Washington State Health Care Authority

School Employees Benefits Board
Meeting Minutes

October 4, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 5:00 p.m.

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

Member Present by Phone:
Wayne Leonard

SEB Board Counsel:
Katy Hatfield

Call to Order
Lou McDermott, Chair, called the meeting to order at 9:00 a.m. Sufficient members were present to allow a quorum. Board self-introductions followed.

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

August Board Meeting Follow Up
Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division, provided updates to Board questions from the August 30 and September 17 meetings.

Slide 2. I believe Terri asked for a copy of the talking points from Kayla Hammer's presentation about the data sets and the chiropractic, acupuncture, and massage therapy limits. The talking points are in bullet format and included in your materials today.

During the same K-12 data description presentation, Pete asked that the Board have access to a complete copy of the data elements within the various data sets. We've

been working on pulling that information together. It proved to be a little more difficult for getting to this meeting, but we will provide it when it's completed.

At the September 17 meeting, we talked about the disability benefit. I will confirm that we have the Employment Security Department, the state agency that's implementing the Paid Family and Medical Leave bill that we talked about in the context of the short-term disability benefit, will be coming to the Board's December meeting. They will provide more information about how that benefit for all employees across the state is being built and to answer some of the questions you had.

Because our September 17 meeting was barely two weeks ago, questions asked about the frequency of Long-Term Disability (LTD) claims, the utilization of the LTD benefit, and taxability provisions with disability payments will be presented to you when we bring long-term disability back to the Board in November.

Collective Bargaining Results

Dave Iseminger, Director, Employees and Retirees Benefits (ERB) Division and Megan Atkinson, Chief Financial Offer, Financial Services Division, provided an overview of what's in the Collective Bargaining Agreement for SEBB benefits.

This summer we began a journey with the super coalition for statewide collective bargaining on health benefits. As Slide 2 indicates, the statute specified we bargain over the dollar amount to be contributed for school employee health benefits. This process will be conducted in even-numbered years.

Slide 3 – Bargaining Timeline. Under statute, we could officially begin the process on July 1. We had multiple meetings with the super coalition. The state team was led by state Human Resources and chief negotiator, Diane Lutz. HCA and OFM staff were subject matter experts to provide context to the bargaining. We had multiple sessions with the super coalition that resulted in a tentative agreement in mid-September. Then the super coalition went through a ratification process and the tentative Collective Bargaining Agreement was ratified. This past Monday it was transmitted to OFM with all the other Collective Bargaining Agreements that were negotiated over the past summer, for the director of OFM to do the financial feasibility study. The transmittal occurred on October 1. We couldn't send you materials until after the transmittal occurred. That's why you got your Board materials on this particular slide deck on Tuesday, instead of last week with the rest of the materials.

The next steps in the process is that OFM will do the financial feasibility study after the November revenue forecast and then there will be a submission about the financial feasibility for this Collective Bargaining Agreement, as well as all other Collective Bargaining Agreements to lead into the governor's budget, which leads us into the legislative session in January.

Slide 4 – Medical Benefit Funding. There are different provisions within the Collective Bargaining Agreement. The first one highlighted here is funding of the medical benefits. What the super coalition and state ultimately bargained over was an "employer medical contribution" (EMC). This is a funding amount specific to the medical benefit part of the portfolio. There are multiple benefits within the program, but this particular part was focused on a dollar amount called the "employer medical contribution" that the state

would pay out through the school districts, that then funnels to the Health Care Authority for the purposes of the medical benefits. For plan years 2020 and 2021, the EMC is specified as "a dollar amount that will be equal to 85% of the monthly premium for the self-insured plan UMP Achieve."

Megan Atkinson: Achieve 2.

David Iseminger: I'm not sure if it's Achieve 1 or Achieve 2.

Megan Atkinson: Anyway, it will be the 88% AV plan. .

David Iseminger: I'm pretty sure that's Achieve 2. The important part is it's 85% of the monthly premium of the self-insured plan that is an 88% Actuarial Value (AV). The Collective Bargaining Agreement language says the plan that's similar to UMP Classic, 88% AV. This effectively means when the portfolio has plans that have lower AVs, if an individual elects that plan, the state contribution will cover more than 85% of the premium. If an individual selects a plan that's more than 88% AV, the state contribution will cover less than 85%. It is very different from the PEBB world that some of you may have heard about.

On the PEBB side is a tiered weighted average of all plans. On the SEBB side, for at least the start of the program and this collective bargaining process, a flat dollar amount is applied to an 88% AV plan. Part of the reason it's different for the two programs is when collective bargaining started for the PEBB Program, the benefits had been around for 15-20 years. There was a lot of data. People knew everything they were bargaining. There is a chicken and the egg issue for basically everything in the SEBB Program, and this was deemed the best way to move forward with the amount of uncertainty on both sides.

Megan Atkinson: Essentially what we're doing by establishing a set employer medical contribution, 85% of the AV plan, that's essentially the state's bar in terms of providing the state's portion of the medical contribution, a certain benefit level. That's the state's view. Then, if the employee wants a richer benefit, you are essentially putting the employee in a position where they can decide if they want to buy up to a higher AV. Those of you who either make your own decisions around an open enrollment period or who have been more involved in health care purchasing, there is a lot of policy discussion around putting individual consumers in somewhat of an economic situation around the benefit richness of the plan that they choose to enroll in. That's essentially what we have set up now where the state's deal is 85% of an 88% AV plan. The employee has the ability to buy up into the richer plans in the portfolio.

For the plans that have a lower AV, to Dave's point, the employee gets more than 85% of their contribution covered up to a certain floor. We've essentially set up the ability for employees to make economic decisions based on their own family situation, their own preferences, their own risk profiles.

David Iseminger: The third bullet on Slide 4 references the floor. The Collective Bargaining Agreement also indicates there will be an employer contribution on all plans. It sets that employer contribution at no less than 2% of the employer medical

contributions. For example, if the EMC by the state is $500, that means the minimum monthly employee contribution for a plan would be $10, which is 2%.

Pete Cutler: Does the 88% AV value correspond to a gold level plan, if it were on the federal health benefit exchange.

David Iseminger: Yes, Pete, it does.

The last bullet on Slide 4 clarifies the EMC that's paid by the state would be paid across all tiers. Policy Resolution SEBB 2018-14 had the tiered ratio of 1 for a single subscriber, 2 for subscriber and spouse, 1.75 for subscriber and child or children, and 3.0 for subscriber, spouse, and any children. That ratio would be multiplied across the EMC and the EMC would be paid across all tiers.

Pete Cutler: I just want to confirm. Am I right that in prior years the dollar amount that was negotiated was more broadly for insurance benefits and included what would be provided as funding for the dental benefits, etc., whereas this year, it's focused, in the collective bargaining, on the contribution for medical care?

David Iseminger: Pete, I think when you're talking about prior you are really comparing to PEBB?

Pete Cutler: Yes. Thank you for clarifying that.

David Iseminger: The structure of this Collective Bargaining Agreement is similar to the PEBB Collective Bargaining Agreement. In PEBB, there is a section about the medical. It's not expressly called the employer medical contribution in that Collective Bargaining Agreement, but the first provision of the health section of the PEBB Collective Bargaining Agreement is about the part the state is providing for medical. That's where it refers to a tiered weighted average of 85% of the medical plans. Then, there is a separate provision, which I'll go through on a different slide, about the other benefits that are 100% fully paid by the state. There is a parallel structure between the two programs' Collective Bargaining Agreements. They were separately described in PEBB and they continue to be described separately in SEBB.

Pete Cutler: Thank you.

David Iseminger: Slide 5 – EMC Concept Illustration. We used round numbers that would be easy to digest. Don't get these numbers stuck in your head. I've tried to model Megan's request to not use numbers that are so close to reality that it starts to stick in people's minds. This illustration is just to show exactly how the employer medical contribution works and the relationship between the EMC and that floor threshold of an employee contribution. And, apparently, here's the confirmation that it is indeed Achieve 1, the 88% AV plan.

Megan Atkinson: Or we're consistently incorrect.

David Iseminger: At least we're consistent in our slide deck. The top of the slide reminds you of the four different tiers. The tiered ratio is in the grey row near the top of the slide and that is the tiered ratio from the resolution from several months ago. And

then, by plan. We're simplifying it and showing you the two Achieve Plans, as well as UMP Plus and not showing the CDHP Plan at this time. It shows how the math would work, what the employer medical contribution would be, how that represents an 85% split, and how it multiplies across, exactly what it would look like. These illustrations would be the employee contributions for those plans. This was just an illustration showing you the math of how those provisions would work out in real time.

Megan Atkinson: This allows you to see that the EMC, that middle row in each one of the larger rows, remains the same across the different plans, whether $200, $400, $350, $600. You can see as you change the actuarial value of the plan, the employee contribution, the bold row, changes as well. If you look at the employee only column, you've got an employee contribution going for $15, $35, or $25. We're showing these all in terms of the UMP products, but this holds true if an employee chooses a managed care option. If we use these numbers in this example, the employer medical contribution of $200, if an employee enrolls in a managed care product, that $200 would also apply to the managed care product program.

Sean Corry: I noticed when I was scanning across these imaginary premiums that the cost for a family is not the same number as it would be if we added up the components of the family. Could you explain why that is? When we add, for the top line, $430, $376, and $215, it doesn't total $645. There are variations in that. I've seen this before in commercial business and that might be helpful to explain why a family rate with dependent children or spouse or partner, the premium's not the same as the total of the individual parts.

David Iseminger: Essentially, the answer to your question is, again, why the Tier 4 ratio is set at 3.0 instead of 2.75 because if you added up the sum components, you would get to 2.75 instead of 3. At the time, when we brought the Board the resolution related to the tiered ratio, I remember very clearly Megan saying there is no perfect tiered ratio. What you're really talking about is how different parts of the population are subsidizing each other. I believe we presented some information about if you compress the tier ratio for the fourth tier at 2.75, like it is in PEBB, we described before your vote about what that additional compression would look like. Our recommendation to the Board at the time was, because there's no perfect number and there's already a lot of shock that's going to go in the system because of all the changes, and the statute allows the Board the discretion up to 3.0, that we recommended going with 3.0 for that ratio. Even though, as Sean's pointing out, it is more than the sum of the parts. Are there things that I missed, Megan?

Megan Atkinson: I think Dave did a good explanation. The math isn't additive math across the tiers. It's multiplicative math using the single employee only amount times the tier ratios. To Dave's point, the obvious ones are if you have a single employee of 1.0 and you have employee plus spouse or partner, essentially a single employee is one adult, employee plus spouse or partner, two adults. That's the easy, logical one that makes sense to everyone. You've got 1.0 for employee only. It is 2.0 for two adults, employee plus spouse. When you get to the next two, the employee only as the only adult plus child or children, and then the employee, partner, spouse, and child/children, those two tiers are where some of the data, the science, and the art comes in on how you want to set up the tier ratios.

I don't know if you recall that information, that conversation, around the child load in PEBB on the employee plus child/children versus that fourth tier and how that looked. We talked about you can chase the data and try to get really exact, but the reality is, you're chasing the data. Also remember that the tier ratios aren't changing the total cost of providing the plan benefit. They help you allocate the cost, the employee's contribution to the cost across the population, and how you segment that population into the different tiers or different segments.

Making the distinction of a 1.75 and a 3.0, it's not intended to exactly replicate the costs associated with each one of those tiers. It's helping you set the relativity of how, from your tier with the fewest number of people in terms of individual subscribers, the fewest number of people per subscriber as your single employee, that's only a 1.0 to your tier that has the most number of family members per subscriber, your employee, spouse/partner, child/children tier and how much distance you spread between those. How much the single employee is subsidizing or not subsidizing that latter tier. Again, for tier ratios you need to use some data in establishing them. They don't change the total cost of the plan that you need to provide. It's helping you distribute that cost, and setting that relativity across the tiers. So, Sean is correct. They won't add up. But the math should work as you multiply across.

Lou McDermott: Megan, just for simplicity, we know that as we move the tier numbers around we're going to have winners and losers, to put it bluntly. If we go from a 3.0 to a 2.75, describe the winners and losers.

Megan Atkinson: If you went from a 3.0 to a 2.75, the employees that enroll in that fourth tier would pay lower than they would have otherwise. Your other tiers would pick up that cost because, again, the total size of your cost would be covered, regardless.

Pete Cutler: Changing the topic. Under the column that deals with the actuarial value that lists the different UMP Plans, they are listed in the order that they're increasing in actuarial value, 82%, 88%, 90%, and the first two make sense that the employee contribution for the one where you have more out-of-pocket cost is lower premium to the employee because they pick up more. When you get the Achieve 1, you're going to pay more premium because you have lower out-of-pocket costs. But then, when you get to UMP Plus, with a 90% AV, your costs as an employee go down. My guess is this has to do with the accountable care networks and there's an assumption that there'll be significant savings from those aspects of the plan that will offset the fact that there's less point of service. I just sense intuitively, for somebody without a further explanation, it seems counter-intuitive that employee cost would go up and then down. I just would like to confirm that's what's driving that reaction, or that outcome.

Megan Atkinson: I actually want to go back and double check with the staff. When we pulled this together, we were trying to do an illustrative example. There's a possibility we might have illustrated this and not got it quite right. As soon as you started talking about it, I realized you have a very good point. Setting aside the numbers on this chart, there are obviously certain things we're trying to achieve for the portfolio, with the plus offering. That is around both increases in quality and the value proposition for the members. Dave, do you want to talk more about that.

Lou McDermott: I can probably take a swing at that, too.

David Iseminger: Let me say one thing before you do, Chair McDermott. I don't think that the slide's wrong because in the PEBB portfolio, the UMP Plus Plan does have a lower employee cost share than UMP Classic, which is the PEBB's 88% AV plan. A lot of that has to do with the contractual risks and rewards built into the network contracts with the Puget Sound High Value Network and the UW Accountable Care Network. Part of how this benefit is funded is the assurances of hitting certain financial metrics. That funds a lower premium to make it attractive for members to go into and have that coordinated care. I do believe that the illustration is illustrating a correct phenomenon that is counter-intuitive.

Megan Atkinson: I think part of what we wanted to illustrate with this, though, is how the Collective Bargaining Agreement works. Setting aside the uniqueness of the UMP Plus offering, as we were explaining initially, as a member chooses to move into a higher AV plan, a higher AV plan is going to have a higher premium associated with it, and the employer medical contribution will not float as an employee selects either a higher or a lower AV plan.

Pete Cutler: Thank you. It helps to have that discussion on the record.

Wayne Leonard: I want to check my understanding on a couple of points. One is the follow up to what Pete asked. The EMC only relates to the medical benefit, is that correct?

David Iseminger: The employer medical contribution is specifically for the medical benefit part of the portfolio. There's a separate provision that I'll go into where the employer covers 100% of specified other benefits. The EMC that we're talking about is specific to the medical part of the portfolio.

Wayne Leonard: I'm trying to make the leap between our current K-12 world and what you're talking about. Right now we get an allocation that covers the entire basic benefits package with pooling. Our out-of-pocket expenses are determined afterward. But, with this plan, pooling goes away, but we're still getting some allocation that's covering the entire basic benefits. But, right now you're just referring to the medical portion of it?

David Iseminger: Wayne, for the purposes of the Collective Bargaining Agreement, there are separate provisions for medical and other benefits. What you're describing, I believe, is the funding rate that the Legislature puts in the budget that is then pushed through the mega model that goes to OSPI, to the school districts, and eventually to the Health Care Authority. It's a rollup of a lot of different components. One of those components will be the EMC. Other parts of that funding component in the state budget will be the allocation for the other benefits. We're just starting to describe the separate components of what will eventually be a rolled up into the funding rate number that is in the state budget. We're only describing a component of what you're currently receiving and then we'll move on and describe other components.

Wayne Leonard: Okay. The reason I ask is that in the last several meetings there's been discussion about increasing the life insurance benefit or the long-term disability benefit. And I just want to clarify that it's all included in the same manner. If we

increase benefits in one area, there's no effect on cost in other areas. I just want to interject my understanding of that.

Megan Atkinson: Wayne, to underscore what Dave's talking about, I think we have been talking globally about the total benefit package and then the total cost proposition for the state that will be presented to the Legislature. That's really going to be the total cost of the Collective Bargaining Agreement, the impacts of the FTE and head count hiring decisions that happen in the school districts. But, for the Collective Bargaining Agreement, to Dave's point, we had the employer medical contribution, which, again, is medical. It's medical and pharmacy but it's a medical benefit. Then, we have the other components that Dave's going to talk about next. Those costs for the benefit offering plus costs associated with the agency administration, building reserves, the loan repayment that has to happen for the start-up costs that were fronted to the SEBB Program, those total costs of operating the program. They get rolled up into a funding rate. And that, I think, is what you're used to seeing, that's specified in the budget bills and then rolls out through your apportionment.

Wayne Leonard: Correct. And will you be touching on whether this overall funding rate includes the K-12 remittance?

David Iseminger: Yes, we will. And the answer to that question is yes, it does.

Wayne Leonard: Okay. Thank you.

Sean Corry: Just to reinforce a point that's come up again, which is that all of the decisions that we are pondering now and will ultimately make as recommendations for funding lead us to the point that the funding request and the funding amount is not yet fixed. It's not yet a zero sum game, when we're considering alternative levels of coverage, for example, on life and disability insurance. If that becomes the ask, that becomes the ask. So, understanding how a zero sum game works, if you take a buck, you have to take a buck from some place to spend it in another place. But we're not quite there yet, because we don't have the fixed dollar amount. So, I'm encouraging the Board to remember that when we're considering what I would think to be, in my view, what will be moderate, maybe modest, changes in life and disability benefits compared to PEBB. But, even still, dramatic deductions in life and disability benefits that are enjoyed by virtually a huge percentage of school employees now.

David Iseminger: I've a little bit of additional context for that piece, but I want to get to it after I get through the 100% portion of the Collective Bargaining Agreement. I'll pick up on that thought in a moment.

On Slide 6, the second part of the Collective Bargaining Agreement is describing benefits that the state will pick up 100% of the premium cost. It includes both dental and vision. The language in the Collective Bargaining Agreement is, "…any offered standalone vision…," because at the time a tentative agreement was reached, the Board had not yet taken action on having a separate vision. Therefore, if the Board hadn't carved out vision, it would have been embedded in the 85% medical because vision would have been with medical. But, since it's carved out by your action, it will now be 100% paid by the state, along with dental. And, because not all districts were used to having the employer contribution paid across all tiers, the language in the

Collective Bargaining Agreement is clear that for dental and vision, it is all tiers picked up 100% by the state, regardless of how many dependents are included on the plan.

Pete Cutler: Dave, just to be clear. There's certain positions. There will be some that will be funded by employers rather than from state money.

