn't necessarily know at the beginning of the year.

Lou McDermott: Do we have any parallels in PEBB?

Barb Scott: We have two categories of eligibility within the PEBB population that come to mind.

PEBB has eligibility for seasonal employees. If you have a season of three months or more, you are eligible for benefits during your season. If you work a season that is nine months or more, you also get off-season benefits. (You're eligible for the employer contribution during your off-season.) That language in the PEBB eligibility stems from work done when school districts were mandated to purchase coverage for their active employees through the PEBB Program, back in the early '90s. We have been looking at the seasonal employee eligibility. In the PEBB world, there's a presumption that if a seasonal employee is brought back for the second season, they're presumed eligible.

In addition to that, PEBB has some complicated language that is very unique to part-time academic employees, specifically related to faculty hours. Their eligibility stays in place until it is not mathematically possible for them to attain the hours.

Pete Cutler: I think Barb, from a policy and overall perspective, a key differentiator here is that with the substitutes, they're not planning on coming to work every day. With seasonal, you may only work a couple months, but you are going to work almost always. It's full time, but even if it's part-time, you have a position and you will be showing up for work. Whereas, with this unique situation with school districts, it’s the employee.

My father was one, he decided once he retired, he was working as a sub when he wanted to work and not when he didn't, which is a very different dynamic. I share the feeling that it would be good to have a third bullet that carves out positions, or people employed in positions that are that substitute. Now, you have to be careful with the use of "substitute" because in the world of a pension policy that some districts call people "substitutes," in reality they are in for covering a full semester or almost a full year. Anything short of a full school year, some districts would call them a "substitute." It's not that the employee doesn't have the option of, "do I want to go to work this day or week?" I wouldn't want the label "substitute" to have them not be included by the general policy. I think an additional qualifier should be included.

Barb Scott: I've shared the concern about a label. There is some litigation history related to that, especially with higher education institutions. Applying a label, just saying that a substitute would not be eligible, reminds me of some of our history with PEBB. We've been trying to figure out the true differences. What makes one position unique, compared to another is really where we want to be. We'll work with stakeholders. If you have specific ideas you want us to consider, I want to capture those, too.

Terri House: Instead of saying "substitutes," taking into consideration no labels, we're considered "continuing employees." If we have a contract year to year, we're considered "continuing." Substitutes, on the other hand would be non-continuing employees and have to achieve those hours in order to be benefits-eligible. Could you use language like that in the resolution?

Barb Scott: That may be very helpful. The reason PEBB has the presumption for seasonal employees is because, through litigation and other work related to that, we found there was somewhat of a practice for employers to bring back employees that they described as temporary or intermittent employees. They worked them similar to how they would a seasonal employee. They would bring the same employee, the same firefighter, back year after year and not give them benefits.

Working to put PEBB eligibility into RCW, where it lives today, was complicated. Working with a number of different stakeholders in order to get that legislation, we came up with the need for a presumption for seasonal employees. That's why we're exploring it here, to figure out if SEBB needs something similar to make sure the eligibility groundwork is laid, and employees know when they're eligible for the employer contribution and when they're not. If there is an appeal, we need to have sound eligibility to support us in that.

Sean Corry: There wouldn't be a problem with districts dealing with this presumption issue to take their time in presuming, leaving it to maybe having a 600-hour threshold, for example, before they're in the queue for the presumption of working 630. 600 sort of pushes it. That's only three days, four days off of 630, but, if you were to set up some sort of watch so you get a pop-up at some point, that might be helpful. Just a practical thought that I wanted to put out there.

Lou McDermott: Barb, in the PEBB world, I know the presumption is a little bit in the eye of the beholder, right? Different agencies apply that differently. Not that we would want them to, we would love it all to be uniform. But, different agencies have different books of business. I'm speaking to Sean's comment, that presumption of 630, many districts could come up with that in a different way.

Some districts could look at the previous years' experience. I know that may not be the best way based on your comments about sickness and turnover and things like that. But some districts, maybe large districts who have the law of numbers, say, "Everyone who got over 630 last year, and if they're on the rolls this year, we assume they're going to get over 630." Then, maybe having a break somewhere that says once you hit this certain amount, we look at how much time's left in a year and we give it to you. Would districts have flexibility to decide what that presumption is going to be?

Barb Scott: I guess that's how we set it up to some degree. In the PEBB world, you're right, not every employer administers it exactly the same, based on their own business needs. For example, I know in working with some of them that we pretty much know there's going to be a certain number of fires and a certain need for a core set of firefighters every single year in Washington State.

