Washington State Health Care Authority

School Employees Benefits Board
Meeting Minutes

November 8, 2018
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 p.m. – 4:30 p.m.

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

Member Absent:
Sean Corry

SEB Board Counsel:
Katy Hatfield

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

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

October Board Meeting Follow Up
Dave Iseminger, Director, ERB Division: There are two pieces of follow-up information from the last Board Meeting and other questions will be answered during staff presentations. Slide 2 is the link to the collective bargaining overview you requested from Megan Atkinson's and my presentation.

Slide 3 addresses the inconsistencies we had in October when we were referencing UMP Achieve 1 and UMP Achieve 2. This is a handy chart that clearly indicates which plan is UMP Achieve 1 and which plan is UMP Achieve 2. Also listed are the AV values, the deductibles, and the crosswalk to the original resolutions the Board passed in June 2018. The CBA presentation in October had the plans backwards. The October afternoon presentation about the fully insured plans was correct.

Fully Insured Medical Benefits

Lauren Johnston, SEBB Procurement Manager. Today's objective is to present plan designs for action later today. Slide 3 – Follow Up From October 4 Meeting. A question was asked about whether or not vision exams are required to be provided in an HMO. The answer is no. There is no provision that requires vision exams to be covered.

Another question was about limits to the neurodevelopmental therapies benefit. It's combined with the rehabilitative benefit. The answer from all carriers is there are no limit to neurodevelopmental therapies when billed with a mental health diagnosis.

A question was asked about the percentage of Public Employees Benefits Board Program members enrolled in the PEBB Consumer Directed Health Plan (CDHP). As of October 2018, 9% of eligible PEBB Program members are enrolled in a CDHP (25,582 total members). Eligible members excludes Medicare enrollees.

Slide 4 – Plan Design Refinement Process. Previously, there was a lot of variability between the plans when it came to accumulators, which includes the deductibles and maximum out-of-pocket, and also the actuarial values. One concern we heard from the Board was that you wanted less confusion from members when it came to open enrollment. We worked with the carriers to refine their plans to provide a portfolio where members had enough options, but not so many that they would be overwhelmed and confused during open enrollment.

Slide 5 – Plan Actuarial Values (AV). This is a slide of data visualizations to give you a side-by-side look at plan actuarial values. The Providence High Deductible Health Plan is a qualifying HSA, but the AV is yet to be determined. If you go across the slide, you can see they have a similar trend. The plans considered the "1" plans have a lower AV around the 80% mark. The plans within the "2s" are around an 84% AV. The plans in the "3s" and Kaiser's KPWA's "4" plan is around the 88% to 90% AV range.

Dave Iseminger: We don't anticipate long-term that the plans will be carrier "insert number," but for now, we didn't want people to get too attached to a specific name. I wanted to assure you that the long-term plan isn't to have it be Premera 1, Premera 2, KPWA 1, KPWA 2, KPWA 3, KPWA 4. We made it simpler for purposes of where we are today.

Lauren Johnston: Slide 6 – Medical Deductible Levels: Single Subscriber and Family. The green bar is the single subscriber and the blue bar is the family deductible. We were looking around four deductibles. Either $125, $250, $750, and $1,250, with the outlier being the Providence HAS proposed. They have a higher deductible because they're the only HSA offered.

Slide 7 – Medical Maximum Out-of-Pocket Levels: Single Subscriber and Family. The single subscriber is the green bar and the family is the blue bar. We noticed a trend of a two-to-one ratio for single subscriber to family. We asked that they keep within that trend.

Slide 8 – Drug Deductible: Single Subscriber and Family. For the drug deductibles or the pharmacy deductibles for a single subscriber and family, the plans between Aetna 2 and KPWA Option 1, there is no pharmacy deductible for either the single subscriber or the family. That means there is first dollar coverage on prescription drugs. If I were to go to the pharmacy and get my prescription, I would not have to meet a deductible prior to paying the copays that you will see later in the presentation. The Premera plans have a deductible for both the single subscriber and the family at different levels for the two different plans.