David Iseminger: Yes. I am sorry for oversimplifying that. Thank you for correcting me. The other part of this employer paid benefits is 100% of the cost of the basic life and basic LTD benefit. This is saying that the overall funding allocation that would go to the state includes 85% of an 88% AV medical plan and 100% of dental, vision, basic life, and basic LTD. Although there is not something that gets you to a specific dollar amount as on the employer medical contribution, the financial underpinnings, and my understanding of how this will be assessed as part of the feasibility. Although, I'm obviously not OFM, my understanding is that the starting point for the financial feasibility on these benefits is the same allocation that will be spent on PEBB as in SEBB. There will be underpinning assumptions within the financial feasibility that OFM has to complete about the total cost of the entire Collective Bargaining Agreement, which includes assumptions about the payment of the 100% premium for these various benefits.

Slide 6 – Wellness. For the Wellness Program, there was an agreement to have a wellness program that you'll get a presentation shortly about that is built off of the wellness program that the agency has and administers for the PEBB Program. Effectively, it sets up a point-based system for people to engage in overall health well-being, including physical, mental, financial, emotional, work, it's a whole person wellness program. By completing certain requirements, and we will go through some of the decisions you'll need to make along the way about this wellness program, individuals would be eligible for a $50 reduction in either their deductible or deposit into an health savings account (HSA) if they're enrolled in a qualified high deductible health plan. They would earn that $50 incentive first for plan year 2020, the launch of benefits, based on doing a well-being assessment in the program during the 2019 open enrollment.

After that first year, for plan year 2021, the incentive would be $125, either, a deductible reduction or a deposit into a qualified high deductible health plan associated with an HSA. We will talk more about the exact mechanisms for this in the next presentation and start that process with you. Essentially, the Collective Bargaining Agreement has a total of $175 in wellness incentives across the two plan years that we're talking about under the CBA. That should tee up for you why there are no plans that anyone will be offering that have lower than $125 deductible, because, foreshadowing that this was coming, you could get in certain plans down to a zero dollar deductible by participating in the wellness program. So, no deductibles will come in under $125 so that there's not a negative deductible situation.

Pete Cutler: I have a question about this. My understanding is state law says that this Board establishes a cost sharing like deductibles for the school employee plans. This wellness program is not something that was part of what this Board is putting together, and yet it's in the actual Collective Bargaining Agreement. To me, there's a disconnect there. How can the Collective Bargaining Agreement establish provisions related to cost sharing the deductibles, etc., in SEBB Program plans if those decisions are in

theory statutorily assigned to this Board? It would be a different thing if it was just a proposal, but here we have a Collective Bargaining Agreement that assumes it as a given fact. I'm also curious, are we going to see dollar amounts about how much these deductible, whatever it's called, the reduction deductible, the HSA contributions -- how much those cost? And if they're not offered, how that would impact, frankly, the ability to fund other aspects that the Board might feel are higher priorities. Is that type of analysis going to be presented to the Board at some point?

David Iseminger: A couple of different things to unpack in your question, Pete. We have a lot of wellness reports that go to the Legislature about the wellness program on the PEBB side that describes some of the cost impacts that you're describing. As we go through the wellness development process with the Board, we can describe some of those impacts, because we're used to describing them in other contexts. The short answer to your question is yes, we'll work on describing some of the potential fiscal impacts. I do want to make sure the Board is aware that in the Board's statutory authority, there are references to wellness. They are in RCW 41.05.740. There are references to the Board's authority to related to the concept of a wellness benefit.

Another important piece with regards to the authority is this Board's authority is statutorily delegated from the Legislature. The Legislature also has its important role whether or not to fund and accept the Collective Bargaining Agreement. There are always things delegated to the Board. For example, sometimes the Legislature pulls back and says, “thou shalt, SEB Board, and all fully insured plans including those under 41.05, cover X” or “won't cover Y.” Just because there is authority to this Board doesn't mean that the Legislature also doesn't have overlapping higher authority to add different parts and dictate different components of the authority that it's delegated to the Board. As long as the Legislature funds the Collective Bargaining Agreement, it's stepping into that role in the same way when it mandates a benefit that's covered. There are overlapping authorities.

Pete Cutler: Just for the record, I am, more than anything else, a legislative staff person over my career and I have quite an appreciation of the importance of deference to the policy setting role for the Legislature. But we're not talking here about something where the Legislature has delegated some authority to some other entity, that I’m aware of. I may be wrong. There may be statutory language I'm not familiar with and that's fine if there is. But, off the top of my head, if there is no such provision for how the wellness program explicitly providing for the collective bargaining process, or OFM, or the Health Care Authority to establish wellness programs that impact the cost sharing arrangements of plans offered to school employees, the lawyer in me wonders where the assumption is that that could be done. Be that as it may, I will look forward to the information about the financial status of the current wellness program with the state employees. I'll look forward to getting more background information. We don't have to make any decisions right now.

Megan Atkinson: Pete, are you focusing in on the connection that Dave made between the wellness benefit that's in the Collective Bargaining Agreement and that being the floor on a plan deductible?

Pete Cutler: No. Just the flat out -- I mean, frankly, when I was on legislative staff, we had questions about does the state actually get back in benefits, in terms of just from a

fiscal point of view, the reduction in claims costs, or reduction in employee absences, or whatever from having a wellness program that we spend, for its administrative costs, for these reduced deductibles, and the contribution to the HSA accounts. At that point, that was when the programs were first being considered. It was very much still, and my guess is that whole area of wellness programs is still in flux, but there was no real data. It was just a guess. It was a, “we think it'll help - we think this will lead to changes in behavior that will lead to reduced cost long term and not so much short term, but long term.” The budget part of me is still really curious about can you really make the case that reducing the deductibles, which increases the premium cost for the employees, no it reduces, it increases for the employer. Right?

Megan Atkinson: This is an employer provided benefit.

Pete Cutler: Right. If the employer wants, would we as a Board prefer that the employer spend that amount of money on something else that we think would be more beneficial to school employees than these incentives? I haven't made up my mind, but it just seems I wouldn't want to take it as just a given that, well, because the state offers this particular program we're just going to automatically sign up, because it does. If it didn't involve employee deductibles or the plans then it'd be, well, it's something that the state administers and it's, you know, not directly related to matters under the Board's authority. But in this case, as long as it deals with and impacts deductibles, it impacts areas under this Board's authority. So, I'd really want to know what is the case for doing this?

Megan Atkinson: Okay, so you're interested more comprehensively in the cost benefits of a wellness program?

Pete Cutler: Yes.

Megan Atkinson: Okay, thank you.

David Iseminger: And just to preview, Pete, you're probably not going to get the answers to your questions in 20 minutes when we move on to that presentation but we will work on bringing more information as we go on the wellness journey with the Board.

Pete Cutler: That'd be fine, thank you.

David Iseminger: Slide 8 – Benefit Allocation Factor (BAF) describes another component of the Collective Bargaining Agreement. If you think about the conversion factor that exists within the K-12 financing mega model, the model used to push money out via the allocation process to the districts, there is an adjustment factor that exists currently in the mega model. This is, in the Collective Bargaining Agreement, an agreement as to what that multiplier will be separately for classified and certificated staff. I'm probably going to oversimplify it, but this is the answer to the FTE to head count conversion question that we've been teeing up and describing for the Board since the first couple of Board Meetings.

Megan Atkinson: One of the things that we have talked a lot about is the benefit funding currently provided to the school districts goes out on essentially an FTE basis. Within the budget bill, there's an additional multiplier used to take those FTE, increase

them by more than one, and drive out allocations to address the issue that there's more bodies out there than FTEs working in the school districts. What the Collective Bargaining Agreement does is, we have that factor now identified as a benefit allocation factor (BAF) which calculates separately for classified versus certificated staff. As you well know through your experience in the districts, you usually bring in more part time classified staff than you do certificated staff. And, again, with eligibility set at 630 hours, you're going to have a certain part of the head count coming in and eligible for benefits.

One of the concerns raised repeatedly by the Board, and when we've gone out and talked with district folks, like WASBO, really any conversation that you end up around SEBB is how are we going to address that head count issue. The Collective Bargaining Agreement does specify two different benefit allocation factors applied to the certificated and the classified staff. As the K-12 model rolls up the number of state recognized FTE, and I want to underscore that because this is state recognized FTE, it will take the state funding, multiply it by these factors, and that drives out the total amount of funding that the state is providing to the districts. There will still be the district hiring practices that drive out district funded staff that won't be addressed in the state funding. These factors were calculated based on information OFM had available on how the hiring practices are currently. That's where the 1.43 and the 1.02 were calculated off of the state funded or state recognized FTE and head count that are in the system currently. These may not be the right factors for the district-funded staff. But, again, they are specified in the Collective Bargaining Agreement and they will be used in driving out the state funding.

Sean Corry: A request for clarification on these factors which came out of the grand bargaining, which was with bargaining units. Essentially in proportion to their heft. But I don't understand. Did district administration get involved in this conversation too? Because I know that administrators across the state were calculating what it's going to cost districts to meet that 630 hour low threshold for all those employees that are not funded by the state. Could you explain how administrators were involved, if at all, in determining what these factors might be?

David Iseminger: In general, with the collective bargaining process, administrators weren't in the room, so to speak, as the negotiations were happening. But, OFM did have a separate consulting committee, if you will. I don't remember the exact word for it, but there was a group convened by state human resources with a set of administrators and they served as another kind of SME for the collective bargaining process, even though they weren't in the room. That's unfortunately the best I can describe as context, Sean. But I can follow up with more information if you'd like.

Sean Corry: No, that’s okay.

Pete Cutler: Just to confirm, this 1.43, it will be applied to all districts regardless of what nuances they have in terms of their HR approach?

Megan Atkinson: That's my understanding, yes.

David Iseminger: Slide 9 – Other Agreements. To Wayne's question earlier, there's a provision describing that employers versus employees will contribute 100% of the K-12 remittance. The funding amount that's paid will be the same, regardless of what type of employee you are in the K-12 system. Everyone is treated the same from a funding

perspective. There is also a brief acknowledgment about the spousal and tobacco surcharge as the state budget provision from the current operating budget requires there be language about the surcharges in the Collective Bargaining Agreement. There's nothing that's different about those surcharges than what was previously presented to the Board. It is just mirroring the language of the budget provision.

Pete Cutler: I'm embarrassed to admit it but I know we discussed those surcharges. Did we actually vote them in? Or did we actually adopt policies adopting them?

David Iseminger: Yes, Pete, the Board did adopt several policies related to surcharges like the definition of tobacco products; the definition of tobacco use, exempting ceremonial religious use; as well as a 60-day look back; and a default if an individual does not attest to the tobacco surcharge, they are assumed to attest to it.

Pete Cutler: I remembered a lot of discussion. I knew we were well briefed on it, it's just with our bifurcated process of discussing topics and then at later meetings voting on them, I have to admit I forgot whether we got to stage two.

David Iseminger: I believe you got to stage two at the June meeting, and it's somewhere around Policy Resolution SEBB 2018-16 through 2018-19.

Pete Cutler: That's way better than I could ask, thank you.

Sean Corry: I want to go back to something we all heard a few minutes ago about, in some way, a general intent to have funding for PEBB equal to, or very nearly equal to, the funding for SEBB out of the Legislature. It brought to mind what I think we've discussed without certainty in past meetings and outside of meetings, that it looks as if the cost and risk associated with insuring school district employees is actually better than feared, and perhaps maybe less than what PEBB costs will be. Is that leaning still part of our thinking, that the costs for school district employees and their families is going to be lower than PEBB employees? And, therefore, does that free up money? How do we work with different costs of care, so to speak, with respect to benefit payments with different groups of employees and families, if the funding is flat across both groups?

Megan Atkinson: I want to clarify something. When Dave made that statement, he was talking about the next step in the Collective Bargaining Agreement, which is a financial feasibility certification that comes out through OFM. OFM is currently coming up with costing associated with the Collective Bargaining Agreement. In areas where you are still defining the benefit package, they are making assumptions about the benefit cost associated with the agreement. Dave was talking about the assumptions on the life and LTD. OFM is taking the cost associated with the benefit packages and mirroring the PEBB cost for the SEBB population on that. There is not a requirement that they need to be equal. In fact, I can't remember the exact language in the statute right now around the funding rate, but there is language around the funding rate comparison between PEBB and SEBB. Dave was talking about the assumptions being used to cost out the Collective Bargaining Agreement because, again, OFM has to make a certification on financial feasibility.

David Iseminger: Related to what I've described previously at meetings as kind of "horse trading," and some of the later presentations in this slide deck, and, in fact, the life insurance and prior slide decks, describes the relationship and starts with that assumption -- the funding for these other benefits is generally the same. You're right, there are some demographic differences. In fact, we saw that pan out in what we presented to the Board on the long-term disability benefit. If you take the same amount of money that's spent in PEBB and apply it to the demographics of SEBB, it's not a $240 a month benefit, it's a $400 a month benefit. That's not probably the number everybody wants, but it is a representation of how the same money and demographics results in a different benefit design. We've described with that starting assumption, these benefits, dental, now vision, life insurance, and disability all represent a similar pot of money as under the Collective Bargaining Agreement, it's a 100% employer contribution. That represents an ability to say there's the zero sum game to play within and how do you trade and spend the same amount of money across the different benefits?

Slide 12 – Legislative Change Clause. Under the terms of the agreement, if the Legislature makes a change in either statute or budget that impacts matters that were bargained, either party can then request to meet and negotiate about the impacts. If something gets changed by the Legislature that impacts the Collective Bargaining Agreement in next session, everybody comes back to the table and talks about it.

This represents our overview of the Collective Bargaining Agreement. I do want to say, during our break, that I believe yesterday, the super coalition released a press release about the Collective Bargaining Agreement and I have a copy of that for everyone on the Board. We'll also set out extra copies for the public as well. It has a lot of quotes from each of the members of the super coalition that really talk about the positive aspects of this Collective Bargaining Agreement. I wanted to make sure the Board got a copy.

Megan Atkinson: There is also information available on the OFM website around their costing of the Collective Bargaining Agreement.

David Iseminger: We will send those links to the Board as a follow up.

SEBB Wellness Program

Justin Hahn, Washington Wellness Program Manager. Dave and Megan talked a lot about the Collective Bargaining Agreement's language for the SEBB Wellness Program. Today I want to begin to describe what the SEBB Wellness Program could look like. Your feedback is important, as at some point in the future, you could be voting on SEBB Wellness Program policies related to eligibility timelines, etc. This is a get to know you presentation about the wellness program idea, referencing the PEBB Program experience.

Slide 2 – Worksite Wellness Programs. The quote on this slide is from the American College of Occupational Environmental Medicine: "many employers have added wellness programs…to their benefits health plans and there is growing evidence for their benefits." Employers can have a positive role influencing the health behaviors of their work force.

Slide 3 – Why School Employee Wellness? These bullet points are from the Alliance for a Healthier Generation and the Robert Wood Johnson's Foundation at Pennsylvania State University. It's recognized that not just teachers, but all school employees, experience high rates of turnover and burn out, and by prioritizing wellness, schools can help staff feel more valued and appreciated. When we did our original survey of school district benefits a year ago, we found evidence that some school districts did offer benefits already in the wellness area. But we were unable to learn what those programs looked like specifically. Worksite wellness programs in the school can help reduce stress, boost morale, in addition through role modeling, can directly have impact on student health as well.

While the focus of the SEB Board is to help design benefits for the school employee population, we know that healthcare itself is only one of the factors that determine a person's health status. There are also your age, sex, inherited genetic factors, your social and physical environment, and your own individual behavior, such as how well you take care of yourself. Slide 4 – What determines Health? is a public health model showing ways that these factors influence health status. Specifically, today, we are going to look at a proposal for a worksite-based wellness program that can influence individual behavior toward improved health status.

Slide 5 – Worksite Wellness Programs – History. Worksite wellness programs began in the 1980s and focused on smoking cessation, stress management, and nutrition. Research began to show the programs that focused only on high cost populations were not effective. So, they started with some big issue items and started to become more nuanced as they moved forward and discovered more as they evolved.

As they evolved, wellness programs began to focus on reducing health care claims costs and getting positive return on investment. It was also discovered that a limitation of this approach was to ignore additional factors that can play a role in employee health, including stress, employee engagement, job satisfaction, fitness, nutrition, sleep, etc. By 2010, there began to be a broader focus on well-being in a more holistic manner. We describe the four overall factors as emotional, physical, financial, and work/life balance.

In 2013, Governor Jay Inslee signed Executive Order 13-06 that established the Worksite Wellness Program and directed the HCA to administer the program. HCA contracted in 2014 with a wellness vendor called Limeade, to provide an online wellness portal to encourage and track participation in wellness activities. In a nutshell, eligible employees register for SmartHealth online. They're recognized through an eligibility file and complete a 200-question well-being assessment. By going through the assessment each year, we're able to tailor the experience to the individual. A good example of that is providing your top three strengths and your top three weaknesses, with regards to this holistic way of defining well-being. If that individual subscriber earns 2,000 points by the end of the incentive deadlines, borrowing from the PEBB example, they qualify to receive a $125 discount by way of a health plan deductible reduction or a deposit in their Health Savings Account, in the following year.

Pete Cutler: When did the program actually get rolled out for active state employee participation? Was that in 2014 or was it not until 2015?

Justin Hahn: The contract was signed in 2014. January 2015 is when it first started.

Pete Cutler: So, the state has three, four years experience with the Limeade program, 2015, 2016, and 2017. And we're in the fourth year.

Justin Hahn: Fourth year right now currently. Correct.

David Iseminger: Pete, a little more context. There was a pre-portal wellness program launched in 2014. There was a requirement to implement a wellness program in 2014 itself. There was an attestation-based wellness program for about six months, and then the online portal was launched in 2015.

Also, the PEB Board actually changed the eligibility requirements and deadlines, between 2015 and 2016. It's not a complete apples to apples data comparison for that first year versus the second and third years. The original deadline was a six-month deadline in the PEBB Program. It became a nine-month deadline for employees in 2016. We're in the midst of the third year of stable eligibility requirements for the program, but we do have three full years of data. Just wanted to make sure it was clear that there were slight differences from the first year to the second year.

Justin Hahn: Slide 8 – The Use of Incentives. The incentives are specifically financial. The Affordable Care Act allows employers to use financial incentives to encourage participation in wellness programs. They tend to result in higher rates of engagement, but the downside is that they are not enough for a sustained improvement of health.

The goal is to get them hooked by what we refer to as intrinsic incent. What interests them and what do they find meaningful? We do things beyond the extrinsic or financial incentives to get people over the hump with sustained behavior change, and sustained engagement in the program. The point is to activate employees to engage in the program, change behaviors, and develop some healthy habits that can be sustained over time. The area of financial incentives is a regulatory moving target and very complex, to say the least. It involves multiple federal agencies, such as HIPAA nondiscrimination, Americans with Disabilities Act, the Genetic Information Nondiscrimination Act, etc. The idea is to influence positive health status, but not use financial incentives to discriminate against people based on their health status. We walk that line to make sure we're getting the best for our members and leaving off the potentially negative aspects of it.