The Department of Natural Resources is going to know that they're probably going to need a certain number of pilots and a certain number of firefighters. They know there is going to be a core season. The season may run long on either end of it, or the season may run short. The season may be a horrific season and they have to bring in an additional 20 firefighters they weren't expecting.

In some of those agencies, they've said there are 70 seasonal positions. If it happens that Scott is brought back each time into one of these 70 positions, then we're anticipating for him to work the full season every year and we bring him back every year. But, if we bring Joe into one of the 20 slots that we need because we're having a really bad year, we don't anticipate we're going to bring Joe back the next year. He's going to get the letter saying, "We don't anticipate you're going to be back next year, so your eligibility ends on a specific date." You're right, Lou. They do it differently depending on what their business needs are within the different agencies. I would expect that we could do something similar to that for SEBB, but I haven't thought it through or worked it with stakeholders.

Dave Iseminger: I think, Lou, in your description you might have implied that there is a 630-hour presumption in the PEBB requirements. While there is a presumption, I don't want it to be implied that it's exactly the same one in here. There is a presumption, I don't think it's 630, and I don't think it matters what the number is.

I think you're brainstorming in a couple of different ways. This is a very difficult process for finding the exact words to use. We'll certainly look at if there a way to reference continuing employees, not using labels. We'll go back and look at the definition of school employee in statute and reconcile things there. Maybe there's a way to do a presumption, a threshold before the presumption kicks in. We appreciate the different ideas. We will do some work on this and still hit that two-business day promise to stakeholders of getting things out. We will definitely take back some of these ideas.

Katy Hatfield: One thing about seasonal workers that's a little bit different in the PEBB world than in the SEBB world that I think is important to keep in mind is that, for PEBB, with seasonal employees, it's not just about working the season that makes them benefits eligible. It's also a secondary requirement that they're expected to be a repeated seasonal employee. If you get hired for one blueberry season and you're only going to work for one blueberry season, you don't get benefits. It's only upon the employer thinking that they're going to come back the next year as well. The presumption in PEBB is about presuming the person is coming back again once they've established a pattern of coming back every year, and you don't have that kind of overlay in SEBB where there's going to be a situation where somebody needs to be presumed to be working the next year to be benefits-eligible. Keep that in mind when you're thinking about brainstorming how to do that, because the seasonal employees for

PEBB, while it is interesting, and I think it's important to look at, it really is quite different than SEBB.

Barb Scott: That's true. They aren't even apples and oranges. In the PEBB world, there is language that says the employee is going to work a season of three months or greater, so it's between three and 11 and the employee is going to work the half-time threshold, which is 80 hours a month for the PEBB Program. Also, they are anticipated to return the following season. It's that "anticipated to return the following season" provision that exists in the PEBB eligibility, which does not exist for SEBB. Part of the difficulty here is that PEBB, through evolution, litigation, and years of work, has substantial eligibility in RCW. SEBB does not yet. We're working off very minimal language in the RCW.

The next step will be to send this out to stakeholders, and bring something back to the Board on October 4. I won't see you, other than in the audience, maybe, on September 17.

SEBB Program Rule Development Plan and Process

Rob Parkman, Policy, Rules, and Compliance Section. Today we'll take a look at our high-level plan, which is our two-year plan we started about ten months ago.

Slide 3 – High-Level Rule-making Timeline. We started our timeline on November 3, 2017. When the program was starting up, we started to work on rules planning. We actually started the development for what we're calling the first cycle, or first phase, which we're in right now. We started that in February 2018 through the end of the year. February was work groups trying to figure out the RCW and figure out a path. Since then, we have actually developed rules and sent them out for stakeholdering.

We'll rapidly transition into the second year, almost the next day. We'll start the second phase or cycle. Within that, we're going to start in early January and be done by October, which is open enrollment. And then, we go live January 1, 2020.
From a rule-making perspective, we need to be done by July 2019. Rules are the starting point for other products that support open enrollment and Go Live. If we wait too long, the other teams will not have time to do their work. We are on a fast pace to baseline rules that can be used to run the program.

The goal for year two is to make additional tweaks to rules from the first cycle and add other rules as needed. We won't be able to get all the rules done in the first cycle. We have already identified rules for the second cycle.