The Providence 2 plan deductible for the single subscriber and the family is combined with medical. If a member has a $50 deductible left and their drug costs $50, they would pay the $50. But, the next time they go in, the member would pay the coinsurance or the copay on the drug.

Dave Iseminger: I want to highlight one of the variances because I know it was something the Board was interested in. When it comes to the drug deductible, the self-insured plans that the Board has so far given authorization to back in June had a $100/$300 drug deductible in one of the UMP Achieve plans. In the other UMP Achieve plan, it had a $250/$750 drug deductible. Depending on what the Board's thoughts are around alignment, there's more variance introduced here via Premera's proposa. Does the Board have any thoughts or concerns about that?

Terri House: I thought we had talked about, in the other plans looking out, having the drug deductibles aligned with the UMP plans? Didn't we discuss that?

Dave Iseminger: We have talked with all the carriers about what we believe is a preference from the Board to not have separate drug deductibles, or if there are separate drug deductibles, to align with being no higher than the highest in the Uniform Medical Plans that the Board has approved. I wanted to highlight for the Board that most of the plans meets that requirement and a couple do not. If that's something the Board wants to work on further with Premera, it would be helpful for us to get that guidance today.

Terri House: Could we ask for that?

Dave Iseminger: We could certainly ask for that. In fact, if that's something the Board wants, when we get to the resolutions in the afternoon, you could proceed and ask for the rate development with the plans that are proposed, and in addition, ask us to work with Premera and do a rate build for one that does not exceed the $250/$750 maximum that's in the UMP.

Pete Cutler: I definitely would like to see closer alignment with the UMP as in nothing above the UMP level. I think school employees are going to be swamped with far more choices than they've had before, and certainly than state employees have had to deal with. Anything we could simplify would be helpful. For example, on Slide 6, I think it would be more accurate to show an extension of the bar that labels the prescription drug deductible, because, if you have a mix of prescription drug costs and other services, this understates how much you're going to have as an out-of-pocket cost

before your coinsurance kicks in. I think something that graphically shows that you really are talking about an extended or double deductible situation. I would appreciate understanding what the policy motivation would be for having a separate prescription drug deductible rather than having the prescription drug costs dealt with, as in most plans, as just part of the overall deductible. I definitely would like to see it. If there is going to be a separate prescription drug deductible, it should be no higher than the UMP.

Dave Iseminger: Pete, to that question, I anticipated in the last day or two that there might be some questions about more policy reasons for separate drug deductibles and was working on being able to provide even more information today. But, again, it's just 90% of the homework. I think there's plenty of time to continue that journey. As we work on these refinements, we'll bring back to the Board some further discussion about the reasons and motivations for having separate drug deductibles. We are also anticipating a more robust pharmacy discussion with the Board over the next couple of months that will be a good opportunity to talk about that policy position.

Pete Cutler: Thank you.

Dave Iseminger: I want to reflect one piece in the conversations I've had with Premera that I think is important information for the Board to know. One of the reasons Premera wanted the proposal to be as it is, they felt it best aligned with their experience with K-12 members and it would be a very familiar plan design that school employees would experience. We are entering a new world where there's a lot of changes and shock going into this system for the amount of premiums people are going to be paying and affordability for dependents. I did want to convey their experience is one of the reasons they were so interested in this plan design. We will work with them to both assess these plan designs from a rate development standpoint, as well as something that more aligns with UMP. I'm seeing head nods in addition to the comments that were made.

Lauren Johnston: Slide 9 - Medical Coinsurance. This slide lists coinsurance for in-network coverage and the coinsurance for out-of-network coverage for all of plans. The majority of them are in the 20% range, with one being at 15% and another 25% for in-network coverage. The out-of-network coverage, you'll see more on the HMO side, the member would have 100% because you are completely outside of the plan's network. The others have a higher cost sharing compared to their in-network coverage.