Slide 9 – Proposal for How Wellness Benefit Would Work Within the SEBB Population. During the 2019 open enrollment we will provide an online health and wellness portal to eligible SEBB Program subscribers who can register, complete the well-being assessment (WBA), and receive points for participating in activities. By completing that well-being assessment, you receive 800 points. Subscribers who complete the WBA will be eligible for a $50 reduction in their medical deductible or Health Savings Account deposit in 2020.

Beginning in January 2020, subscribers who miss the 2019 open enrollment window can register or complete their WBA and participate in activities. The early adopter subscribers that started in January who complete 2,000 points by the deadline of 2020

and are still enrolled in a SEBB medical program the following year will receive $125 reduction in their 2021 medical deductible or Health Savings Account deposit.

Patty Estes: When we're talking about eligible employees, how many plans with PEBB, because I know that this is with PEBB, have the SmartHealth eligible?

Justin Hahn: It works for all PEBB plans.

David Iseminger: Patty, the other way to describe it is the eligibility for the wellness program and wellness incentive is based on being a benefits-eligible employee. It's not dependent on being enrolled in a specific medical plan.

Patty Estes: Perfect, thank you.

Terri House: What's the percentage of PEBB employees currently participating?

Justin Hahn: The eligible population, as of yesterday, was 142,518 persons. Registered was 66,541, or approximately 47% of eligible. For 2018, we have close to 40,000 PEBB-eligible subscribers, of which approximately 28% have completed the well-being assessment.

Pete Cutler: Do you know how many have reached the 2,000 point threshold to qualify for the reduction in the deductible for next year?

Justin Hahn: I do know that. I did not write that down, so I'm going to have to get back to you on that.

David Iseminger: But of course, Pete, it's a subset of the well-being assessment. The PEBB Program deadline annually is September 30, so we just crossed that threshold. I think Justin was trying to get the data but it usually comes out a week after. We'll follow up with that.

Pete Cutler: I fully understand. I'm actually one of the people that gets those messages. I do have other questions.

From my experience, back when I was working with these issues, there was widespread agreement that if you could motivate people to exercise regularly, to get more exercise in, to watch their diet, to stay active, that it could significantly reduce health care costs and improve the health of those individuals. Those were worthwhile goals to promote. At the same time, when I left working in the field at the end of 2015, to the best of my knowledge, no program had shown a material ability to motivate people to actually do those things. There were all sorts of ways that people had strategies for trying to engage people, but at the end of the day, for sustained periods of time, it was very, very hard to get people who were not used to being active, to become active, or who were not used to watching their diet, to watch their diet. That would be my question, does the state have evidence that its program is actually being effective in motivating people to take actions that they would not otherwise take and that then it's leading to healthcare savings. That would be, for me, the $64,000 question for this kind of program.

David Iseminger: Pete, we will follow up. As we continue talking about wellness with the Board, we'll bring some information about what we've been providing. I think we've produced six legislative reports since the wellness program began that are all publicly available. We will synthesize some of the information that's in those reports that hit on the questions you're asking.

Pete Cutler: Thank you.

Justin Hahn: Slide 11 – SEBB SmartHealth Financial Incentive Eligibility. There are three basic steps for the primary SEBB benefits subscriber to qualify and receive a financial wellness incentive. The first one is meet the SEB Board's criteria for SEBB medical plan eligibility. For example, 630 hours or more per year. The second step would be to qualify for the SmartHealth incentive by completing wellness activities before the incentive deadline. For PEBB, it's September 30.

David Iseminger: And for this Board, we'll talk with you about the appropriate deadline. This is describing the framework, and then Justin a little bit later will describe some of the decisions you'll have to make. One of them is the incentive deadline.

Justin Hahn: There is a two-step process for receiving the incentive. It's qualifying, getting it registered, and qualifying for the incentive by participating in the program, meeting the requirement by the deadline, but also, you must be enrolled as a primary subscriber in a SEBB medical plan the following year, when the financial wellness benefit is rewarded. For instance, I'm a subscriber. I completed the incentive before the September 30 deadline. I earned 2,200 points and I'm the primary subscriber on my UMP Plus. In the beginning of January, how it works for PEBB, if I am still the primary subscriber on a PEBB medical plan, I will receive $125 off of my medical plan deductible because I don't have a Health Savings Account.

David Iseminger: But if you left state employment in December, you aren't enrolled in a plan come January, then no incentive for you because you're no longer in a medical plan under the PEBB Program.

Justin Hahn: There's no place for the $125 to go.

Sean Corry: Justin, this implies, and I just want to have it clear for us, that there is no incentive for dependents, spouses, for example. Can they participate anyway? Is there any rule? Of course spouses incur claims costs, too. I don't know, maybe the rate is even higher.

Justin Hahn: On the PEBB side, the spouse/domestic partners have access to the portal, the SmartHealth Program. They have access to all the website and signing up for activities, gaming points, the game-ification, all that sort of behavior change model, but they are not eligible for extrinsic incentives.

David Iseminger: And we would envision a similar model on the SEBB side, that there would be access, but not incentive abilities for those folks.

Justin Hahn: Okay, and as Dave prognosticated a little bit earlier, the PEBB experience with SmartHealth included decisions on eligibility and financial incentive

deadlines. We anticipate that, moving forward, the SEB Board would be viewing additional wellness presentations, having conversations, getting more feedback from you to help inform decisions on how you feel about the whole idea, about policy, such as eligibility, deadline, etc. This presentation has been at a higher level. There's more information to come, based on the feedback.
I would like to direct your attention to one of the screens because we are going to play a demo that our partners at Limeade put together to walk through a Smart Health subscriber's experience. (SmartHealth video demo played.)

Justin Hahn: Slide 15 – Secure. Private. Confidential. We follow stringent HIPAA privacy standards. Data from groups with fewer than 20 people is never revealed. When HCA gets data reports, we get aggregate data reports that are not personally identifiable. Federal law prohibits disclosure of personally identifiable health information to the employer. That means this personal health data is never shared with the employer or HCA staff. The only information that we see is anonymized and at the aggregate level.

David Iseminger: In the presentation, you heard that sometimes there will be data reports that can be used to help influence, encourage, and shape a strategy on wellness. What's being described is this aggregate data reporting would be able to come back at a school district by school district level, as long as the school district has at least 20 employees. For those school districts that have at least 20 or more employees, they would get aggregate information and determine what they want to promote based on their results.

Justin Hahn: I'll just add a friendly addendum to that. This also applies to the subgroups within that. If you have an employer group of 20, then they'll show up as an employer group of 20, but once you start to break that down, it falls within the no-go zone, as far as reporting.

Pete Cutler: My recollection is they have very strict password requirements and I've been curious from day one of why is it so important to have such a high, strict password standard when I don't see myself interacting with any personal information on the website. I'm not quite sure why Limeade is afraid that somebody else might use my name to somehow go on to my account. My account pretty much to my vague recollection, may show some activities I've been involved in, but it was primarily "here's 1,500 different things you could do." I'm just curious about why? What's the rationale behind having a really strict standard for accessing in terms of security?

David Iseminger: Pete, there are at least two things that I'm thinking of with that question. First, in the well-being assessment itself, you're answering some questions that relate to your mental health status, as an example. There are also how much you feel sad in a given time period, or indications of potential depression. Also, at the end of the well-being assessment is an opportunity for you to input results of your blood work. You can put in what your A1C level is for your sugar. What your most recent blood pressure is. It's optional to put that in, but some people do put in those lab report type examples. That's another protective measure.

In general, as our office has been bringing up more systems, I can't remember what OCIO stands for, but there are pretty stringent IT requirements as we bring forward new

systems. There is a very robust password requirement that goes through a lot of the things you're used to seeing when you were making your password for the Limeade portal. As more systems are coming up, higher password requirements are being required across all state systems to ensure accurate security. It does things like require length of password, resets every 90 days, working towards two-factor authentication like many of us have when we access our bank accounts. Those are things that are being rolled out as a standard security measure across platforms.

Pete Cutler: Actually, I was not aware that after I did the health assessment at the beginning that I had any access to those answers. My impression was that it got launched somewhere to Limeade folks who then had suggestions for strengths and areas to focus on. But I did not think of it as data that I would access. I could understand how that would be considered sensitive information. Your observation about the general state move towards very strong password protection for online access sounds pretty familiar. Okay. Thank you.

David Iseminger: And that means we have feedback to help members understand how they can access their old well-being assessment answers. Because I know personally that you can do that because I have done it recently.

Justin Hahn: You will have further opportunity for discussion. But if you have questions in the meantime, contact Marcia or me. Our contact information is on Slide 16.

Group Vision Plan Benefit Designs

Lauren Johnston, SEBB Procurement and Account Manager. Slide 2 – Objective, to propose vision plan designs for Board action at the November 8, 2018 meeting. The next few slides are what the member will pay; out-of-network coverage, what the member will be reimbursed up to.

Slide 3 – Proposed Vision Plan Designs In-Network Coverage. These are the proposed vision plan designs for in-network coverage for Davis Vision, EyeMed, and MetLife. For a routine eye exam, one exam is covered every 12 months, and the member pays zero dollars. For frames, one pair of frames is covered every 24 months. All three of the plans have zero dollar coverage up to $150. Then, the member will pay 80% of the balance over $150. Davis Vision has a little bit more in their plan design where, if you purchase a pair of glasses from Vision Works or they purchase glasses from the Davis Vision frame collection, the member will pay zero dollars.

Sean Corry: I have a quick question that relates to a slide that's coming about locations. We have different sets of benefits, essentially. There are variations in benefits for the three likely candidates, but they're not each in every place. I just wonder about the fact of that, and what will become, I guess, obvious from the question, is that some employees will have access to certain benefits that others don't. How do you deal with that with respect to enjoying better benefits from Davis, for example, in the way they've proposed plans for us.

David Iseminger: There are a couple of different pieces. First, all three networks were asked to work on their provider networks, and we're expecting a check-in with them on what the status of their provider network is in February. That's to give us a better sense

as to what the provider network is looking like, especially as were trying to align different pieces with where we need to give information to the Legislature on the financial model. As provider networks could impact finances, we wanted an update on their provider networks. Also, with regards to vision, we're still evaluating this, but because it's about the location of the provider, it doesn't necessarily mean that an individual could only enroll in this vision plan if they resided where the provider resides. Although MetLife may have a provider network that goes in more counties than the other two, as it stands today , that doesn't mean that an individual who lives in a county where there's only a MetLife provider under contract, couldn't enroll in the other plans. From the vision plan, although there would be travel associated with that, and that would be part of their calculus in the plan that they select, we're: a) working on provider network, and b) we're not envisioning at this point that there would be a limitation for vision benefits based on where you live.

Lauren Johnston: For lenses with Davis and EyeMed, the member will pay zero dollars. For MetLife, there will be a $10 copay. For progressive lenses, the copay ranges are listed, as well, which are all in the same area.

David Iseminger: Lauren, for progressive lenses on MetLife, it shows zero dollars. Correct me, but my understanding is that's for the most basic lens. As you get into more complex progressive lenses, the cost shares more closely align with the other plans.

Lauren Johnston: Correct. With progressive lenses, there are different tiers, standard, premium, and custom. The zero dollars could be up to $175 for MetLife. Some of their providers have deeper discounts. It depends on what provider you see to get your progressive lenses.

Slide 4 is a range of copays by carrier, and then by the different lens options a member could select when purchasing their lenses. These are all a copay range as well, and the same comment for MetLife, for anti-reflective coating, scratch resistance, polycarbonate, transitions, and tinting, those are all "up to." If the member sees a provider that has deeper discounts for those specific areas, it could be less than $41, $17, $31. It depends on the provider's discounts.

Pete Cutler: The numbers shown on Page 4, do they correspond to the range on Page 5 for the progressive lenses? Or do they stack on top of each other?

Lauren Johnston: They stack on top.

Slide 5 shows what the member will pay for contact lenses. For Davis and EyeMed, zero dollars up to $150, and then 85% on the balance over $150. For MetLife, zero dollars up to $150, and then 100% of the balance over $150. For disposable and conventional lenses, Davis Vision has an additional plan design that, if you purchase four boxes from their collection of lenses, you receive those four boxes within the $150. You don't pay anything else for those four boxes. The medically necessary lenses is zero dollars for all three.

Pete Cutler: Can I ask when are contact lenses considered medically necessary, compared to glasses?

Lauren Johnston: Yes. If you have cataracts or you just had surgery. Those could be a reason why you would need medically necessary contact lenses.

Pete Cutler: Contacts instead of the glasses?

Lauren Johnston: Yes. Usually it's in cases where you can't wear glasses or you can't wear other types of contact lenses. The only thing you can wear to improve your vision is through medically necessary contact lenses.

The next few slides are for out-of-network benefits. They are the same slides you saw with in-network benefits. Slide 6 – Proposed Vision Plan Designs Out-of-Network. For the routine eye exam, the member reimbursement is up to $40, $84, or $45, depending on which plan they are in. For frames, the member reimbursement will be up to $50, $75, or $70. You can go down the list and see reimbursements for each of the lenses all of which have a different cost that for reimbursement. For the out-of-network benefit for lens enhancements, Davis Vision does not reimburse for any of the options, whereas, EyeMed reimburses $55 for scratch resistance and polycarbonate and zero for the others. MetLife is between $30 and $100. The single bifocal, trifocal, lenticular, and progressive, whatever lens options you select would go towards that $30, $50, $65, and $100.

Slide 8 is contact lens coverage. Member reimbursements up to: Davis is $105, EyeMed is $150, and MetLife is $105, depending on contact lens selection.

Sean Corry: Going through and hearing this, it reinforces what I thought when I was briefly looking at it yesterday, there is a pretty significant variation in benefit levels through the slides. It implies to me that it's that way because they need it to meet a financial target and the adjustments that were made were in the benefits. Because, the agency could have said, "this is the set of benefits we want you to offer, price it out." Am I seeing that correctly? That's the different benefit levels from these proposed carriers are really a function of needing to meet a financial request?

David Iseminger: I would say that was certainly a factor, but it wasn't the only piece. We asked the carriers to present to us, based on their experience within school districts, what they thought was the benefit offering that would be most attractive to school employees. We described to them what we thought the claims experience was for vision expenditures if the product would have been embedded with the self-insured and fully insured plans based on prior information we've gotten over the years from the PEBB side of the house. We SEBBified that, now a word in my vernacular, SEBBify, we SEBBified that with the SEBB assumptions and then said here's a general expenditure framework, and within that, show us what you propose.

We'd heard from this Board that there is interest in providing choices for people about different types of coverage levels. Knowing that this benefit is ultimately going to be 100% paid by the state, there is that high-level piece that sets a ceiling. We didn't want to specifically impose on all three carriers to only have $100 for contacts, only have $150 for frames. If this Board wants more uniformity across the plans, we will certainly go back to the carriers and indicate the Board has instructed that they want more uniformity. Our understanding and impression from the Board was variability is

desirable. We asked for some variability but we didn't want there to be so much variability that there is significant adverse selection across the products.

Sean Corry: Thank you, Dave. And for me, the driver on that would be school district employees and family members having access to the choices.

David Iseminger: And that gets back to, Sean, where I'm saying we aren't envisioning, at least for the vision product, enrollment on the plan would be based on the county in which you live. As a school employee, you would know that the provider network for Davis requires you to go to the neighboring county sometimes if you wanted to go for a certain benefit design versus one that's closer to you that has a different benefit design.

Lauren Johnston: But the goal is to get them in every county.

David Iseminger: Except for Columbia and Garfield because there are no providers in those counties.

Lauren Johnston: Slide 9 – Other Member Savings, shows some of the additional member savings each of the carriers provided. These are savings to the member. If a member were to purchase an additional pair of glasses, they would get 30% off of those through Davis, up to 40% off through EyeMed, and 20% off through MetLife. There are discounts for Lasik surgery, as well.

Slide 10 – Considerations. These are considerations for the Board when you vote on the plan designs at the November 8 meeting. Included are the members' purchasing experience and their out-of-pocket costs. This could include independent retail or online purchasing and what the member pays versus member reimbursement. There are two distinguishing factors between fully insured and self-insured plans. Premium tax paid on fully insured plan premiums. Additional reserves needed to provide a self-insured group vision plan.

David Iseminger: Our recommendation to the Board is three fully insured products, one from each of the three carriers on Slide 11. We did the analysis of a self-insured plan, with two of the carriers, they were announced as apparently successful bidders for potential self-insured plans. We got pricing from them, compared that to the fully insured, and to use a rather simple analogy for purposes of making up time, the juice wasn't worth the squeeze in pushing toward launching a self-insured plan. You overlay that with needing to build up reserves for the self-insured plan, although it's not nearly at the scale of a fully insured medical plan, self-insured reserves would still be required to be able to cover those claims expenses. We went forward and brought to you a recommendation for three fully insured products, but it was a very worthwhile exercise initiated by the Board when we originally presented the draft RFP information in June. Before it was released, I believe it was Sean that asked some questions as to whether or not we were looking at a self-insured plan. It was a very fruitful exercise to go through, but at the end of the day, the juice wasn't worth the squeeze.

Lauren Johnston: And the plan designs are the same, so regardless of if a fully insured plan or self-insured plan, when it comes to what the carrier benefit is, it's the same for both. It's not a different experience for the member, depending on whether or not it's fully insured or self-insured.

Pete Cutler: Is the premium tax 2%?

Lauren Johnston: I believe so.

David Iseminger: We'll follow up with exactly what the premium tax is.

Pete Cutler: And that, as far as you know, is the only major obvious additional expense that's levied just on insured plans?

David Iseminger: Correct.

Lauren Johnston: Slide 11 – Recommendation. HCA's recommendation is to offer fully insured group vision plans for benefit-eligible school employees, through Davis Vision, EyeMed, and MetLife. Now moving into the resolutions.

Slide 12 - Proposed Policy Resolution SEBB 2018-40 - Fully Insured Vision Plan (Davis Vision). Beginning January 1, 2020, the SEBB Program will offer a fully insured vision plan by Davis Vision as presented at the October 4, 2018 Board Meeting.

David Iseminger: Before Lauren moves on to the other resolutions, I want to set up the structure of the resolutions. On the self-insured plan and medical, we had you vote on different co-insurance levels. One slide said, “match the cost shares for the UMP Classic,” and another one had bulleted voting on different specific cost shares. When it comes to fully insured products, you're buying the whole bundle of sticks. If you have a question or you want more uniformity in the plan, you give that direction publicly. The carriers, who are all on the phone, presumably, as they've been instructed, are listening. They start that guidance, they run and sharpen their pencils, and they get going until Lauren gets back to her desk and says, "Did you hear what the Board just said? We need to work on these changes." The Board doesn’t get to pull a stick out of the bundle and say, "I don't want that stick." You buy the whole bundle of sticks.