Slide 4 – 2018 SEBB Program Rule-making Plan. This graph is the HCA rule-making plan sheet. The legend on the bottom left has a triangle that's actually statutory requirements we will follow. The oval identifies HCA requirements. Starting at the top left corner, we start with the CR101, which is one of the formal rule-making products we need to produce. We started working that in May and turned it into our rules coordinator on June 1. She filed it with the code reviser on June 6 and our CR101 was published in the Washington State Register on June 20.

Dave Iseminger: Rob, a CR101 is trying to describe the scope of the forthcoming rule-making. It's a very high-level description of the work that's about to be done under The Administrative Procedures Act rule-making process. It's very high level.

Rob Parkman: Correct. For this one, since they're all new rules, we opened three new chapters and we will be conducting eligibility, enrollment, and appeals within these chapters. Then, on the left side coming down vertically, you can see where we've actually done a lot of the drafting and stakeholdering. That began on February 1 and went through July 20. That's where we developed the first set of rules and sent them out on July 21 through the first part of August for internal review. The internal review is the inside HCA review with a little legal help outside of HCA. That produces multiple comments, which shapes the future product. That shaping happened in mid-August this year. The blue box is the external review, and that's where we stand now. That was sent on August 20 and it should be concluded by tomorrow. We already have multiple comments and have started to work.

Dave Iseminger: Rob, can you tell the Board how many stakeholders currently receive the rule-making products?

Rob Parkman: We send to the same group of stakeholders we sent all of the proposed resolutions to, which is a group of about 10 or 15. We sent it out through GovDelivery, which is about 450 email addresses. It was the first time we used GovDelivery for rule writing. It was a very broad reach.

Dave Iseminger: Anyone can sign up for the rule making on the Health Care Authority's website.

Rob Parkman: I want to talk about the external review document that was sent out on August 20. Today's Board meeting had a number of resolutions, three of which you passed. Those are in that document. We were trying to get as much into it as we could because external stakeholdering is a key piece of the process. We don't want to add too much after we get through external stakeholdering. One thing I did add that I will soon be taking out is Policy Resolution SEBB 2018-32. It was withdrawn today so it will come out of this external review. We will not be moving forward with that at this time.

Dave Iseminger: Rob, similarly, if the Board had delayed action on one of the other resolutions today, or had not taken action on it as had been anticipated, those pieces would have been removed as well. We don’t presume to know what the actions of the Board will be, but it's easier to pull than it is to add. That's how the annual rule-making process works.

Rob Parkman: We’re trying to get as much as we can in the first cycle. Once we complete the external review tomorrow, next week and through the middle of September we will be reviewing those comments and probably using them to shape the next document, which is the CR-102 document. This is our last review before the CR-102 cycle. After we get done in mid-September with external review, we go to the typing service. Mid- to early October we will be sending to the typist who put it in exactly the right form the Code Reviser needs. Across the bottom now is the CR-102 on the left, and then the CR-103 on the right. We will file the CR-102 through the HCA

rules coordinator on October 19, file October 24 with the Code Reviser, publish on November 7, and hold a public meeting right after Thanksgiving, which is an open public meeting for anyone to provide comments on the rules.

We will file the CR-103 on November 30 with the HCA rules coordinator. She will file those on the December 5 and they become effective January 10. That will be our first year of rule making.

Dave Iseminger: Your takeaway from Rob's presentation is that this is a very complex process, which the agency has a lot of experience with.

Rob Parkman: Slide 5 is the 2019 SEBB Program Rule Making Plan. We start the next drafting of rules on January 11. Very similar slide. Just the next year. I'm going to start with the upper left blue box. The last plan ended on January 10 and this plan starts on January 11. We will start rule writing in the fall and winter, so we can roll right into it. It's a much shorter rule writing this time, with internal review in March, and then out for external review. The goals is to get the rules in place so our Communications Team can start to produce necessary documents and our Outreach and Training Unit can start to produce the documents they need to support open enrollment and Go Live on January 1, 2020.

Slide 6 – SEBB Program Rules High-Level Authority. The green box in the middle of the slide is the Washington Administrative Code (WAC). That is what we are producing. We have authority to produce those rules from multiple places. At the 12 o'clock position is this Board. The power for this Board comes from RCW 41.05.740. A vast majority of the resolutions that Barb Scott has been bringing to you over the last few months directly flow into the rules. At two o'clock position, you see the Revised Code of Washington. There are other RCWs that influence the rules, for example, the other parts of 41.05 and Title 48, which is the insurance code. At about the 4 or 5 o'clock position, you see the state budget. Besides the money that comes out of the state budget, which is very important, but, not so much of a rules impact. A rules impact is a budget proviso that requires us to do surcharges. From that, we get the spousal surcharge, spousal/state-registered domestic partner surcharge, and the tobacco surcharge. Those are included in rules.