Slide 10 – Plan Treatment Limitations. This chart lists plan treatment limitations for chiropractic, acupuncture, massage therapy, and a rehabilitative benefit, which is occupational therapy, physical therapy, speech therapy, and neurodevelopmental therapy (OT/PT/ST/NDT). We asked Aetna if they could separate their massage therapy benefit from their rehabilitative benefit combined number of visits. Unfortunately, their systems are unable to do so. However, they could increase limits if the Board wished.

Dave Iseminger: We'll keep that in mind for the refinement process. As it stands now, the current chiropractic, acupuncture, and massage (CAM) therapy limits within the

UMP designs the Board authorized is 10 for chiropractic, 16 for acupuncture, 16 for massage, and combined 60 for the OT/PT/SD/NDT.

Lauren Johnston: Slide 11 - Providence HSA Plan – AV TBD. The AV is yet to be determined. This is a preferred provider organization (PPO), so there's not necessarily a limited network that the member would have to go through. There are a number of providers available. The deductible single subscriber/family would be $1,750 for a single subscriber and $3,500 for a family. The coinsurance is 20% for in-network and 50% for out-of-network. The maximum out-of-pocket is $5,000 for a single subscriber and $10,000 for a family. For pharmacy, the deductible is combined with medical for a single subscriber and family, $1,750 and $3,500.

Pete Cutler: Quickly, on Slide 8 for Providence HSA, it shows a separate pharmacy deductible that doesn't show it as combined. Slide 11 shows it as combined.

Lauren Johnston: We left the numbers in there so you could see it's fairly higher than the rest of them. But it should be combined.

Pete Cutler: Combined. Okay, great. Thank you.

Lauren Johnston: The coinsurance for pharmacy for generic drugs is 20%, for preferred drugs is 20%, non-preferred is 50%, and specialty is $50. Any cost share a member would pay towards their drugs accumulates towards the maximum out-of-pocket listed under the medical. It would either be towards the $5,000 or the $10,000.

All services, emergency room, hospital inpatient, hospital outpatient, primary care, specialty, and urgent care, are all at 20% coinsurance. There's no copay on those services. There's the 20% coinsurance and they are all subject to the deductible. You have to meet the deductible prior to paying the 20% for each of those.

Dave Iseminger: We're not going to go through every plan slide like Lauren just did. We'll go to the comparator slide. The AVs at the top are always estimated, so we rounded. Don't get hung up on the precision of those pieces. As you flip through slides 11 to 26, you'll notice the change in color. All of Premera's are yellow, all of KP Northwest's are green, all of Providence's are purple. It was another way for you to have a snapshot to easily know which plan you were looking at. You could mix and match your slides to put all the yellows together and sort by carrier, etc.

Lauren Johnston: Slide 12 – Premera Plan 1 – 80.8% AV – PPO. For medical, single subscriber versus family, their single subscriber deductible is $1,250 and the family deductible is $3,125. The coinsurance for in-network coverage is 20% and 50% for out-of-network coverage. The maximum out-of-pocket for medical services is $5,000 for a single subscriber and $10,000 for a family.

There is a separate deductible under the pharmacy benefit the member would have to meet; $500 for a single subscriber and $1,250 for a family. The deductible is waived for generic pharmacy coverage, which means if you have a prescription for a generic drug, you would only pay the $7 copay instead of having to meet your deductible before

getting to that $7 limit. The generic for the copay is $7, preferred drugs are 30%, non-preferred is 50%, and specialty is 40%. That is what the member would pay. The maximum out-of-pocket for pharmacy is the same as the medical. It accumulates towards the medical maximum out-of-pocket. Whatever you spend on your drugs goes towards either the $5,000 or the $10,000, as well as your medical services.

Other benefits, like an emergency room visit, has a $150 copay plus a 20% coinsurance. For hospital inpatient and outpatient coverage, the subscriber pays 20% and primary care is a $20 copay. For specialty care, it's a $40 copay, and urgent care is a 20% coinsurance. Some services are subject to the deductible, so you need to meet the deductible prior to paying what your member cost share would be. The two exceptions for office visits for primary care and specialty care. You would pay either the $20 copay or the $40 copay and wouldn't need to meet your deductible first.