When we present resolutions to you on the fully insured products, we're asking you ultimately at the end of next year to endorse rates. That rate comes with an implicit ratification of the underlying benefit design. Here, you're seeing that play out where we're saying endorse the plan. We don't have rates for you yet, but at the end of the day you'll vote on rates, for example, in the fully insured medical plans and that will be your endorsement and an offering of a plan with the benefit design that comes with those rates. That’s how it works over time. It also plays out this afternoon when you see the fully insured plans and it says, "endorsing a benefit design for purposes of going into rate development." You can continue to refine those benefits and ask questions of the carriers, and have the agency work with the carriers to refine benefit design for purposes of modifying the rates. At the end of the day, you would pass rate resolutions that ratify the benefit design that underlies them.

Lauren Johnston: Slide 13 - Proposed Policy Resolution SEBB 2018-41 - Fully Insured Vision Plan (EyeMed). Beginning January 1, 2020, the SEBB Program will offer a fully insured vision plan by EyeMed as presented at the October 4, 2018 Board Meeting.

Slide 14 - Proposed Policy Resolution SEBB 2018-42 - Fully Insured Vision Plan (MetLife). Beginning January 1, 2020, the SEBB Program will offer a fully insured vision plan by MetLife as presented at the October 4, 2018 Board Meeting.

David Iseminger: Is there any direction by the Board to alter plan designs?

Pete Cutler: The question I have has to do with the networks. I understand you're asking them to expand their networks, but I don't feel like I -- and maybe it was presented prior -- but my recollection is we haven't seen the number of providers split out by the three different proposed successful bidders by county. I certainly would feel a lot more comfortable if I could get a sense, even if we had to go with the networks they have today, what kind of coverage is there?

David Iseminger: Pete, at the August 30 meeting there was an updated slide that has de-duplicated provider counts by county. It's in the appendix of Lauren's presentation. It does not show them separated by carrier, but we can provide that if you like.

Pete Cutler: I think that'd be relevant. I'd also be curious what we know about, for the school employees currently, they have access to a variety of vision plans, standalone vision plans and networks. It keeps coming down to that. Will they be able to go to providers that they're used to going to? And so, some kind of reassurance about there being a very large amount of overlap between what they are able to do now and what they'd be able to do, or where they'd be able to go, if we adopt these three plans would certainly be reassuring for me.

David Iseminger: We'll work on giving you the carrier county provider amounts, as well as what we can provide about potential provider disruption.

Sean Corry: Following up on Pete's question. We have these resolutions lined up and there's a shell in each of them, but we don't yet have information about what provider access each of the plans will provide to school district employees and family members across the state. Nor are we yet fixed, apparently, on what the benefits are actually going to be because there's some variability there. I'm wondering, on behalf of my fellow Board Members, how do we go about reassessing? Once we've passed these resolutions, once we've said "these are the three we're going to do business with," when we run into issues we've talked about, how will we go about assessing that? When will we learn that we have a problem here or there, so that we can perhaps revisit?

David Iseminger: A couple of things. I want to make sure it's clear. We have provided to the Board at previous meetings information and we always have this debate as to how much of the previous presentations do we put in an appendix and all of your materials to have right in front of you in these meetings. But we have provided an overall county by county combined provider map de-duplicated for the three carriers. We'll provide the additional provider context that was requested today, to give insight on that as well as potential provider disruptions that we can dig out of the claims data that we received back in April from the carriers.

I do want to be clear that the resolutions here would be an endorsement of the slides and the benefit design that Lauren presented between Slides 3 through 8. The question I had whenever we shifted to the last part of the presentation was are there things that

you want us to bring to you differently? If there are things you want us to bring to you differently, then we would work with the carriers between now and November 8 to refine Slides 3 through 8, put them in your slide decks for November 8, and modify the resolution to say, "as presented at October 4 and modified on November 8." This is a specific benefit design proposal that you would be ratifying by passing Policy Resolutions SEBB 2018-40, SEBB 2018-41, and SEBB 2018-42. I want to make sure that's clear.

Unless you want something changed within those slides, that's the benefit design you are saying you're offering through these three carriers. It's the three carriers with the benefit design that's being proposed to you right now. As I've said a couple of times over the journey with the Board, we're leading up to having up to 90% of your homework done. After the funding comes in and we know what the true funding rate is from the legislative session, we'll come back to the Board right after the funding rate is in the operating budget, whether that's April, May, or June. We'll come to you with information about what that funding rate is, how it stacks up with the entire suite of benefits that you've previously presumably endorsed by the end of the November meeting, and say, "There's a little more funding than we expected. Here are ways you could spend it in the different benefit pieces." Or, "The funding is lower than the benefit designs that have been negotiated with the carriers. Here's the way to make up the gap." We would give you different options along the benefit portfolio to show how you can make up that gap and where you would go back and refine different pieces of each of the benefit designs.

I've said you're the lead and the anchor in the relay race when it comes to the benefit design piece. We're asking the Board to endorse, at least for purposes of the rate development, and to go into the legislative session to say, “here's generally what could be bought with the money that looks like it's on the table.” On the back end, once the dollars are locked in, do some refinement benefit by benefit. That's how it would come up on the back end, Sean.

Fully Insured Dental Benefits

Beth Heston, PEBB Procurement Manager. Slide 2 – Objective. Today I will share proposed fully insured dental benefits for Board action at the November 8 Board meeting. Slide 2 – Policy Resolution SEBB 2018-06. In March you passed a resolution to leverage the existing PEBB fully insured dental plans, and you would evaluate in 2020 whether SEBB should pursue a fully insured dental plan procurement.

Slide 4 – HCA Fully Insured Dental Plan Contracts. We currently contract with Delta Dental of Washington, who is also the administrator for our Uniform Dental Plan, and Willamette Dental for our fully insured plans. Those plans differ from the self-insured plan in that the claims are paid and risk assumed by the vendors. The carrier is fully responsible. In these plans, they're like an HMO. Subscribers have to see in network dentists in order to have their care covered by the plan, except in cases of emergency.

Slide 5 – Proposed Fully Insured Dental Plans. This chart should look familiar. We've been showing you these categories of care and costs for the self-insured plan and here is the comparison between the fully insured plans. They're very much alike in coverage. No annual maximum, no deductible, general office visit is zero, preventative and

diagnostic care covered at 100%. We have copays to go along with the actual care in other categories.

David Iseminger: Beth, before you go on, can we go back to the previous slide? I do want to make sure it's clear that there is an embedded orthodontia benefit within the fully insured dental. I know that is not common within the K-12 districts at this time in their coverage. It's usually separate/standalone. But, just as there's an orthodontia benefit that was in the proposed self-insured design, there is embedded in the fully insured dental. Beth, is there a difference between the self-insured and fully insured dental -- orthodontia benefits?

Beth Heston: Orthodontia benefits, yes. In the fully insured dental, the entire cost of orthodontia is $1,500. In the self-insured plan, it is a lifetime maximum of $1,750.

David Iseminger: So, to clarify, on the self-insured side, there is a capped amount paid by the plan. On the fully insured side, there is a capped amount paid by the member and anything above that the plan covers. That is a key difference in the orthodontia benefits between the two products. I am sure there are countless examples of it in the audience, but what I hear over and over again is people will switch to the fully insured plans when they know their kids are about to get braces, and then they have more coverage for orthodontia. I wanted to call attention to the orthodontia benefit because I know it is of keen interest to school employees.

Sean Corry: I know that many school districts do not offer orthodontia benefits because it frees up money for other things. I'm actually looking forward to that conversation here so we can see the cost of orthodontia benefits and weigh that with other benefits in other areas. Whatever that cost is going to be. I know that Seattle, for example, did a survey some years ago of employees and got a very high response rate to the survey. A substantial percentage, majority, said “no, let's not add orthodontia.” I mean, there's those circumstances where it comes at a cost. And it may not be a cost that's wanted by the majority of the employees who are going to get this. I'm just pointing out that this may be an area that we could put money on the table for something else, maybe within the dental plan or elsewhere.

Beth Heston: These are the choices that the PEB Board made in the past to have it included in all of their benefits. But certainly, even though the resolution was that you would be leveraging similar benefits, we certainly can take that back and look at it.

David Iseminger: We did have some conversations with the carriers about that, and we'll get into some horse trading insight later in this slide deck.

Beth Heston: Slide 6 – DeltaCare Coverage Map by County. Slide 7 – Willamette Dental Coverage Map by County. Slide 7 has has been before you a couple of times in different variations. It is also different from the one that was printed for the public to pick up out on the table in the hall. The difficulty that we had was that we want to show you which counties Willamette Dental Group has clinics in. In the past, we were using where they have subscribers. Their feeling is that any person eligible for benefits may enroll. But the dark blue counties on this map is where they actually have brick and mortar clinics. I wanted to make that very clear.

David Iseminger: This is a good illustration, similarly, for vision. This is describing the same thing where a member knows up front where the network is. If they want this plan, where they would have to travel to for providers, yet everyone in the state could enroll in this plan. Again, your Board booklets in front of you have the correct map. Slide 7 is the correct map. The one that's printed out for the audience is the wrong map. And the one that's online that people can access has been updated to be the correct map. So, everybody's is correct except for the stack of papers in the hall.

Pete Cutler: No, actually that was very helpful. Otherwise, I would have not interpreted the map correctly. But with your explanation, it came into focus and was very helpful. And I think it is good to show both. A question in terms of the number of providers and the number of providers taking new patients for both of these, is that what they're called, managed care?

Beth Heston: Yes, managed dental care.

Pete Cutler: Managed dental care. Do we have information on how many providers there are and especially distinguish between providers who are actually taking patients? There's been some controversy in the past, maybe more with medical organizations, but sometimes dental, where somebody will be listed and then you contact them and find out they have a contract, but not taking patients anymore.

Beth Heston: Yes. And both of these plans offer coverage through WEA and other school districts.

Pete Cutler: Fair amount of overlap. Great, thank you.

Beth Huston: But we'll get you the numbers of dentists accepting patients in both plans and as much information as we can about that.

David Iseminger: I know everyone doesn't remember all the meetings and resolution numbers as well as I tend to, but I would be remiss if I didn't remind the Board that back when you passed the resolutions in March, Kaiser Northwest came forward and had some concerns about provider disruption in southwest Washington. We have done some provider disruption overlap and many of the providers, I believe, are in one of these networks.

That discussion was more about how well it could be integrated with a medical plan or not. It does not seem that there would be as big of a provider disruption because we did more analysis.

Beth Heston: If I remember correctly, there are only 26 dentists that were not overlapped between Delta Dental network and Willamette network or DeltaCare network.

Slide 8 – Fully Insured Compared to Self-Insured. This is a comparison to juxtapose the two kinds of dental plans. In a fully insured dental plan, the member has to choose a contracted dentist within the network before receiving services. On the self-insured side, you choose your own dentist, who may participate at varying levels in the network. They may be fully in, they may be partly in, or they may be out-of-network, but you can

still see them and get coverage. On the fully insured side, that's not the case. We have a lot of "dental confusion" in PEBB, because people don't understand that they are in a managed care plan, or they choose the wrong plan because they confused the names. But these are the basic differences between fully insured and self-insured. Predictable out-of-pocket costs, because it is copay not coinsurance.

On a self-insured plan, coinsurance is a percentage of the cost and the total cost depends on the provider. It is possible that, on the self-insured side, you might pay less than the copay on the fully insured side. It depends upon the provider. Also, there's no annual maximum under a fully insured plan, and we know that under the self-insured plan there is an annual benefit max. Fully insured orthodontia covered completely with a copay, self-insured orthodontia partially covered with a separate lifetime maximum. Fully insured available clinics and providers may be limited by geography. On the self-insured side, our current TPA has 94% of state dentists participating in their network.

Those are the basic considerations. Why you would choose to offer a fully insured plan compared to a self-insured plan? Many people like the choices in a fully insured plan. That's why the PEB Board decided to offer both.

Slide 9 – Recommendation. Our recommendation is that you offer the fully insured dental plans through Delta Dental, called DeltaCare, and Willamette Dental, called Willamette Dental Group.

David Iseminger: This would be a supplemental to the self-insured plan previously recommended and are asking the Board to take action on later in this meeting.

Beth Heston: The proposed policy resolutions are much like the vision resolutions. Except, in this case, they say with the same coverage services and exclusions, the same provider networks, same clinical policies, and same copays as the existing DeltaCare plan under PEBB. And the next slide says the same thing for the Willamette plan under PEBB. And this, I believe, gets back to Sean's question earlier about orthodontia.

Slide 12 – Dental Portfolio Alternative Benefit Design. We looked at some alternative benefit designs. We could, for the purposes of horse trading, reduce the dental annual benefit maximum from $1,750 to $1,625. And we could increase the employee share to 30% on Class II restorations. In other words, the plan pays 70%, not 80%. We could also adjust the fully insured dental plans to introduce copays for office visits and increase the copay on fillings and/or crowns. And those combined changes could generate some annual premium dollars that could support increasing the long-term disability benefit to around $800 per month. I believe the magic chart from Betsy's presentation is in the appendix to this, if you want to look again at that.

David Iseminger: Beth is correct, Slide 16 is the chart you received at the September 17 meeting that showed some of the incremental costs and expenses that would lead to higher basic LTD benefits. I know that we have tried to present to you the context of a horse trade for LTD benefits because we heard from the Board pretty clearly that, if there was a way to increase that benefit, that was an area to focus on. We could certainly describe horse trades in other directions, but it seemed, based on Board comment, that it was primarily focused on how could we do a horse trade to make the

LTD benefit higher than $400 if the same per subscriber per month (PSPM) was spent as in the PEBB Program. That's one reason why it's described the way it is, to describe the trade in the context of long-term disability.

We went through a variety of different options, many of them I will say more Draconian than the one that's before you. We didn't want to show too many different ways, but if there are other ideas you want us to look at we will, and I'm sensing we'll probably be asked what orthodontia looks like, if orthodontia was altered. I want to get a little more feedback from the Board on the types of changes in that area. We can bring that back to the Board in November. This was one example of how you can change the entire dental portfolio. You couldn't pick just the changes in uniform dental or just the changes in fully insured dental because that would create too many adverse selection issues between the portfolio. One of the challenges is, because the fully insured doesn't have an annual benefit maximum, there has to be something that's changed differently for them. And that's where, in partnership with our carriers, the ideas of introducing an office copay, or similarly increasing copays on fillings and/or crowns, led to having something that would offset the difference across the portfolio from an adverse selection standpoint.

We also put an example here that showed a higher increment you could do from life insurance. When we get to life insurance after lunch, you'll be reminded about the potential horse trade of taking the life insurance benefit from $35,000 to $25,000. That trade could get you a $600 basic LTD benefit.

I wanted to give a little bit more context for what this benefit design is. It's not our recommendation, but of course, if you want to make this type of trade, you could. I'll be interested to hear more about other things you're interested in, including details about orthodontia.

Pete Cutler: I specifically would like you to check on what the savings might be and the feasibility, vis-à-vis the insurers limiting the orthodontia coverage in the insured plans to the dollar maximum that applies in the self-insured plan. So, if it's $1,750 or whatever it is, just having that.

David Iseminger: So, having it align to the same plan maximum coverage instead of an area where the plan picks up everything after a dollar amount?

Pete Cutler: Correct.

David Iseminger: Because I get stuck in this trap, it's not really right to call it savings. It's really lower projections on claims expenses. It's lower projected expenses, and then trying to think about how to appropriately account for those potential lower projected expenses, and how they can be converted to premium dollars that are paid in LTD. That is another layer of this. I've been reminded that it’s not “savings” so I want to make sure that’s clear for the Board.

Sean Corry: Two things. One, I want to thank you for beginning to show us this kind of information because it's helpful for us to know that we have choices in this way. But I still want to push back, at least for my own benefit, continue to remember that this type of analysis, “this can buy that” within our benefit package, implies a fixed dollar amount

which is not known yet. I just want us to know that the funding for what benefits we would like to have for our fellow employees and school districts is not known yet. It's still not yet a necessary zero sum game. So, we could have both. We could have orthodontia and better life benefits, knowing that it's going to cost $20 a month per employee, to make up a number. It could be that's what we want to have happen and that could be what we ask for. So, I'd like to have us continue to understand that's a path that we could pursue as opposed to continually just fixing on a number that we don't know as the amount of money that we have to spend.

David Iseminger: For the Board, we will talk more in Executive Session about the financial picture, some things that we can only share in Executive Session. I would just remind the Board that there are assumptions throughout state government about building the financial cost of this program. I alluded to this in the collective bargaining piece, that OFM is doing a financial feasibility of the Collective Bargaining Agreement and a starting assumption for the cost of the fully employer paid benefits is the amount of money that's spent in the PEBB Program. There is, at least, a reason for the assumption that we kept bringing to the Board about a zero sum game using PEBB dollars. The Board can agree or disagree with that assumption, but that is the basis for the assumption. I want to make sure that everyone is clear about the basis for that assumption.

We're definitely going to talk with the carriers about capping the orthodontia benefit in the fully insured plans to match the cap that's within the self-insured plans, and bring back the incremental projected cost savings of what that would do to the fully insured plans. Are there other benefit design pieces that the Board is interested in? For example, are you interested in not having orthodontia coverage at all? That could be something that is currently what many K-12 employees experience as a separate option. If the Board's interested in us pulling orthodontia out completely, that's something we could look at.

Pete Cutler: I was going to say I thought I heard Sean at least ask that we have the financial analysis done of what would be the savings, and if he hasn't asked, I'll add that to my request as a second option.

David Iseminger: I wanted to be clear if that is a request, to fully pull out orthodontia.

Sean Corry: And see the cost impact.

David Iseminger: The cost impact of eliminating orthodontia. We will do two analyses, one of which is capping orthodontia at the same benefit as the proposed self-insured dental plan, and pulling orthodontia out of both fully and self-insured. Just to be clear, as we go forward this afternoon asking for a vote on self-insured dental, it would include the benefit design of having orthodontia in, but we could certainly, if the Board wants to make that trade in November on the fully insured plans, we could bring another resolution back to modify the self-insured dental resolution, assuming it passes today, to change that part of the benefit design structure. I'll count that as Sean's request. Pete asked for capping, Sean asked for the analysis if it were taken completely off.

Beth Heston: Just to reassure you, both plans are present in the meeting so they've heard exactly what you're asking for.

David Iseminger: They already have their homework assignment is what Beth is saying.

Beth Heston: Slide 13 – Next Steps – November. For the November Board Meeting, we will take action on Policy Resolution SEBB 2018-43 and Policy Resolution SEBB 2018-44. We will include all the analysis and present it to you at that time so resolutions can be modified.

Pete Cutler: I want to congratulate Beth because you managed single handedly to take us from being 30 minutes behind schedule to being back on schedule, so thank you very much.

Lou McDermott: 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 42.30.110(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.

Self-Insured Dental Benefit

Beth Heston, PEBB Procurement Manage. I am back to talk about our self-insured dental benefit. We discussed this at the August 30 meeting. Today the resolution is up for action. The plan is administered by Delta Dental of Washington. Claims will be paid from SEBB funds subject to financing decisions. Subscribers may see any provider that accepts the Uniform Dental Plan, which is a preferred provider organization. About 94% of the dentists in Washington State participate in the UMP network. It is statewide coverage, with coverage also across the United States and internationally.