Dave Iseminger: The budget proviso, if you want to go find it, is in Section 504 of the budget. It's in the 500 series.

Rob Parkman: Correct.

Dave Iseminger: I believe it was also included in your Board packets in either April or May as the authority for some of the resolutions this Board passed related to setting tobacco use and tobacco product definitions.

Rob Parkman: At about the 7 o'clock position, is the Health Care Authority. The power for the Health Care Authority comes out of 41.05 RCW and, in particular, the major impacts is the appeals. The authority for appeals is with the Health Care Authority. We also have the cafeteria plans, and run the programs. Around the ten or eleven o'clock position, you have federal laws. They certainly do impact. The rules that are out now

are a section on COBRA and a section on the Family Medical Leave Act, or FMLA, which, again, are related to federal legislation.

Slide 7 – SEBB Resolution Tracking. This slide is a tracker of what we currently have going on. All the resolution numbers that come before the Board are tracked on this spreadsheet. We track them not only for where we are right now, but for historical purposes. I have done a little filtering and you can see that we have 2018-12, 2018-26, and 2018-27. We also track the description. We show these are currently active, they were passed by the Board, and the date they were passed by the Board. The box on the right shows the WAC in which the resolutions were incorporated.

This is a living document. At some point, you could change any of these resolutions. I will make the resolution inactive and indicate it was superseded by another resolution. Then, I would track that other resolution to where it's actually used in rules. Over time, this will help us keep track of how we make changes.

Slide 8 – Draft SEBB Program Rule. This slide is an extract out of the current WACs currently out for external review. This particular one is WAC 182.31.040, establishing eligibility. The first big block says, "Sub 3 school employees eligibility criteria." It's the actual resolution you passed, SEBB 2018-12, and now it has been incorporated into rule. The smaller box on the right is SEBB 2018-27 and the bottom box is SEBB 2018-26. This slide is the flow down from your approved resolutions into rules.

Pete Cutler: On Slide 7, where you make the references to its use within WAC 182.32.040, or whatever. I'm 99% sure you're talking about these are proposed rules or proposed drafts? We really don't have any rules just yet, but we have drafts.

Rob Parkman: By January 10, 2019, we would hope to actually have effective rules.

Pete Cutler: And then they will be the actual rules? Great. Thank you.

Rob Parkman: Slide 9 – SEBB Program Rules Structure. This is a living document. As of August 10, the asterisk at the bottom indicates changes can be made. Actions of the Board influences that change. There are three chapters: 182-30 – Enrollment Chapter, with 12 sections; 182-31 – Eligibility Chapter, with 18 sections; and 182-32 – Appeals Chapter, with 45 sections. At this moment, we have 75 sections, 64 of which are currently out in external review and we are processing in this phase of rulemaking.

Next SEB Board Meeting
September 17, 2018
1:00 p.m. – 2:30 p.m.

Combined SEBB & PEBB Meeting
September 17, 2018
2:45 p.m. – 4:45 p.m.

Potential Agenda Items for September 17, 2018 Board Meeting

Dave Iseminger: At the September 17 meeting, we'll discuss the vision benefit stand-alone resolution along with reviewing stakeholder comments received; disability benefit designs and propose resolutions for action in November.

We'll have a joint meeting with the PEB Board for further discussion of the K-12 Retiree Report that's due from the agency at the end of the year.

I have one item to correct in the record. I forgot to do it while Beth was here. Under Tab 11, in your Appendix, Slide 3. We realized we switched the framework as we were moving from left to right over the columns. On Slide 3, on one of the dental comparison charts under the Health Care Authority PEBB benefits, it says preventive screening -- zero dollars. That framework was from the members' perspective. But, the entire rest of the chart is from the plans' perspective. If you look at preventive screenings for the Health Care Authority column, it says zero dollars, but then in the other columns it says, 100% paid. It should be corrected in the Health Care Authority column that the preventive screenings are 100% plan paid. As we prepare these comparisons for the fully insured at the October Meeting, we will make that correction as well, but I did want to make that correction on the record.

Lou McDermott: Thank you, Dave. Again, I want to thank you and your staff for all the work and I want to thank the Board members. These are long days and the topics are complex and there's lots of questions. Answers aren't always readily available and there are delays on getting answers, so, I appreciate all the work you're putting in.

Meeting Adjourned at 3:40 p.m.