Dave Iseminger: Lauren is going to transition to the comparator slide and not go through the next 15 slides in the same manner. We wanted you to have a snapshot of the plan to be able to see how the inner workings of each plan works. Slides 11 through 26 are in order by escalating AVs, just like the very first visualization.

Lauren Johnston: The new SEBB Program medical benefits comparison chart includes the fully insured plans as well as the self-insured UMP plans. These plans are subject to legislative funding and final decisions by the SEB Board.

There are several levels of deductibles. The levels are either $125 or $250, $750 and $1,250. Aetna decided to present two plans, one at the $750 deductible level and one at the $1,250 deductible level. Their maximum out-of-pockets are $3,000 for a single subscriber and $6,000 for a family, and then $5,000 for a single subscriber and $10,000 for a family. The coinsurance for both plans is 20%. In general, unless you see something different within the plan design below, a member is going to pay 20% for in-network coverage.

I already discussed deductibles. It's the same thing with the maximum out-of-pockets. The majority of them kept a two-to-one ratio. The same applies for the UMP plans. They have a two-to-one ratio. The coinsurance across the board for in-network coverage is 25%, 20%, and 15% for all plans.

Air ambulance is 20% across the board, regardless of the plan you select. There is a 20% coinsurance on your ambulance for either air or ground per trip, with the outlier being Premera 1 Plan at 25%. There are other outliers in primary care, which are not on the chart - all of the Kaiser plans have a $0 copay for children 18 and under.

Dave Iseminger: Also, you'll see that for the networks in the Uniform Medical Plan Plus, the farthest right column, there is also that emphasis on access to primary care that similarly has a $0 cost share. That's the yellow primary care row on the far right under UMP Plus. Plan 4 under Kaiser Washington on the PEBB side is called SoundChoice. It was introduced at the same time as the Uniform Medical Plan Plus was introduced on the PEBB side. That's why those benefit designs tend to align.

You might question the four plans within Kaiser Washington and why nobody else has four plans, other than UMP. When we get further into service area, Kaiser Washington's proposed service area will not have overlap between Plan 3 and Plan 4. It would be one or the other. It's similar to the limited service area concept that exists within UMP Plus, which is the only UMP plan that is not statewide.

As you look at this, do you have concerns? Should we focus on trying to standardize this more? If you think of anything today, let us know. We still have multiple months to go through the refinement process. If you identify anything in particular in the next month or two as we move towards a rate build, it would be important to understand if there's other things that you're concerned about trying to align better.

Patty Estes: On the mental health visits, I know some plans have limitations. Is there a way to find out those for the future? I forgot to ask at the last meeting if any of the plans have those limitations. I know that it has copays on here, coinsurance, all that. But do they have limitations on how many visits you can have?

Lauren Johnston: We can confirm that information and bring it back.

The second page is for the pharmacy comparison. The Aetna plans and the Kaiser plans have no pharmacy deductible, whereas Premera has a separate pharmacy deductible, and the Providence plan pharmacy deductible is combined with their medical deductible. The UMP deductibles are there as well, the $250/$750, $100/$300. The UMP High Deductible is applied to the medical deductible and then there is no drug deductible for UMP Plus.

Dave Iseminger: We provided an updated version of this slide and it is slightly different from the one that was in the original Briefing Book materials, as well as the one that's on the website. We'll get the website updated in the next couple of days. There were four particular cells updated to be consistent with the rest of the materials you were provided, and that is under Providence's plan under the prescription deductible. The version on the website and the one you previously received had the word "none" rather than reflecting it was combined with the medical deductible. That really is the difference. The other plans that don't have a deductible, there's first dollar coverage and Providence's is combined. That's one of the areas that was updated.

The second area that's updated is under retail Tier 3, the next to last row on the far right in UMP where it says "50%, 50%, 15%, 50%," that first 50% and second 50% on the original slides reflected “10% to 50%,” in fact, it’s actually just 50%. I wanted to draw attention to those and make sure it was very clear what the corrections and updates were that prompted us to give you a new version today. And we'll get that up on the website.