Slide 4 – Proposed SEBB Self-Insured PPO Option. We want to correct a few things. First, when we presented the crowns in August, we had them covered at 80% and they are actually covered at 50%. That's why the red ink on the chart. For orthodontia, we promised that we would clarify that 50% of the costs are paid until the lifetime maximum $1,750 is met. That is a different $1,750 from the annual plan maximum. There is an annual maximum of $1,750; and for orthodontia, a separate lifetime maximum of $1,750. The considerations for offering this, again, statewide coverage, comparable rates to the PEBB Program self-insured plan, orthodontia coverage included, a competitive benefit structure. You asked us to look at incentive plans in comparison. What we've discovered was that many incentive plans, after two or three years, have greater coverage. However, our plan has better initial coverage because Class I and Class II are covered. Class I is covered 100%. Many of the incentive plans do not have 100% coverage from the beginning, you have to earn upwards.

Dave Iseminger: They have a lower coinsurance that's covered initially. Somewhere around 70% or 80%. After three or four years, it becomes 100% coverage. Whereas, the proposed plan starts immediately. Everybody has 100% coverage of preventive services Class I.

Beth Heston: Crowns would be treated as Class III compared to many dental incentive plans that offer opportunities for a higher coverage.

Dave Iseminger: That's the flipside of what I just said. The incentive-based plans, there are often opportunities to have a higher coinsurance coverage by the plan and less for the member in subsequent years for crowns. There are tradeoffs and we wanted to be clear about those different tradeoffs.

Beth Heston: Right, because members would be entering at year one. In incentive plans, they would not have that coverage until they had earned in a couple years. The proposal before you is a popular and rich plan. It has great coverage. Our recommendation is that you offer the self-insured dental benefit design as proposed at the August 30 meeting.

Dave Iseminger: There is one piece I want to make sure we add on the record. We did go through the same stakeholder feedback with this resolution like we do with all the other. We received three comments. One was checking on who the administrator of the plan will be. Beth has already clarified it's Delta. Another comment from WASBO was supporting the motion as written. The third comment, "This benefit design is different from what some school employees experience. I hope you communicate it well." We agree that's going to be the challenge of communicating all the benefits because of the variability that exists in this system. We acknowledge the need for great communication.

Pete Cutler: I want to re-confirm that we have asked for a cost analysis of what would happen if we dropped the orthodontia benefit or capped it off. I guess the insured one was about capping off. Even if we adopt this, the understanding is it could be amended in the near future, i.e., before the end of the year if we so decided. Great. Thank you.

Sean Corry: Just a comment. I do want to point out that, at least for the school district clients that my firm has, this is actually a noticeable and substantial reduction in benefits. The vast majority of employees in Seattle Public Schools, for example, are at the 100% on the incentive benefits, not just incentive in Class I. That's an example of what will be a noticeable change in benefits.

Lou McDermott: **Policy Resolution SEBB 2018-37 – Vision Benefit**

Resolved that, beginning January 1, 2020, and subject to financing decisions, the SEBB Program will offer a self-insured plan with the same covered services and exclusions, same provider networks, and same clinical policies as the Uniform 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.

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

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-37 passes.

Basic Life and AD&D Insurance

Beth Heston, PEBB Procurement Manager. The objective today is to take action on Policy Resolution SEBB 2018-30, originally presented at the July 320 Board Meeting. In July, we recommended employer-paid benefit levels of $35,000 basic life insurance, $5,000 basic AD&D insurance. We are now presenting to you the information that a decrease to a $25,000 basic life insurance benefit could generate annual premium dollars that could support an increase in the basic long-term disability benefit to approximately $600 a month. We had a lot of stakeholder feedback that's contained in the appendix to this presentation.

There was one outstanding Board question. We presented MetLife's findings for the ten non-PEBB benefits participating school districts that they had. Someone asked how many total employees they covered. The answer is 3,887 total employees.

Dave Iseminger: Slide 9 in the appendix has information benchmarking insight from MetLife and that's what Slide 4 relates to. It's the information originally presented in August when we were answering stakeholder questions and that's where that question was generated.

Pete Cutler: First of all, I want to confirm that this is similar to the dental benefit resolution we just passed, that if down the road we decided to go with a lower, say the $25,000 amount rather than $35,000 that's proposed, that we could make that adjustment there again sometime before this gets locked in. Beth is nodding her head yes.

Dave Iseminger: In fact, Pete, you could do that today. If you wanted to amend this motion and change it today, you could. If you did that, the direction of the agency would be when we bring back the LTD benefit resolution in November, we would automatically move that to $600 because of the decision you could make today. Or you could do it later. As a reminder, it's in the last clause of the resolution, "unless modified in a subsequent resolution by the Board." We don't write it over and over again in all the resolutions. But the reality is, all of them are subject to another one. At the time we were presenting this, there was a fair amount of concern from the Board about the veracity of that statement. So we put the words on the page. They're true whether they're there or not.

Pete Cutler: Thank you for pointing that out. I'm not ready to lock in on a decision, but I do think the long-term disability benefit is especially one of concern, and even the $35,000 is a low number. But a month or two from now, I think we may have a more information and be in better position to know what, if anything, at least, that I would support for a change. So, thank you for answering that question. And once more, just for the record, if it were up to me, I would eliminate the accidental death disability benefit because I think it doesn't really make much policy sense. But I will not let that hold me back from supporting the life insurance benefit.

Lou McDermott: Your position is noted. [laughter] Does the rest of the Board concur with leaving the $35,000 for now? Okay.

Policy Resolution SEBB 2018-30 – Basic Term Life Insurance and Accidental Death and Dismemberment Insurance.

Resolved that, the employer-paid life insurance provided to eligible employees beginning January 1, 2020 will be a $35,000 death by any cause benefit, and a $5,000 accidental death and dismemberment (AD&D) benefit, unless modified in a subsequent resolution by the Board.

Katy Henry moved and Dan Gossett seconded a motion to adopt.

Voting to Approve: 9
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-30 passes.

Dave Iseminger: Wayne Leonard has a lot of pressures on his time today and needs to leave the meeting since we have completed the action items on the agenda.

Wayne Leonard: Thank you, Dave. Bye.

Eligibility & Enrollment Policy Development

Barb Scott, Manager, Policy, Rules, and Compliance Section. I am going to introduce two policy resolutions you today, SEBB 2018-32 and SEBB 2018-36. Staff have included the original resolutions for these two policies in the appendix.

Proposed Policy SEBB 2018-32 is being reintroduced because it changed significantly as we went through stakeholder feedback. The policy was originally introduced to address stakeholder concerns related to 12-month employees hired in full-time positions beginning July 1. When we first talked to stakeholders, they indicated that they hire principals, superintendents, and a number of 12-month type positions hired for whatever reason, July 1 based on their business needs. The policy was constructed around that. Since then, we've been asked to look at not just 12-month employees, but the nine- to ten-month employees. That's why you're seeing significant change from where we started to where we are today.

The policy was expected to allow for employees to begin benefits in July when they're hired if they were anticipated to work 630 hours in the next school year. Where the biggest change occurred is in how we address the number of hours that are needed during the remainder of the year once they're hired mid-year. It will provide eligibility to employees hired late in the year. The Board's eligibility can't be more restrictive than to require an employee be anticipated to work 630 hours within the school year. This particular policy is more generous than that eligibility.

With that, we received stakeholder feedback around the title. We originally had in the title the word "positions." We've removed that because it's not position-based. It's based on what the employee is expected to work hour-wise. Stakeholders wanted us to recognize that school employees work somewhere between nine and ten months rather than nine months, which is what we originally had. You'll see that in the policy before you today, we've changed that to nine to ten month school employees. One

stakeholder was concerned that it would be difficult to administer two different monthly standards.

We have gone back and forth between a 52.5 hour standard per month and a 70 hour per month standard for employees. Stakeholders were also concerned that the requirement for a set number of hours per month would be problematic for specifically the months of April due to spring break, May due to Memorial Day, and June, mainly because it's a short month for your nine to ten month employees. One stakeholder suggested using the 52.5 hour per month standard and another stakeholder suggested addressing the concern by prorating the 70-hour standard.

Another stakeholder suggested the prorated number of hours should be a weekly standard of 17.5 hours, which is what you see on the proposal before you today. For the 17.5 hours, we took the 3.5 hour daily standard times five. When we worked it out, it comes out to the higher 70 hour a month standard. The policy resolution itself would cause the employee to have to meet, depending on which type of employee they are, one of the two standards. It proposes a single standard so it's easier to administer, which was important to stakeholders. It also allows us to fix this for both types of employees. It doesn't matter whether you're a 12-month employee or a nine- to ten-month employee. If you're hired mid-year, there's a way you could become eligible mid-year even if it's late in the year.

Staff included a number of different examples to help you see how this would be applied.

Katy Henry: Can you talk about how you determined six of the last eight weeks and the use of the word "partial" and "full?

Barb Scott: Yes. As we went through this with stakeholders, we struggled with looking at certain weeks on the calendar. Some folks saw those as full weeks and some saw them as partial weeks. This was especially noticeable when we looked at the week of Memorial Day. It really is a partial week. Monday is typically the holiday. It also was something that came up when we looked at the month of June for the nine- to ten-month employees. We wanted to be clear that it doesn't matter if it's a partial week or if it's a full week. That week would count in the calculation.

Dave Iseminger: The way you would think about this is to go to your school district calendar and determine the last day of school. That's week eight. Count back on the calendar to one. Look at those eight weeks and determine if the employee worked 17.5 hours in at least six of those eight weeks. That's how we got to eight. We looked at about a dozen school districts and did some examples. We know there's a lot of shifting at the end of school because of how school started in some districts, and exactly when school started, so we came to realize if you did an eight week look back, starting with the week that has the last day of school, in no instance did we hit and leapfrog over spring break.

The whole scenario then always describes a post-spring break employment anticipated-to-work world. We thought that would be easier to administer because in some school districts, if you lept over spring break, sometimes you're looking at March. Sometimes you're looking at April. There was a lot of calendar counting that went into this seeing if

we could get a reasonable amount of time and that ended up being eight weeks. We settled on the recommendation based on different pieces that we heard as concern from stakeholders. Let's give people two bye weeks, one of them in many instances will be the last week of school just by sheer nature of sometimes it's a one-day week, some days it's a four-day week. And then another bye week, depending on your employment status because of Memorial Day. We tried to add some flexibility.

Barb Scott: We've got it in our heads as we walk through these examples, that to have a standard like 17.5 hours per week works in this particular policy because it's more generous than the required eligibility. To apply a 17.5-hour standard beyond this policy, we would have to look at each instance separately because you could cross over into being more restrictive, which you're not allowed to be. The reason you're seeing a weekly standard here, and not necessarily in other places in policies that I bring before you, is because this is more generous eligibility than what is required by the statute.

Example #1 is a school employee who's a new principal, not anticipated to work 630 hours during the current school year because of the time of year they're hired. They are anticipated to work at least 630 hours during the next school year. In this case, the principal's first day is July 1, 2020. They are going to work at least 17.5 hours per week for at least six partial or full weeks in the last eight weeks, which would be during the months of July and August 2020. The question is, when are they eligible for SEBB benefits. Their eligibility begins July 1, 2020. Based on Policy Resolution SEBB 2018-12, paragraph two, coverage would begin August 1, 2020 because that policy resolution says for a new employee, coverage begins first of the month following the date of hire.

Example #2 is a bus driver who's not anticipated to work at least 630 hours during the current school year because of the time of year hired, but they are anticipated to work 630 hours during the next school year. Her first day of work is April 20, 2020 and she's anticipated to work at least 17.5 hours per week in six partial or full weeks of the eight weeks before summer break, which begins for this district June 18, 2020. The employer contribution towards SEBB benefits is April 20, 2020. Coverage begins May 1, 2020 based on paragraph two of Policy Resolution SEBB 2018-12.

Example #3 is a new teacher who's not anticipated to work 630 hours during the current school year. The first day of work for him is April 1, 2020. He is anticipated to work at least 17.5 hours per week for at least six partial or full weeks in the last eight weeks before summer break, which, for this district is June 16, 2020. He is eligible for the employer contribution towards SEBB benefits April 1, 2020 and coverage begins on May 1, 2020 based on Policy Resolution SEBB 2018-12 paragraph two.

Typically when we bring the resolution back to you, we include the examples and I let you know whether or not I've made any changes. We will be adding an idea in the resolution itself, which is these would be looked at as compensated hours, which is different from hours worked, which is what we're using every place else because, again, hours worked is what comes from the statute. Because we are in the world of being more generous than what is required by statute, we've included the concept of compensated hours. You may not see us use compensated hours any other place. But because we're in the world of more generous eligibility, you're seeing it here.

Pete Cutler: Just to be clear, would that suggest that for this resolution, if a person is paid for a holiday, or sick leave, or whatever that those would be compensated hours? They would count as hours whereas they might not be counted as hours under when you're talking about hours worked?
Barb Scott: Correct.

Dave Iseminger: I also thought of another answer to Katy's question from earlier of where eight weeks came from. For many school administrators, if you go to the end of the school year, August 31, and count back eight weeks, you hit the 4th of July. If you do a number greater than eight, you're counting hours and weeks before many people are hired. We learned that a lot of school administrators are hired and start around July 1. We were also trying not to leapfrog back into June so that you were somehow penalized for hours before you were an employee.

Barb Scott: You're seeing us use compensated hours here, which is very different. And that's because it's also our understanding that superintendents and principals are hired effective July 1 and immediately put on leave. They are using vacation leave right away. They have to come to work based on the way their annual work actually plays out.

Proposed Policy Resolution SEBBf 2018-36 – Eligibility Presumed Based on Hours Worked the Previous School Year. This policy is intended to address concerns that certain employees whose hours hover around the 630 mark will automatically be presumed ineligible at the beginning of each year but will actually work the 630 hours and receive eligibility late in the year resulting in an annual gap in eligibility. It will also address the concern that substitutes will always be presumed ineligible at the beginning of the year even if they've worked 630 hours or more year after year. The policy's being reintroduced with the addition of a two-year look back.

Following the last Board meeting, I talked to a number of you and there was a concern that substitutes needed to be carved out. We struggled with that and looked at a number of different methods to try and achieve that. This policy resolution began with the idea of addressing substitutes and these employees who hover right around the 630 hours, addressing their eligibility and trying to alleviate this gap that could occur annually. We've reintroduced this with a two-year look back. And we believe that that will help to mitigate the concerns brought to us last time around. In addition, we had a good amount of stakeholder feedback.

Dave Iseminger: Barb, just to clarify, feedback on the prior version, this same concept but the prior wording?

Barb Scott: Yes, this concept but the prior version wording, correct. A stakeholder was concerned that the presumption is not being granted to employees who have control over the number of hours they work in a school year. A stakeholder was concerned that certain employees will have a gap in coverage year after year even though they meet the annual requirement.

Example #1 is a part-time bus driver who's earned eligibility in April during each of the prior two school years and is returning to a part-time bus driver position for the third year. She is eligible for the employer contribution towards SEBB benefits when she

returns to work in the same bus driver position for the third school year, unless the SEBB organization informs the bus driver in writing of the specific reason why she would not be anticipated to work 630 hours in the current school year.

Example #2 is a part-time food service worker who earned eligibility in April during each of the prior two school years and is returning to a part-time food service worker type position for the third year. He is eligible for the employer contribution towards SEBB benefits when he returns to work in the same food service position for the third school year unless the SEBB organization informs the food service worker in writing of the specific reason why he is not anticipated to work at least 630 hours in the current school year.

Dave Iseminger: We're being very clear about the need for in-writing reasons that comes with appeal rights. That is really true for any negative employee eligibility benefits determinations. Any time an employee is told that they aren't eligible for benefits, they have appeal rights. We've been working on the appeal rights because that's under the jurisdiction of the agency's authority. And this was a clear tie to make sure that those individuals who may believe that they are eligible, get definitive written explanations they could challenge on appeal if they so felt. I wanted to be very clear about that tie to the appeal world.

Pete Cutler: That's exactly what I was going to ask about. I was surprised words about how to appeal the eligibility termination were not included in examples because I think that's an important component of the notification. But clearly, the agency plans to incorporate that in its rule making. I think that's a really important aspect of it. Thank you.

Barb Scott: Yes. And the requirement to provide those appeal rights to employees is required under statute. I don't have the RCW number in front of me but it is in 41.05 series. Statute itself requires them to provide the employees with appeal rights related to their eligibility decisions. If you have no feedback, I will bring these back to the November Board Meeting for you to take action.

Dave Iseminger: But in the intervening month, it will undergo stakeholder review.

Barb Scott: Yes, these will go to stakeholders early next week.

Dual Enrollment

Kim Wallace, SEBB Finance Manager. The purpose of this presentation is to present some background information and to provide the opportunity to discuss SEBB-SEBB dual enrollment as the Board prepares to consider a policy resolution included in this deck. There will be a request for a vote at the November 8 Board Meeting.

Slide 3 – What is Dual Enrollment? SEBB-SEBB dual enrollment occurs if one SEBB member, an individual person, adult, or child, was enrolled under two SEBB medical plan accounts, two SEBB dental plan accounts, or two SEBB vision plan accounts. Contrasting with that in bullet two, SEBB-PEBB dual enrollment, we are not going to discuss at length today but we did want to acknowledge it's on the minds of a number of people. SEBB-PEBB dual enrollment would occur if a SEBB member was enrolled under a SEBB medical plan account and a PEBB medical plan account, or dental, or

group vision as well. Today, we're going to continue the discussion of SEBB-SEBB dual enrollment.

Slide 4 – Example of SEBB/SEBB Dual Enrollment. This example focuses on two employees who are married and both are SEBB benefits eligible, the most basic scenario that comes to mind when we think of dual enrollment. In this example, a benefits eligible employee enrolls as the subscriber in one of the medical plans offered to her as an employee, UMP Achieve 2 or UMP Achieve 1. Her spouse, who is also a SEBB benefits eligible employee, enrolls as the subscriber in one of the medical plans offered to him as an employee. It could be the same plan or it could be a different plan. Bullet three is where the dual enrollment occurs. One or both of them *also* enroll the other as a spouse dependent on *their* plan. Regarding the monthly premiums, per Policy Resolution SEBB 2018-14, which established a tiered premium structure for SEBB medical plans, this creates a Tier 2 employee, plus spouse enrollment scenario. Under Tier 2, the employer and the employee pay their premium contributions for both the employee and the spouse. You remember Tier 1, we talked about the medical contribution earlier. Under Tier 2, that gets multiplied times two and the employer pays that amount and the employee also pays their premium contribution times two. In this dual enrollment situation, now the employer and the employee are essentially paying premium contributions twice conceivably for both individuals.