Pete Cutler: Patty's question about mental health services rang a bell with me that, in some areas, and prescription drugs comes to mind, it's not just the cost share that's an issue in terms of member access, but there's also questions about medical management practices of different carriers. For example, is a step therapy approach required for access to non-generic or non-formulary drugs? I think that's what Patty was

getting at with behavioral health or mental health. While there is both federal and state mental health parity legal requirements, there are different mechanisms that plans use to deal with or try to influence utilization. Some would say to try to discourage utilization. Are we going to get an overview of that kind of information down the road, specifically with mental health and with the prescription drug benefit?

Dave Iseminger: Pete, we can definitely work on providing that information to the Board. These are the types of questions that would be very worthwhile for us to have and bring to the Board in the next couple of months while we're waiting for the final funding. It could inform refinement without actually teeing up votes on trying to get too precise until the funding answer comes in. We can talk more about the utilization management practices across the plans of step therapies, any behavioral health limitations, and those sorts of things. If there are other topics you want information on, send them to me so we can put them into the pipeline for the January and March meetings. We can work on the description and how it would work in the fully insured plans and the UMP.

Pete Cutler: And that certainly meets my needs. Thanks.

Dave Iseminger: I know there's concern about the number of plans that might be in the portfolio and how information would be presented. This was our first attempt to show some of the out-of-pocket impacts that members would experience. What are your thoughts about the digestibility of this information? This obviously isn't the only thing that we'd be sending out to members, but we're trying to think of different tools. For purposes of bringing it here at this point for this Board, we came up with this, hopefully high enough level, chart to try to compare. It also represent the breadth of options that could be on the table at the end of the day. What are your thoughts as you visualize for the first time, essentially, what 16 plans in a portfolio looks like?

Katy Henry: I think it's easy to read this way. It's nice that you can get it all laid out in one place. I think the size of it might be cumbersome for people, but being able to see it all at once, I know that it's what our district is used to. We have it all laid out in the same fashion. It would be nice to be able to have it replicated.

Patty Estes: I second that. This is pretty much exactly what we got when we switched over to PEBB and it was very easy to understand. Obviously, people have more questions about premiums and more specific questions that we can't answer yet. But I think the way this is laid out is perfect.

Lauren Johnston: Side 27 – Recommendations. HCA recommends moving forward with the fully insured medical portfolio presented today for rate development to see where rates fall for different plans and AV levels. Once the funding is set by the Legislature, next summer the Board will vote on 2020 employee premium contributions for the SEBB Program's offerings, and refinements to plan designs can continue until the Board votes on 2020 employee premium contributions. It falls in line with asking Premera to refine their drug deductibles.

Dave Iseminger: For clarity, even though I'm the one who wrote that last sentence, I realize it could be even more precise. Obviously, you won't be able to change the benefit design and vote on premiums on the same day. There will be a stair step from that because we will have to push things through the system. It'll be pretty close. You'll be able to do refinements after the legislative budget comes in. If that's in April, you'll be able to do that in the May/June area and maybe even early July. We then run things through all the models and bring that information to you towards the end of July. I don't want to give false precision that on the day that you vote on employee premiums, you would also be able to change benefit design. There will be a finite stopping point, but there will be meetings in the spring where you can do some refinements.

Lauren Johnston: The policy resolutions all say the same thing. The only thing inserted differently is the policy resolution number and the carrier name.

Dave Iseminger: These will come before you this afternoon for action. We talked about this at the last meeting that we weren't ready to show you where all the benefit designs were. We talked about the journey of where they were in Executive Session. We got your insight for further refinement. We brought them to you this morning hoping there would be time later this morning for you to reflect and ask questions, and ask you to take action in the afternoon. We purposely put action in the afternoon to give you as much time as possible reflect on these pieces today.

Pete Cutler: On the very first one, that's the particular plan that involved prescription drug deductibles larger than the UMP. It seemed we had several Board Members who supported the idea of not offering a plan with a higher prescription drug deductible than the UMP. Would you anticipate to convey that this would be a mandate as it's shown on page 28 to show that, or is that something that could be dealt with just as being in the minutes and then have your discussions with that?

Dave Iseminger: For clarity, Pete, I believe you mean Policy Resolution SEBB 2018-49 with Premera.

Pete Cutler: Premera, you're right.

Dave Iseminger: You could do it either way. I think it's sufficient if the Board is interested in seeing what the rates would look like, but at the same time, want a third plan design for Premera that better aligns the separate drug deductible, the $250/$750. You could either amend the resolution and we could work on some of that language to bring that to the Board this afternoon if you want it in the actual resolution. Or, I'm also comfortable if you want to just put it on the record as you're taking action on that resolution. I feel that's sufficient as well. It's either way. If there's consensus among the Board that you want it in writing, I could have people work on that now. If you want to put it on the record verbally, then they don't have to do that work in the next couple of hours.

Terri House: I would feel better if it was in writing.

Katy Henry: I agree.

Dave Iseminger: Lots of head nods. We will get to work on a refined version of Policy Resolution 2018-49 to allow them to go forward with the rate development of the two as presented, and an alternative that does not have a drug deductible higher than $250/$750. Thank you for that insight.

Wayne Leonard: If you go back to Slide 27, it talks about the second bullet point, once the Legislature sets the funding. Could you refresh me on the timeline on that? I'm particularly interested in when you think we will know what the legislative funding level is going to be? In terms of the K-12 individual school districts doing their budget, they start in the spring, and most adopt their budgets in summer. I don't think they need to know, necessarily, the premiums, but they would certainly need to know the funding level.

Dave Iseminger: I'll answer for now, we're also planning a more robust discussion about what the next six months looks like from a funding perspective at the December meeting. You've heard me talk about the chapters of the Board's work. We're coming up on the conclusion of Chapter 3. Chapter 4 includes legislative funding and the full rate development process. We have a much more robust presentation about that. But, in general, first the Governor's budget will come out in mid-December that will have a proposed funding rate that will be a starting point for the conversation as legislators come to town. HCA will be working on a rate development with the fully insured plans and the build of the rate development for the self-insured medical plan. Our goal is to have that completed by the end of February so we can provide that to the Legislature at the beginning of March. The chambers typically release their budgets in the later part of March, after the March revenue forecast for the state. Those proposals will be the biggest indicator of the funding rates, as to what the final solution is.

The regular session ends the end of April. History has shown that we sometimes get our budgets in April, sometimes in May, and sometimes in June. I think we're all very hopeful that we'll have that on the earlier range of that timeline. After the funding rate comes in, we'd be able to take the bid rates from the plans and shape out the employee premium contributions that we would bring to you. But that funding rate would also be the final indicator for local districts.

[break]

Vision Benefits

Lauren Johnston, SEBB Procurement Manager. The objective for today is to take action on the plan designs presented at the October 4, 2018 Board Meeting. Slide 3 – Follow Up from October 4 Meeting. A question was asked if there was a premium tax. On the fully insured plans, the answer is yes and it's 2%.

Slides 4 through 6 answer the question of the number of providers in each county by carrier. Providers are not unique to the carriers. This is the number of providers each carrier has in a county. At a previous meeting, you did see unique provider counts by county.

And lastly, there was a question of how much member disruption regarding providers will there be? HCA encountered some data limitations for this question. However, we feel that if all three of the apparently successful bidders are selected to move forward, the disruption is likely to be minimal.

Dave Iseminger: On the provider point, the carriers are all in the midst of seeing what they can do about expanding their provider networks and we've asked them for updates from the vision providers at the beginning of February. Some of these things could change a little bit, but this represents where they are today. If they're successful in further expanding their networks, that would minimize disruption even further.

Lauren Johnston: Slide 4 – Davis Vision Provider Coverage – By County. King County, which is the darkest blue, has the most providers, and it goes to through to the lightest blue, which I believe is Stevens County with one provider.