Slide 6 – Benefits: How are Claims Paid? We've all have heard about coordination of benefits and many of us have participated in this. There are a couple of general points to be made. The plan determined to be primary pays its share of the cost first. The general rule is that an employee's own plan is the primary. Rules for Coordination of Benefits (COB) do vary. But generally, if there is any remaining amount owed by the member after the primary plan has paid, the secondary plan processes the claim and may cover some or all of the rest, in knowing that the member will not receive coverage for more than 100% of the allowed cost.

Slide 7 – Financial Considerations. Financially, if SEBB-SEBB dual enrollment is allowed, the employer, as I stated earlier, will pay premiums for an individual employee twice; once to cover their enrollment as an employee and once more to cover their enrollment as a spouse. The SEBB bullets on this side simply repeat what I already mentioned about the employee owing. If the employee owes part of the monthly premium, they pay twice as well, or two times.

Dave Iseminger: I want to interject one piece because I had this conversation with a lot of folks over time. It's important to remember that in the state world when the employer makes a contribution for medical, the same contribution is then paid out across the tiers for the dependents. That is not necessarily how many employers do it or how many employees experience it. When we talked earlier this morning about the Collective Bargaining Agreement and we described how the employer contribution is paid across all tiers, that's really what Kim's describing. I was thinking about it sitting here and I went back to the collective bargaining slides and pulled out the EMC concept illustration (TAB 4, Slide 5). Essentially what's being described on that slide is if you looked at the 82% AV plan, if the employer medical plan contribution is $200 at the employee only level and somebody has enrolled their spouse, the state is putting forward $400. They're contributing that for the husband and their wife on one account and they're also paying that same $400 on the other account where the wife is the subscriber and the

husband is the dependent. Essentially $800 in employer contribution is being put forward into the system, whereas if dual enrollment is prohibited, only $400 is put into the system. The same applies for the employee side. For example, on the scenario that I was just describing from the earlier slide, normally, it would be $15 at the employee level and $30 in the illustration. The employee would pay $60 instead of $30. But there would be $60 worth of employee contributions collected versus $30.

Kim Wallace: Correct. I think in terms of round numbers to consider, an employer medical contribution is not going to be $200. It will be more than that. And so you start to multiply and it adds up fast. If you want to think about a dental premium and the same dynamic happening under dental, you remember that the employee is not going to be paying any of that premium. The employer is covering maybe $40 to $50 times two and then perhaps $40 to $50 times two again.

Speaking of dental, Delta Dental of Washington, a carrier with currently over 200,000 K-12 enrollees, shared with us that they see at least 5% of that membership are currently dually enrolled in dental plan coverage. We asked them that question because we were trying to understand how often that happen. How many people would be dual enrolling in medical coverage, in dental coverage, in vision coverage? Delta Dental provided this estimate to us. We do have another source who suggested that they felt it would likely be at least 5% and that it could be about 10%. If you have any information about that from your experience in your work, that would be fabulous to hear about as well. But if we use the 5% to 10% estimate, it really does have a significant impact.

If dual enrolment were allowed, it would increase the cost of launching the SEBB Program. The employers would be covering that increased premium cost at the Tier 2 level instead of Tier 1 for every additional adult who enrolls in this dual situation. We didn't speak a lot about the children, but of course, a similar dynamic happens there as well in that we would be moving then not just to Tier 2 but we'd be moving into Tier 3 or Tier 4. And again, as Dave mentioned, there is an increase in the employer contribution as you move to Tier 3 and Tier 4, as well. We want to share that to the degree dual enrollment is allowed to be present in the SEBB enrollment rules, it will create pressure on the Legislature to consider how to address that cost. We know that the assumptions and the understanding to date from the Legislature, and in our conversations with OFM, is that the working assumption has been, and therefore, our modeling has followed this, that there will not be SEBB-SEBB dual enrollment allowed. Neither is PEBB-PEBB dual enrollment allowed in the PEBB Program. That creates this precedent for people's working assumptions going forward.

That said, this conversation and this presentation is definitely meant to provide you with information and food for thought.

Dave Iseminger: I know you're probably looking for what is the dollar amount it costs to buy this, because if the working assumption from all parts of the authorizing environment are like PEBB, dual enrollment would be prohibited within the Program. The natural question is how much does it cost? I'll point out, without getting into too many details, that we talked about general costs during the Executive Session. Anything related to the increase cost for this would be on top of that discussion that we had during Executive Session. We've tried multiple ways to come up with a dollar range to provide to you and they all have significant challenges and significant issues with the

assumptions that are necessary. But it is clear, especially because of how we've described the results of the collective bargaining, that it would be a significant additional cost on the state side because it's 85 cents of every dollar on medical and 100% of every dollar on dental and vision. When I said $400 goes into the system or $800 goes into the system, and we know those are artificially low numbers, the key assumption is how many people would dual enroll in each benefit. That's proven to be a very elusory, challenging number to get minds to coalesce around what it would look like. But the magnitude of it, we hope we've tried to illustrate by describing who pays what. The extra information from the Collective Bargaining Agreement really starts to show you the potential order of magnitude and that the authorizing environment has been under a very core assumption that dual enrollment within the program is not within the financial picture.

Pete Cutler: I've dealt with coordination of benefits (COB) quite a bit while at the Insurance Commissioner's Office. It was a huge hurdle to administrative simplification for processing of claims. Most electronic claim systems, could not handle COB-type situations. I also have a bias against having COB situations in general in health care.

Secondly, I think the state's goal, and certainly with the PEBB Program originally, and I think now extended to SEBB, is to provide comprehensive medical coverage to employees and with a very strong commitment to affordability for family coverage. It's like a defined benefit type commitment of policy. It's not just treated as, "Okay, we give you so much salary and here's some dollars and you go spend those dollars however you want for health care." It's a, "We want to make sure employees can cover themselves and their families with good comprehensive coverage and at a reasonable cost."

In my mind, the cost involved with coordination of benefits, while it would be obviously much appreciated by those who would benefit from it, doesn't really contribute to that policy goal. If you haven't guessed by now, I'm a fan of the resolution. I'm not a big fan of coordination of benefits as a priority for spending money in a health plan.

Dave Iseminger: Proposed Policy Resolution SEBB 2018-15 – Dual Enrollment in SEBB Benefits is Prohibited. This is the same resolution that was originally presented in May, the same exact wording. It will go back out for stakeholder review and we'll provide their feedback part of the process.

Kim Wallace: Proposed Policy Resolution SEBB 2018-15 – Dual Enrollment in SEBB Benefits is Prohibited. School Employees Benefits Board (SEBB) medical, dental, and vision coverage is limited to a single enrollment per individual.

Lou McDermott: A clarifying question: if you had two people that are together, they have a child, then one of them could cover themselves and the child on one account and you could have the other one cover on the other account. And that's not dual enrollment?

Dave Iseminger: I believe what you said is if Kim and I are married and we have a child and the child is on my account, Kim could be on her own separate account. Kim and I can't have the child on both our accounts.

Kim Wallace: I don't have the child also on my account.

Lou McDermott: But that's not considered dual enrollment.

Dave Iseminger: It's not considered dual enrollment when I have the child on my account and my wife, Kim, has her own separate account. We get married a lot here in our examples. [laughter]

Kim Wallace: We do. We do.

Dave Iseminger: There's lots of examples.

Lou McDermott: Congratulations!

Kim Wallace: The theme there, the guiding principle is no human being, no one individual is enrolled in more than one account, child or adult, no matter how old.

Lou McDermott: Understood. I just wanted to make sure that was clear.

Fully Insured Medical Benefits

Lauren Johnston, SEBB Procurement and Account Manager. I am providing a brief overview of the outcome of the RFP proposals. There were six apparently successful bidders. The contract negotiations have begun with all six of them. We are going to request the Board take action at the November 8 Board Meeting to proceed with rate development on the proposed plan designs that you will see later in the month, then again on November 8. There are no rates at this time. The contract right now is focused around developing the plan designs, as well as operations, clinical programs, etc. However, we will go into not to exceed rates, which we hope to obtain sometime between December 2018 and January 2019. Out of the RFP proposals, there are two HMO plans and four PPO networks.

Dave Iseminger: I want to make sure when we talk about rates, the full picture is set out for folks. We would be asking the Board to say preliminarily go forth with rate development on the designs in November. We would then take that and go through the not to exceed rate-setting process with the carriers in December and January. That will give us the first real indication as to the high water mark for rates. That will then be used to guide legislative budget final assumptions as the Legislature finalizes its decisions. After the budget comes in, we go back to the carriers and say here's the real number. This is how it looks once you apply an EMC of 85% of the 88% AV plan. We'll come to the Board and say here's what the premiums are looking like. Are there benefit design changes that need to be tweaked before we settle in on final rates with the carriers?

When the Board votes next summer, at that point employees will be able to know exactly what they would put forward as their employee contribution for the entirety of plan year 2020. It's come to my attention recently that sometimes school employees don't know exactly what they're paying until the month that they're paying. I wanted to make sure that it was very clear for everyone that once the Board makes its decisions in roughly July 2019, anyone who's looking at these materials will be able to see via the Board vote what the employee contribution is. All school employees will have

information before them when making their elections that will definitively have what they will be paying in the new system. It just came to my attention that's not the way every school employee experiences the benefit system now. I did want to make sure that was very clear for the Board, as well as members of the public that are paying attention.

For example, I am about to get my PEBB newsletter that has the rates I will pay for 2019. I will get that information two to three weeks before open enrollment. I have that context. I make my selection in November and I know exactly what I'm going to pay for all of 2019. That is a similar model for this program.

Pete Cutler: Can we hope that the school employee communication next year might have a longer lead time than just a couple weeks before open enrollment just given how huge a change this is?

Dave Iseminger: I think the crunch time is going to be whenever the Legislature gets out of town and how quickly we can land the rates with the carriers. We're projecting open enrollment to begin on October 1. We're also planning to have a more extended open enrollment. In PEBB-land, we do a four-week open enrollment, the month of November. We're planning for a six-week open enrollment because of all the change that's happening in the system. We're working on ways to make sure the communication gets out. It really depends on when the final funding comes in and how fast we can get it for that open enrollment period.

Pete Cutler: That's understood. I just hope it's very robust.

Dave Iseminger: I would say information will be on the websites quickly and anybody who wants can go to that information. But the individual, tailored mailing we typically align that closer to open enrollment so that people get it and don't lose it in the month intervening. The information will be publicly available, just not in the hands of everybody individually. But it will be very robustly publicly available as soon as the Board takes actions on the rates.

Pete Cutler: Great. Thank you.

Lauren Johnston: Slide 3 – Initial Plan Development Process. In the RFP, we asked the carriers, in addition to submitting a proposal, to submit plan designs. Their original plan designs were not scored. We wanted to use that as a basis for starting the conversations around plan designs, but not have them scored.

At the end of August, we instructed all apparently successful bidders (ASBs) to submit updated plan designs based on some initial parameters, which include about two plans for Clark, King, Snohomish, and Spokane counties and around three plans for the other 35 counties. We reminded them of the self-insured SEBB plan actuarial values. We also foreshadowed to assume that the vision benefit would be carved out of the medical plans. In addition, we let them know that the premium tier ratio would be applied to employer contributions for medical benefits.

Sean Corry: Lauren, in my long-term memory, I believe that at least a vision exam is a required benefit under the old HMO rules. Is that no longer the case? At Kaiser

Permanente, for example, with their HMO model, they used to have to have at least a vision exam baked into their HMO benefits. I don't know if that's the case.

Lauren Johnston: I remember looking this up because this was asked the last time and I believe the response is no.

Dave Iseminger: I did want to give more context to everyone as to why two plans in those four counties and why three plans in all the other counties. Part of it was based on the initial proposed service areas. The saturation point that could be reached with the number of plans in certain counties looked like it would be greater in the four counties that are listed here. We wanted to make sure we were signaling to other carriers that there was this concern, at least from the agency. We want to validate and get some insight from this Board regarding concerns about too much choice. We gave them that direction of about two plans in those four counties and about three plans in the others

Sean Corry: For clarity, would you help me understand what plan means in this case. Because for me, a plan is a plan choice. Maybe it could be four from a carrier. Are you talking about the plan being the insurance company, for example?

Lauren Johnston: No, I refer to that as a carrier.

Sean Corry: So, they could have multiple offerings?

Lauren Johnston: Yes. There could be a carrier who offers two plans in Clark, King, Snohomish, and Spokane. And that same carrier could offer three plans in the other 35 counties.

Sean Corry: Got it. So we just need the number of carriers and we can do the math.

Dave Iseminger: Correct. And the other way to think of it is although UMP is not a carrier, you could think of it as one, and the Board has authorized four UMP plans. That's the equivalent here. For example, Premera is one of the ASBs. They could offer about two plans in those four counties and about three plans in the others. Right now we're negotiating with six carriers. Multiply by two. Add four for UMP and you're at 16 potential for Clark, King, Snohomish, and Spokane Counties. The other counties, it's not quite six carriers and that's what we were trying to account for with about three plans because the service areas don't overlap in the same robustness as they do in those four counties.

Sean Corry: But we're in the teens.

Dave Iseminger: We're in the teens.

Lauren Johnston: Slide 4 – Accumulator Variability. The accumulator variability is based on plans requested from the information provided at the end of August. We've gone through three iterations: the unscored plan designs submitted with the RFP, the plans submitted in mid-September based on information given in August, and an update to the plans at the end of September.

This slide is based on the information provided in August with the updated plans in mid-September. The proposed plans included a wide range of accumulators. For the medical benefit, the deductibles for a single subscriber came in between $125 to $1,750. For a full family, the range is from $250 to $5,250, with a maximum out-of-pocket between $2,000 and $5,000 for a single subscriber and $4,000 to $15,000 for a full family.

Pharmacy benefit deductibles were combined with the medical deductible, or between $0 to $500 for a single subscriber, or $0 to $1,250 for a full family. For the maximum out-of-pocket, all plans said their maximum out-of-pockets for their pharmacy benefit accumulated towards their maximum out-of-pocket of their medical benefit.

Slide 5 – Benefit Cost Share Ranges. The green row at the very top is the general coinsurance submitted. When you look at a list of benefits not included in the covered service types in blue on this page, you would apply either the in-network or the out-of-network coinsurance within the green row, depending on whether or not you see an in-network or out-of-network provider. The range for in-network is 10% to 25%, depending on selected plan. Out-of-network is 40% to 100%. When we take a look at some of the covered services, we wanted to provide coverage services that most people tend to look at when they think about their benefits. What am I going to pay when I go to the emergency room? What would I pay if I had to have surgery and I'm in-patient in the hospital? Those types of things. We carved out areas we felt were important. The copay for the emergency room was $0 to $250 and a coinsurance of 10% to 25%.

Dave Iseminger: Lauren, to be clear, there's not a plan that has both a copay and coinsurance. Some plans are copay, some are coinsurance?

Lauren Johnston: They all are. For the plans that you pay a $0 copay for the emergency room, you will pay a coinsurance. But there are some plans where you might pay $150 copay and pay a coinsurance of between 10% or 25% on top of that, depending on which plan you select. The same applies to hospital in-patient. You're going to pay $0 to $300 copay per admission, plus 10% to 25%. Again, for those where you pay $0 for the copay, you would only pay the 10% to 25% coinsurance. Out-patient, none of the plans had a copay for hospital out-patient services. They all have a coinsurance of 10% to 25%. For primary care office visits, there is a copay between $0 to $40 or 15% to 20%. When it comes to the office visits, it's unlikely that you would pay both. You're either going to pay a copay or the coinsurance, depending on what type of plan you select.

Sean Corry: This is a question out of confusion. I'm sure we'll see this in a minute, but just for the purposes of this, did we get proposals from, I'm presuming Kaiser Permanente for HMO only service. Is that where this doesn't really apply that there is no out-of-network except in an emergency?

Lauren Johnston: Yes, you are correct that the Kaiser Northwest and Kaiser Washington HMO plans do not have out-of-network coinsurance except for when, and that's what the asterisks are for, emergency care and for some carrier's urgent care where you would pay the in-network coinsurance.

Dave Iseminger: Did that answer your question, Sean?

Sean Corry: I think so.

Lauren Johnston: Office visits for specialty care, you'll pay either a copay of $30 to $50 or a coinsurance of 15% to 20%. For urgent care, $0 to $50 for copay or 15% to 25%.

Slide 6 – Proposed Treatment Limitations. We have listed a range of limitations. Acupuncture, depending on the plan is either 12, 16 or 20 visits. Chiropractic is 10, 12, 20, 52, or no limit. Those are your options depending on what plan you select. Massage therapy is limited to 45 or 80 visits, depending on the plan. There is no limit for occupational therapy/physical therapy/speech therapy/neurodevelopment therapy (NDT) for one carrier. For some carriers, their massage therapy benefit is separate from their other therapies. You're going to have 12, 16, or 20 visits. Some have a combined occupational therapy, physical therapy, speech therapy, and neurodevelopmental therapy benefit of 45 or 60 visits combined per calendar year, depending on the plan.

Sean Corry: Were there some proposals from carriers where there was a limit on neurodevelopmental therapies as the limits are for occupational physical therapy?

Lauren Johnston: Yes. The 45 to 60 combined applied to some carriers.

Sean Corry: Even if it's coded in the DSM 5? So it's not covered? You're saying that it's not covered under the mental health parity rules?

Dave Iseminger: We'll do some follow-up questions with the carriers about that piece. But from what we got in their proposals, it was a combined treatment limitation, at least on paper, the same way that it is in the Uniform Medical Plans. You'll recognize the structure is similar to the structure of the self-insured plans. We'll follow up.

Sean Corry: Well, just to make the point, I know that after the mental health parity laws were passed, there was a set of years during which the carriers were not, in my view, correctly interpreting the new law and were denying benefits. That's the key therapy that drove lawsuits all the way up to the State Supreme Court, neurodevelopmental therapy. I think now, universally to be covered under the mental health parity act and on par with other medical conditions. I think that restriction might be problematic.

Dave Iseminger: We will further clarify with the carriers exactly that part of the box and make sure we address that piece, Sean. I will say one of the reasons we made sure that we put this information in is because of the questions this Board had about treatment limitations in the self-insured plans. We knew that you would be particularly interested in seeing these pieces. I did want to give you insight on the limitations. Chiropractic, for example, and the number 52. I did want to be clear that is one of the plans. If you say that we got somewhere between two to three plans, we have six carriers, you're looking around 18-ish plans. Out of those 18-ish plans, one had a 52 limit and one had no limit listed. The rest were either 10, 12, or 20.

You might be curious about what options school employees are going to have. If you want variability in the system, that comes from the fully insured side. I want to be very

careful because we're still in negotiations about some of the service area aspects. But what I could say at this point with what we know, it looks like most school employees, most districts, and most counties would have some options in that 10, 12, 20 area for chiropractic; 12, 16, and 20 for acupuncture; 12, 16, and 20 for massage. The self-insured plans you've authorized has 10 chiropractic, 16 acupuncture, and 16 massage. If you try to line those up, you see that it looks like, unless this Board directs otherwise, there could be variability in the system on these treatment limits. Some variability for most school employees in most areas. I know those are all very general statements.

Sean Corry: I guess I have a question about practice because in my firm, as an insurance broker, we would ask carriers for particular benefit designs or variations on what their standard designs would be. When you got these drafts, I don't know if they're proposals yet or what, did you specify the set of benefits they should try to emulate, imitate, copy?

Dave Iseminger: Sean, we made sure they knew what the benefit design was they would be competing against in the self-insured part of the portfolio. And they had a complete copy of the benefit treatment limitations, the benefit coverage levels of those so that they could try to position themselves in the market somewhat appropriately. And the next question for this Board, previewing a couple slides down, so the theme of the last couple of slides from Lauren has been, there's a lot of variability. And the question is, how much variability is too much variability. And so that's a question for the Board, are there areas you want us to be focusing on reducing variability? Do you want us to ask the carriers to match the self-insured design? Or do you want this variability? We started from a place of variability that we can collapse, versus the other way around. They were given the context of the plans for the Uniform Medical Plan self-insured plans that you authorized in June as a guidepost for what they would be competing against in this portfolio.

Lauren Johnston: Slide 7 – Actuarial Value (AV) Ranges. From the plans, we saw fairly even distribution from approximately 79% to 91% AV. There was a concentration of plans between 83% and 84% AV. We had one AV at the lowest at approximately 76% AV and two plans with the highest at approximately 91% AV. Just as a reminder, the Uniform Medical Plan AVs are UMP Achieve 1 at 82%, UMP Achieve 2 at 88%, and UMP Plus at approximately 89% to 90%.

Dave Iseminger: This is where I say, at least slide deck number one that Megan and I did this morning was internally consistent. And this slide deck is internally consistent. But the decks aren't consistent with each other about which AV is UMP Achieve 1 and which one is UMP Achieve 2. We will make sure that in the November packet, there is a follow-up in my presentation at the beginning that has a crosswalk from the resolution, to the plan, to the AV, and to the deductible so everybody has one piece of paper they can always go to forever and ever. I will acknowledge they are not internally consistent in this briefing book. I know which one I think is right. [laughter]

Lauren Johnston: Slide 8 – IRS Qualified High Deductible Health Plan (HDHP). For the IRS qualified high deductible health plan, we received one HDHP, which would not be available statewide. However, the UMP high deductible health plan is available statewide.

Dave Iseminger: If this Board is interested in sending a direction that you want more high deductible health plans, we would appreciate knowing that here. But in general, with the constraints and portfolio that we described to the carriers, they didn't bid many high deductible health plan levels or offer them statewide.

Sean Corry: Could you ballpark the percentage of PEBB employees who have chosen that plan?

Lauren Johnston: I want to say on UMP, it's around 12,000 to 13,000.

Dave Iseminger: I think it's somewhere in the 10% to 15% in a high deductible health plan. We'll also follow up with that context.

Patty Estes: How not statewide?

Dave Iseminger: I would say a few select counties, but they tend to be more populous counties. Small when you talk number of 39 counties, larger when you go percentage of employees. Again, all of the service area pieces are still in flux. But that's pretty much where it looks like it'll probably land.

Lauren Johnston: Slide 9 – Variability Impacts. On one hand, standardizing some cost-share aspects of the plan design could help make comparing plans easier, as well as improve the member plan selection experience and provide parity among the health plans. On the other hand, standardizing all cost-share aspects of plan designs could potentially limit the range of AVs, as well as shifting the primary focus of member selection away from the plan design into the provider networks. Things to consider when we're looking at the variability of the different plans and whether or not there are different things you would like to standardize.

Pete Cutler: From your discussions with the carriers, do you have an impression about whether having more or less variability might have an impact on premium bids? Do they think they have some secret sauce with whatever particular mix of plan provisions they want to propose, that they think allows them to provide the overall plan at a lower cost than would be the case if they were required to adjust to a common set of plan provisions?

Lauren Johnston: We set up the meeting in August for them to put their best foot forward. We possibly already have those.

Pete Cutler: Did any of them, during discussions say, “I can give you a good deal if you allow me to do exactly what I want. But I don't know if I can give you such a good deal if I have to make my plan follow your template." Any kind of conversations like that?

Dave Iseminger: Pete, to this point, because we aren't into the rate-setting aspect of it, there hasn't been significant chatter of that nature. Discussions from some carriers are based on their experience with the market, school employees might be more accustomed to this type of plan design versus that type of plan design. We want to make sure that we're as attractive as possible with plan designs. If a school employee is already familiar with the carrier name, the carrier wants them to be as familiar with the plan design they're proposing as well.

But that's part of the challenge. Is there so much variability in the system right now that you could end up with just as much variability in the SEBB portfolio? When the deductibles come in, I was counting in my head, and between the 18-ish plans, there were somewhere between nine and ten different deductible levels. That's an area we could standardize to make it easier for members when comparing benefits. We've selected a couple of different deductible levels based on the Board's prior actions and what we were seeing in the carrier responses. We asked them to resubmit, collapsing to these four different numbers. We got some push back from some of the carriers because their experience with deductibles was different than our request. They indicated they had X number of school districts that offer this level of deductible and Y number of school employees. We said we understood but there is value in having coalescence around a few deductible numbers.

Are there other areas you think are important to collapse?

Lauren Johnston: Slide 11 – Questions for the Board. To piggyback off what Dave said, are there other components of plan design where you are interested in seeing more standardization? Areas that might apply to this are the maximum out-of-pocket costs and office visit copays. Is there a point where you become concerned about too much plan choice for a member?

Sean Corry: Yes. Well, I find it confusing now. I wonder, because the question for the Board about plan designs is if we're interested in seeing more standardization, I think that's going to take conversation here. So my vote is yes. When school districts have an opportunity to choose among several plans, usually there's common language across the columns. It's relatively understandable changes in number of visits or what the copayments are going to be, etc. Then it changes the premium down below. What I saw here was something I could not track. It was just jumble. I vote for simplicity and I haven't seen it yet. I don't know what else to say.

Lauren Johnston: Remember what you saw earlier were ranges based on the 18 different plans we received. When we do put out communications for open enrollment for members to be able to select a plan, it will look like that. There will be coinsurance for different types of services. It will look the same and it's not going to be a range. It'll be one number for each of the different plans that they could select from. So we just wanted to show you that one of the reasons why we are going through the standardization process is because there's so much variability right now to select from.

Sean Corry: How are we to answer your question here about what we would like to do? What's that process where we can give you input?

Dave Iseminger: To some extent, Sean, our Executive Session tried to show you more about where we are in the contract negotiations. After previewing for the public, we're going to go back into an Executive Session at the end of this meeting to continue the conversation with very specific variability we're seeing. We want to at least have, in the public meeting, the ability for you based on what you see even just at the range level, to see if you think office copays in the $40 range feels like too far. Can you collapse that to two or three numbers instead of a full range of options? There's some direction from the Board about trying to coalesce just like we did for deductibles to three or four numbers for some of these other areas. Or, on Slide 4 you might think the maximum

out-of-pocket, ranging from $2,000 to $5,000 in a medical deductible, seems like too much. Are there more numbers to focus on or more buckets that we can collapse like we did for deductibles? We tried to use deductible to show an exact illustration. If you're concerned about too much variability on a specific accumulator or a specific coinsurance cost share, then we would take that direction and go back to the carriers and ask them to look for more standardization in areas.

Sean, you've expressed a view of wanting more simplicity. I don't know how far to take simplicity. We could go all the way to match the benefit design of the 82%, 88%, and 90% AV plans for UMP so you're down to comparing those three buckets of plan benefit coverage and then focusing on provider network. That could be one way to go. But that would then collapse the range of AV and affordability and you wouldn't end up with any AV plans lower than 82%. We weren't thinking that the Board wanted us to go so far to collapse to a couple of AVs with a couple prescriptive buckets on some of the accumulators, which are the drivers of AV. We think the Board is interested in more variability. The question is how much variability? What are the areas you want to focus on?

You can save your comments for Executive Session when we have specific pieces before you. But if there's anything that you're aware of at this point that you want to say publically, we would welcome that as well.

Pete Cutler: I, like Sean, would say yes and yes in terms of wanting to see more standardization and being concerned about too much plan choice. Also, probably just concerned about fragmentation of the enrollment and the instability that could lead to for the overall program. If you have 20 different plans offered by six different carriers, I'd want to have a hard look at does it look like these can all be successfully moved forward on a financial basis for more than just one year. Or would we end up with something where we had a lot of complexity and a lot of different plan options that don't really have much obvious difference from each other that we then have to engage in different communication efforts the following year because various plans have been dropped or changed or carriers have dropped out?

Having some kind of balance where there's a range of choices, certainly more than maybe what state employees get, given the number of six apparently successful bidders we have. But something short of The Exchange. We had one carrier on The Exchange who must have loaded 30 or 40 different plans. If you're a health care professional being paid to look at it, you couldn't figure out exactly what the differences were and you didn't see what value that added to the people who went to The Exchange to try and figure out what plan they wanted. I think some movement towards having a modest selection, but one where it's clear, without too much effort and you can distinguish this plan has this strong point. And the tradeoff is this rather than just a plethora of options that are hard to sort out. That's all very general but that's what I have so far.

Dave Iseminger: A couple of other things to keep in mind is when Lauren gets to the resolutions, we're teeing them up and asking you to endorse some plan designs for the purposes of going forward with rate development. That would not lock you in to final offerings and multiple plans from all of those carriers. If as you go through the rate development process and learn there are 18 plans with six carriers in King County, and that’s too much, you could not offer a carrier’s plans or work with us to talk to the

carriers about offering fewer plans. I want to be clear that you're still at the high water mark and you could do pruning along the way as you get more information about the total service area and total premiums as we get the not-to-exceed rates.

The Board wouldn't be locked into offering plans under all six carriers by passing the resolutions next month. We do have ways of appropriately unwinding a contract if the Board ultimately does not include a carrier's offerings in the final portfolio.

Sean Corry: If we were to go through that process the way I think you just described it and asked the carrier to drop a couple plans, for example, would that create some sensitivity with respect to the pricings of the other plans? Is it going to impact what the carriers think they need for the remaining plans if some other plans are dropped, because they would get a different risk mix.

Dave Iseminger: As we get further into the not-to-exceed rate-setting process. I'm sure more questions will come up from the carriers. What we typically do in the rate-setting process is take the complex funding model and the agreed amount under the Collective Bargaining Agreement to identify what is the likely employee premiums. We talk with the carriers about what the self-insured plans are going to look like. That tends to guide the discussion quite a bit as to refinements on their bids and their plan designs. That's typically part of how that process proceeds.

Patty Estes: I know that you are in negotiations. Are some of the providers still trying to broaden their networks to cover more service areas within bargaining or are they pretty set on where they're providing their services?

Dave Iseminger: I would say that it's still a somewhat fluid process right now. You have to realize that some of the carriers we're negotiating with have long-standing relationships with the Health Care Authority and understand how different pieces of the puzzle work. Other carriers are completely new to the Health Care Authority, at least on the commercial side. I'm helping them understand how different pieces work and their comfort with different contract language allows them to be more risk tolerant with regards to their service areas. There's still a lot in flux at this point.

Patty Estes: I know from my experience, the biggest question that I've gotten as this transition is going to happen is, "Can I see my doctor?" That is definitely a factor in my decisions, who we go with on the broader provider network. I mean, we're going to have some variability. But that's actually a pretty big factor.

Dave Iseminger: Patty, I know that we struggled a little bit with the vernacular earlier, let's just for purposes of all of our conversations say "carrier." Carriers have plans. What you're talking about, I think, is the provider network offered by different carriers. And you may be interested in more carriers across the portfolio with fewer plans than more plans and fewer carriers.

Patty Estes: Yes.

Dave Iseminger: I saw at least two smiles and a head nod. I wanted to see if that resonates and get that on the record for Connie. Okay, some interest in more

variability, provider networks, less plan offerings per carrier but more carriers. At least preliminarily. Okay. Lots of head nods. Lots of smiles. Go Patty! [laughter]

Lauren Johnston: Slide 12 – Next Steps. HCA will incorporate Board insight into ongoing negotiations. At the November Board Meeting, specific plan design components will be shared, which you will see on Slide 13. The information will be provided to the Board as early as possible prior to the November meeting. Action will be requested on Policy Resolutions SEBB 2018-45 through SEBB 2018-50 at the November Board Meeting to proceed with rate development.

Slide 13 – Proposed Medical Plan. This is the proposed medical plan design. Basically, carriers will come back with their plan designs using this template.

Dave Iseminger: Our question for you, is there anything else that you think at a high level would be areas you want to see in this type of chart? We focused on those key accumulators, as well as the copay and coinsurance of different pieces.

Patty Estes: Some treatment limitations would be great to see on chiropractic, acupuncture, etc. because I think that is, for some of us, deciding factors on some of the plan designs because we want to have that variability.

Lauren Johnston: I likely won't include it in this format but it will be on another slide. It'll be like what you saw before, but broken out by plan.

Dave Iseminger: We'll have a supplemental slide that goes through all carriers and their plans.

Lauren Johnston: Slide 14 – Proposed Policy Resolution SEBB 2018-45 – Fully Insured Medical Plans (Aetna). The SEB Board endorses Aetna's proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Dave Iseminger: Lauren, I don't think you need to read all the resolutions. They are the same syntax, different carrier name. This will give you the opportunity at the end of the day if you do want to prune a carrier, so to speak, or prune plans. That would be the mechanism. That's why we tee them up as carrier by carrier votes.
Slide 16 – Proposed Policy Resolution SEBB 2018-45 – Fully Insured Medical Plans (Aetna). The SEB Board endorses Aetna's proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Slide 15 – Proposed Policy Resolution SEBB 2018-46 – Fully Insured Medical Plans (Kaiser Foundation Health Plan of the Northwest). The SEB Board endorses Kaiser Foundation Health Plan of the Northwest's (KPNW) proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Slide 16 – Proposed Policy Resolution SEBB 2018-47 – Fully Insured Medical Plans (Kaiser Foundation Health Plan of Washington). The SEB Board endorses Kaiser Foundation Health Plan of Washington 's (KPWA) proposed fully insured plan designs

presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Slide 17 – Proposed Policy Resolution SEBB 2018-48 – Fully Insured Medical Plans (Kaiser Foundation Health Plan of Washington Options, Inc.). The SEB Board endorses Kaiser Foundation Health Plan of Washington Options, Inc. (KPWAO) proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Slide 18 – Proposed Policy Resolution SEBB 2018-49 – Fully Insured Medical Plans (Premera). The SEB Board endorses Premera Blue Cross' proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Slide 19 – Proposed Policy Resolution SEBB 2018-50 – Fully Insured Medical Plans (Providence Health Plan). The SEB Board endorses Providence Health Plan's proposed fully insured plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

[break]

Centers of Excellence Program

Marty Thies, Program Manager. Last month I was here to tell you about the Centers of Excellence Program. Today is to provide some highlights. In the PEBB Program, The Centers of Excellence Program is an overlay for the UMP Classic Plan and the CDHP. We offered our first bundle in January 2017, total joint replacement. The Program has proven both cost effective and clinically effective. The SEB Board can choose to adopt this as a program overlay on UMP Achieve 1, UMP Achieve 2, and UMP High Deductible.

First of all, we have two bundles. One is underway, one is going to be inaugurated on January 1, 2019. Total joint replacement is finishing up its second year and the second bundle is for spine care.

We anticipate future bundles for years to come. We try and select procedures and conditions that have high utilization; and therefore, there's a greater effect and/or high variability in cost and outcomes. We issue RFPs for a certain procedure, soliciting responses from facilities that are interested in becoming a Center of Excellence. They have adopted, or will adopt, the Bree criteria and have a proven record of great services for these procedures.

Examples of the Bree criteria: appropriateness, conservative therapy; surgeons must begin before 5 p.m. and do a minimum of fifty procedures per year; and member fitness.

Slide 4 – Benefit Design. For both current bundles, we incentivize toward quality. The participation in the Program is voluntary; low to no out-of-pocket cost, except for the CDHP programs due to IRS regulations; in-patient services; implant and durable medical equipment; case management for members from beginning to end; and transportation for those who don't live in the proximity of a Center of Excellence, and accommodations. This is a prospective payment. That is, we have agreed to a case

rate for these procedures in the contract, which stabilizes our costs at the Center of Excellence. There is a 90-day warranty. This is between the Center of Excellence and the Health Care Authority for specified complications over a 90-day period.

Dave Iseminger: The transportation accommodations is for a member who lives outside of 60 miles of a Centers of Excellence. For total joint replacement, the single Center of Excellence in the state is Virginia Mason Medical Center in Seattle. Anyone who lives 60 miles outside of Virginia Mason would have a travel benefit. For the spine care bundle that we're launching, there are two Centers of Excellence. Virginia Mason Medical Center in Seattle and Capital Medical Center in Olympia. Anybody who lives outside 60 miles of either of those Centers of Excellence would have a travel benefit.

Lou McDermott: I know the answer to the question, but I'm asking it so we can understand it. Why is there only one Center? Why aren't there multiple Centers throughout the state? Why didn't we pick one on the East side and the West side to get better state coverage?

Marty Thies: And that was the idea. We do have two for spine care. For the first Center of Excellence, we put out an RFP. We asked for information about their outcomes. And for total joint, the outcomes at Virginia Mason were far and above what anyone else in the state was able to report to us.

Lou McDermott: We did want to spread it throughout the state because we understood that was going to be an issue for some folks. But when the results came in and we looked at complication rates and readmission rates, one of the middle of the road entities had a 15% readmission rate. So 15 out of every 100 people are going back in the hospital to spend more time. And Virginia Mason's rate was .2. So 2 in a thousand. The difference was so stark between Virginia Mason and the other entities in the state that we just could not call another entity a Center of Excellence in good faith and tell our members to go there. The difference was that amazing.

Katy Henry: Can I ask a follow up to what Lou said? Is there a criteria, then that you're basing that on or is it just that Virginia Mason was so much more successful than the other centers that submitted information?

Lou McDermott: The basis for their clinical program is the Bree Collaborative. So the Bree Collaborative has done hip and knee bundles and said if you're going to do this right, you're going to have low readmissions and high outcomes, and you have to do these certain things. That is what's helping to make sure that the right people are getting the right service at the right time and they're prepped and ready for surgery and there's proper follow-up care and all those things are done. To be honest, some people aren't doing a very good job of that. And that's why they're having poor outcomes, which makes sense.

There are areas where the surgeon's done three of these in a year. I don't want to be the first and I don't want to be the third. I want to be the 85th! It's just one of those things where Virginia Mason, in partnership with Bree, has followed those criteria very closely and they're just getting their results. The only unfortunate part is that if someone were to go and be denied by Virginia Mason saying you're really not a candidate because you didn't do x, y, or z, or we don't really think you need a knee replacement,

in our program today, they can still go somewhere else and have that done. We're still evaluating to see if people who aren't qualifying for Virginia Mason are going elsewhere and trying to have the procedure done.

Marty Thies: There were only about eight or ten who were referred by Premera, our third party administrator of this Program, who did not go ahead and have the surgery. Family issues or perhaps they couldn't stop smoking or couldn't get their BMI down to the appropriate level. We haven't checked yet to see if they went and got a surgery elsewhere. That's something we can do.

Slide 5 – TJR Quality and Costs. Outcomes have been exceptional. To date, we have zero readmissions for members who have received their joint replacement at the Center of Excellence and zero complications when we checked the Regence data if they went elsewhere. Member experience surveys are issued 30 days post-discharge. There are a number of questions, one of which is, "How would you rate the overall program?" The average with a 70% response rate was 9.5 out of 10.

Lou McDermott: Marty, what's the total number of people?

Marty Thies: The total was 95 surgeries. We had a 70% response. With regard to cost, members have saved the average out-of-pocket, or ballpark out-of-pocket, year over year somewhere between $800 and $1,000. It depends on where someone goes for their surgery. Each surgery performed at the Center of Excellence was less expensive than those performed elsewhere in the Regence network.
Slide 6 – Recommendation. Our recommendation is that the SEB Board adopts the Centers of Excellence Program for these UMP Achieve 1, UMP Achieve 2, and the UMP High Deductible.

Slide 7 – Proposed Policy Resolution SEBB 2018-51 – Centers of Excellence. The SEBB Program will offer the Uniform Medical Plan Centers of Excellence Program (COE) starting in Plan year 2020.

Dave Iseminger: I want to make sure that I get something very clear on the record. On Slide 6 there are three plans specifically named. The Uniform Medical Plan Plus is not listed, but the recommendation and wording of the policy resolution covers the entire Uniform Medical Plan. The only reason we're recommending launching with just UMP Achieve 1, UMP Achieve 2, and UMP High Deductible in 2020 is we've not been able to reach terms with the networks in the UMP Plus to integrate that payment model and COE within that plan. But if we were, I wanted to be clear that the wording of Policy Resolution SEBB 2018-51 would be the Agency, if we are able to execute contracts with those networks, this resolution would give the authority to immediately imbed the COE Program upon execution of the contracts.

Just a slight clarification about the implementation within three plans, yet the resolution actually, would give authority for all four plans if the contract mechanisms ultimately exist. You're authorizing a program. So for example, now we've described to you the total joint replacement and the spinal bundle. As a result of Policy Resolution SEBB 2018-51, whatever bundle number three is, we would come back and talk with you about its implementation, but you would not have to vote bundle-by-bundle to incorporate it. You're authorizing a program that includes current and future bundles.

And as we describe things to you, if there was a particular concern about implementing, we would obviously address that with you at that time.

Uniform Medical Plan (UMP) Follow Up – Exclusions and Treatment Limits
Shawna Lang, Senior Account Manager; **Kim Wallace**, SEBB Finance Manager
Shawna Lang: We did a comparison of exclusions between the fully insured plans that came in for SEBB and the Uniform Medical Plan. In the comparisons, services that were not compared at all were Health Technology Clinical Committee's (HTCC) determinations because Uniform Medical Plan is mandated to exclude those types of services. If the majority of carriers aligned with UMP, we also didn't have those as anything we looked at either because the majority of carriers looked the same throughout. If we could not contractually change an exclusion then those were also not compared.

Pete Cutler: Shawna, can you explain what you mean by "contractually, the exclusion cannot be changed?"

Shawna Lang: You've heard about substantially similar language between the PEBB Program and the SEBB Program.

Pete Cutler: It's really to stay in alignment with that statutory provision that the benefits have to be substantially similar.

Shawna Lang: Our contractual provision, yes.

Pete Cutler: Oh, it's a contractual provision. Okay, great. Thank you.

Dave Iseminger: Shawna's going to go through some examples. There's only one thing that was knocked out because of that last contractual exclusion piece, just to be clear.

Shawna Lang: Slide 3 – Comparison Results. No services past all of those criteria. It means that the fully insured carriers and the UMP exclusions align. Examples of services that the criteria were applied to are skilled nursing facilities or confinement where the primary use is really a place of residence. Air ambulance if ground ambulance can serve the same purpose. Non-Affordable Care Act (ACA) immunizations and treatment caused after voluntary participation of riots, rebellion, or illegal acts.

Dave Iseminger: What we're saying is, these exclusions as they're described in the Uniform Medical Plan, a majority of carriers aligned with that. We didn't even look at anything that was HTCC related. That was the first cut. These first three are examples of things where there are exclusions in UMP but also the fully insured or majority of carriers had them as well. The last one is the example of something that doesn't completely align with the fully insured carrier proposals, but is contractually required to be maintained because of substantial similarity with the PEBB Program. It should come as no surprise that's a very humorous exclusion, but we are very participatory in our government here in this state.

Shawna Lang: We actually did look in claims and we haven't had any of these.

Lou McDermott: Excellent.

Sean Corry: I have a general question. There are lots of regulations in the insured world with respect to coverage and exclusions, permitted or not. Are there exclusions that come to mind that the insured companies would have in their plans that the self-insured plans do not? Any differences because of regulation or practice?

Shawna Lang: I will say for the most part, UMP tries to follow OIC regulations just to align as much as we can. I can't think of anything outside of HTCC that we don't cover and some of the fully insured's do. I can't think of any.

Kim Wallace: I am going to walk through chiropractic, acupuncture, and massage (CAM) therapy treatment limit data and information you have been considering over the past three to four months. The purpose is to give you an opportunity to think through the data and all the different numbers we presented to you and things that you've considered as you get very close now to determining what type of CAM therapy treatment limits you would like to have in the self-insured medical plan.

Slide 6 – SEBB June 13, 2018 – Fiscal Impact of Increasing Services. The first data we showed you was this chart. Essentially, it was comparing the PEBB UMP Classic treatment limits 10, 16, 16, and 60 with the limits that we named SEBB. That column is the high water mark, the high limits that existed in K-12 plans. We compared, moving left to right, if the limits were to be increased to this higher level that was existing in K-12, then what would we estimate the fiscal impact being for SEBB? We came up with that first $2 million a year figure.

Slide 7 – SEBB July 30, 2018 – Illustration – Changes in Visit Limits. Then you asked for us to consider, rather than just the big leap from current state to 52 and 52, for some gradation, some steps in between. On July 30, we came back and shared Option #21, Option #2, Option #3, and Option #4. Again, these numbers were based on the application of these different treatment limits to the PEBB population in UMP Classic, non-Medicare state active employees trying to get to the apples to apples comparison. What would the impact have been financially on that PEBB population of employees? We used that to predict an order of magnitude change for SEBB. We were careful not say this is what you'll see in SEBB. It's meant to be informative.

Dave Iseminger: We provided a copy of an email exchange between Sean and Kim in your Board briefing materials that are related to that exact page. It directly relates to Option #4. I bring it up because the resolution at the end relates to column four. There's another version of this slide that shows a different number for Option #4. The crux of the question between Sean and Kim was about the assumptions and the linearity of the costs as they went across the table. There was an uptick in the benefit utilization assumption that our actuaries recommended in Option #4 that was higher than in Option #1, Option #2, or Option #3. We produced an alternative version of that analysis without that uptick and that's the other version you see in the email exchange from Kim and Sean.

Pete Cutler: I'm a little slow but are you saying that the $2.30 PSPM, that calculation was done without the assumption that there would be that additional increase in utilization?

Dave Iseminger: Other way, Pete. It includes an uptick because of additional utilization when, for example, a provider feels more confident in saying do chiropractic care because you're going to have it on a more regular basis. The one that's in your email that's part of the exchange between Kim and Sean was if you take out that uptick, then the numbers are lower than $2.38 and $1.7 million.

Pete Cutler: You wouldn't happen to remember that number off the top of your head? I'll research it later.

Kim Wallace: It went down slightly.

Dave Iseminger: It's between $1.30 and $2.30. Sean might remember.

Sean Corry: I don't remember the specifics but with each incremental addition of coverage, the incremental cost went down until the last column, when it jumped way up. I questioned why there would be a reversal of cost for the incremental change.

Kim Wallace: Benefit-induced utilization assumptions.

Sean Corry: Right. So in any case, it didn't seem to make sense to me.

Pete Cutler: We can have this discussion later, but to me, that implies you believe that you don't have a medical necessity standard that would catch that. I do know that there were certain massage therapists who, back in the good old days, were pretty quick to sign off on weekly massages when even the person getting them admitted they didn't think they had a medical issue. I know that can be a problem. But it would seem to me that would be something that should be addressed.

Kim Wallace: Agreed. I think that one of the themes we've been carrying with us through all these discussions in all the different assumptions, is that we wanted to provide a reasonable scenario, reasonable set of assumptions, allowed you to challenge those assumptions. We changed some of them and tweaked them. And I hope that you feel we've been responsive in that way. What we've shown is that when you do change those assumptions and tweak them, such as the benefit-induced utilization rate, you see a change in the estimates. We've had extensive conversations with our consulting actuaries, challenging them, back and forth based on lots of your input and other thoughts we have.

Pete Cutler: Thank you, very much.

Kim Wallace: Slide 8 – Data and Methodology. This slide is also from July 30. It's a review of the caveats and cautions about the data we were using. We wanted to fully disclose and be careful about how we viewed and understood the data and the estimates that we were sharing with you.

Slide 9 – SEBB August 30, 2019 – Benefit Change Impact Analysis Follow Up. On August 30, Kayla Hammer shared our attempt to do the same type of analysis and estimating about changes in treatment limits and the fiscal impact based on the K-12 data instead of based on the PEBB UMP Classic state active data. She reported that we were unable to duplicate that July 30 Option 1, Option 2, Option 3, Option 4

analysis using the K-12 data. She pointed out a couple of interesting things that we saw in the K-12 data that the amount spent per subscriber on these benefits appeared to be lower, actually, in the K-12 population than in the UMP Classic state active population. She also shared that the average number of visits per claimant, for every person who had a claim, didn't actually reach the 10, 16, 16 limits that exist in the current state scenario matching UMP Classic. Likewise, she reviewed the components that were reviewed to estimate the costs and noted on bullet two that the percentage of members who actually were claimants and the average visit per claimant were both lower in K-12 than in the PEBB state active population in UMP Classic. We saw a lot of variation in the average cost per service.

Slide 12 – Comparison of Treatment Limits – Proposed Fully Insured Medical Plans. You've already seen this slide. Just as a reminder, the fully insured plans are proposing to us these limits. It gives you a way at a glance seeing where the current state that HCA is recommending, how it compares.

Slide 13 – Recommendation – Align with Current State for 2020. You've seen this before as well that our recommendation is to align with the current state. And that's the 10, 16, 16, 60. We shared earlier that we felt, if there was a desire to increase the treatment limits, we felt that Option #1 Option #2 would be prudent, increasing to the 16 or the 24. And then increasing the combined therapies to 80.

Slide 14 – Proposed Policy Resolution SEBB 2018-52* - Self-Insured Plans Treatment Limitations. This slide is a proposed policy resolution that's responsive to a request, from Board Members.

Dave Iseminger: We've said all along that if there's something the Board wants to consider, I would much rather work with you to find the best way to write it and have the Board consider an action. Dan and Katy had both requested a resolution and we've crafted a resolution. The structure of it changes, Resolutions SEBB 2018-20, SEBB 2018-21, and SEBB 2018-22, which is essentially UMP Achieve 1, UMP Achieve 2, and UMP High Deductible. I make no promises that's the correct order of those resolutions until I get you a crosswalk. But this relates to the three plans that are not UMP Plus. We have multiple contracts. There's three contracts related to UMP Plus. We don't believe that it would be prudent to try and change those when we haven't gotten a commitment from the networks.

The proposal that was requested was to put together something that could increase the treatment limits for chiropractic, acupuncture, and massage to 52. Ultimately, you'll see that there's no bullet related to the PT/ST/OT/NDT combined. The Proposal leaves that at 60, which is part of the original resolutions that were passed. By taking action on this resolution in November, the Board would be making changes to each of those three plans. We provided the structure to you. And again, we won't ask you to take action on this resolution today. This is teed up for you in November. In addition, per the prior presentation where Patty asked, and everyone nodded their heads, we'll show the fully insured medical CAM limits plan-by-plan in the November meeting. That may also further inform your decision as to whether you want to move forward with changes in the self-insured plan or not. We'll continue to tee all of that up so you have the flexibility at the next meeting.

Patty Estes: If we look back to Slide 13, with the PT/OT/ST/NDT being at 80, would that affect that hypothetical plan cost, with it being at 60 instead of 80?

Dave Iseminger: Would that change the numbers below?

Patty Estes: Yes. Because that one says 52, 52, 52, 80.

Kim Wallace: Right. The driver or drivers of the increase cost are in the chiropractic, acupuncture, massage treatment limits, not in the increase of the therapies from 60 to 80.

Patty Estes: Okay, it would probably be miniscule or nothing at all?

Kim Wallace: Call it nominal.

Pete Cutler: Diminimus.

Patty Estes: Okay.

Kim Wallace: I won't say miniscule.

Katy Hatfield: Patty, you can see that on Slide 6.

Kim Wallace: From June 13. We did indicate no change there.

Patty Estes: Oh, okay. Thank you.

Dan Gossett: I brought this forward. It's a placeholder, I guess, that can obviously be changed any time. When I look back to a chart that we received earlier about what school employees' options are right now, there's a wide range. I'll focus in on chiropractic for the record, with our comparables we did, which was Lynden, Seattle, Spokane, and the WEA select plans, when it came to chiropractic in Lynden, it was ranged from 10 to unlimited. In the Seattle School District, it was unlimited chiropractic. In the Spokane School District, it was 12 to unlimited. And in the WEA select plans, it was 12 to 52. The other one where there was a difference but it's hard to do because it's apples to oranges with massage because massage is pulled out in some plans. And in some other plans it is included with OT/PT/ST/NDT. With massage, there's a range because in Seattle, it includes PT/OT/ST/NDT and massage, it's 25 max. In Spokane, it was a 15 to 45 range. In the WEA select, it was 15 to 80. In Lynden, it says unavailable. I'm assuming the data was unavailable in Lynden. I wanted to point that out that people are used to this wide range.

Lou McDermott: When we say our limit is x, they can still exceed that if it's medically necessary? Is that correct? They can do a prior authorization request? An exemption? How does that work, Shawna?

Shawna Lang: Regence would ask for a group level exception and that comes to HCA to either approve or deny. We send it to our clinical team.

Lou McDermott: We use a clinical determination to see if additional visits are valid. So there still is that medically necessary as the backdrop behind the treatment limitation.

Public Comment

Fred Yancey, School Administrators and School Principals. I'd like to thank the committee for all their hard work and expertise. I'm sitting there learning as I go along and learning what I don't know as well. Two comments I'll make and then I'll be done.

The first concern is an example. Your issue of, let me think if I can get a resolution on it. This was the mid-year hires when you were talking about that. It was 2018-32 is the resolution. Your resolutions use the term "school year." And when I read that, I'm very confused. I don't know if you're talking a school year as defined as when kids are in session. Are you talking a fiscal year for a school year because that's why principals and superintendents start on July 1 because that's the start of their fiscal year. I mean, I'm just not sure what that term means. And you bandy it about in every resolution and I would just urge some sort of definition. Usually in RCWs, they have a definition of "school year." It seemed like some people were implying it was when students were present and then when they're gone then are you employed or not? And then I just am not sure what that term means when you use it.

So the other thing is from a consumer standpoint. And I don't know if this makes logical sense but if the baseline program that's been negotiated has an AV of 88%, AV as I understand what the Collective Bargaining Agreement said. Standardization across plans would be my and I think most consumer's preferred option because they're going to be given more choices I believe than we've ever had before. And in terms of comparing things like numbers of visits, annual deductible, copayments, annual out-of-pocket limits, wherever those could be standardized so that you're comparing apples to apples as much as possible, on that 88% AV because I know as the AVs change, then you're going to see the differences because that's how they change. I mean, so I would just urge standardization. And I know the committee was invited to make suggestions on what areas could be standardized if any. And I would urge you to look seriously at trying to standardize as much as possible so that the consumer can make a clear choice. That's all I have. Thank you, very much.

Lou McDermott: Thank you. Barb, do you want to say what we mean when we are saying "school year?" If we know, which I hope we do. Okay, what do we mean?

Barb Scott: “School year" is going to be September 1 through August 31 and that comes from Title 28A. I don't have the citation on the top of my head. And I couldn't find it fast enough. But it is a defined term. We've consistently applied it to mean September 1 through August 31 of each year.

Dave Iseminger: That's partly because in Senate Bill 6241, a definition was added to RCW 41.05.011 that says "school year" means what it means in Title 28A. It's already in statute in RCW 41.05 via the legislation passed last year.

Julie Salvi : Good afternoon. I'm Julie Salvi with the Washington Education Association. First, I wanted to thank Health Care Authority for all the work they've done on eligibility -- that keep coming back and keep getting reworded. I think the two that were re-presented today have come a long way and are addressing a lot of concerns. I

might have just a little bit more input as we go back and reflect on it. One example I can think of is the one that is looking back at the 17 and a half hours per week, the last six of the eight weeks. That averages to 3 and a half hours a day. And in the last eight weeks of school, there is probably by default, two weeks that are partial weeks where somebody who's working just three and a half hours a day will meet that standard if there are no other school weeks that are partial weeks, if there's no other early release day or day for professional development. And so I have a couple ideas popping around in my head about maybe we just make it six of the last eight full weeks or some other way to get to that issue just to make sure that everyone has an essentially equal opportunity to meet that standard.

In terms of treatment options, I just wanted to reiterate what Dan had talked about, that this is something where we are managing a very big change for K-12 employees who have been used to varied systems across the state. And this is one area where what's been out there and been accessible for educators is very different than what is being talked about in terms of limits here. When I look at the dollar impacts, I don't want to speak too lightly about those dollar impacts. But at the same time, they are relatively small in the scheme of the whole that is being offered. And when I see information, the presentation that talks about the per subscriber is less in K-12 than what was seen in UMP, it makes me wonder if we can accommodate within the same dollar amount that, say, UMP experiences. If we can accommodate a slightly higher treatment limit just because maybe the demographics are different.

There are a lot of moving parts as you consider everything that you can fit into your benefit amount. And while there was information that was provided that the average usage was within the limits that were being considered in terms of comparing to the UMP, what I would like to see is the numbers - if there is this information available - the numbers of people who are using above those limits. How many people are we talking about who might really be utilizing above what those limits are today and what might that impact be? So thank you for your time and consideration.

Next Meeting:
November 8, 2018
9:00 a.m. – 5:00 p.m.

Preview of November 8, 2018 Meeting
Dave Iseminger, provided a preview of the November 8 topics for discussion.

Lou McDermott: The SEB Board will return to Executive Session for the same reasons read earlier in this meeting.

Next Meeting

November 8, 2018
9 a.m. – 5:00 p.m.

Meeting adjourned at 4:07 p.m.