Dave Iseminger: There are providers everywhere but Columbia and Garfield Counties. We've asked the carriers to make it a priority to try get providers in their networks so there are providers in each county for each carrier. We've also provided them with what looks like the population distribution of K-12 and asked them to work on having similar provider member ratios for the populations in each county as well.

Lauren Johnston: Slide 5 – EyeMed Provider Coverage – By County. This map has the same set up as Davis. King County has the most providers, and Klickitat and Skamania Counties are the lightest with one. Slide 6 – MetLife Provider Coverage – By County. MetLife has providers in every county except for Columbia and Garfield Counties, which are the two counties with no vision providers for anyone.

Some things to consider as you take action on the resolutions is regarding the members purchasing experience and what their out-of-pocket costs will be, the premium tax paid on the fully insured plans, and then the additional reserves that would be needed if providing a self-insured plan.

Dave Iseminger: These were the same considerations mentioned in September. Obviously, the premium taxes paid on fully insured premiums wouldn't be a line item members would see. There was a question from the Board about having a self-insured plan. We brought forward fully insured plans only because of the need to build up reserves on a self-insured plan.

Lauren Johnston: Slide 8 – Recommendation. The recommendation today is to offer fully insured group vision plans for eligible school employees through Davis Vision, EyeMed, and MetLife.

The stakeholder feedback we received on the resolutions was positive. They agree with having a separate group vision plan for these carriers.

Lou McDermott: We will vote on the resolutions individually.

Katy Hatfield: I wanted to point out there is an appendix that shows what was presented on October 4 if people need to see that.

Lou McDermott: **Policy Resolution SEBB 2018-40 – Fully Insured Vision Plan (Davis Vision)**

Resolved that, 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.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-40 passes.

Policy Resolution SEBB 2018-41 - **Fully Insured Vision Plan (EyeMed)**

Resolved that, beginning of January 1, 2020, the SEBB Program will offer a fully insured vision plan by EyeMed as presented at the October 4, 2018 Board Meeting.

Dan Gossett moved and Patty Estes seconded a motion to adopt.
Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-41 passes.

Policy Resolution SEBB 2018-42 - Fully Insured Vision Plan (MetLife)

Resolved that, 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.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-42 passes.

Fully Insured Dental Benefits

Beth Heston, PEBB Procurement Manager. Today's objective is to take action on the fully insured dental plan designs presented at the October 4 Board Meeting. There is an appendix to show you what was presented on October 4.

There were a few questions from the Board that I'll address first. There was a request to evaluate capping both the fully insured dental plans' orthodontia coverage at $1,750

lifetime to match the Uniform Dental Plan. Our actuaries and finance staff found that the change would not generate sufficient annual premium dollars to increase the long-term disability basic benefit because the enrollment in the fully insured plans is not projected to be that high.

Dave Iseminger: We had discussions with both Willamette and Delta, everyone's actuaries, and everybody's finance people. The experience when looking at K-12 enrollment in dental is that there is a predominant movement towards a PPO plan. Since the Uniform Dental Plan would be the only PPO plan in the mix, the lion's share of the enrollment is projected to be in the Uniform Dental Plan, which already has a cap of $1,750 per lifetime. In the PEBB Program, the experience is also that the lion's share of enrollment is in the Uniform Dental Plan. Everyone agreed with the enrollment assumptions, and because of the enrollment assumption projections that were mutually agreed to by everyone, it didn't pan out as an option for a horse trade.

Beth Heston: The current enrollment in PEBB is 80% in the PPO. The second request was to evaluate removing orthodontia from all dental plans, self-insured and fully insured. We found that this change could generate sufficient annual premium dollars to support a basic long-term disability benefit increased to about $1,000 a month.

Dave Iseminger: But we continue to recommend, as we did before, the inclusion of orthodontia within the dental plans. The resolutions that the agency has brought forward for action today don't make this horse trade. If this is something the Board is interested in doing, that would be something you could move as part of the resolution process.

Beth Heston: The next question was how many dentists are accepting new patients in all of the plans. On Slide 5, the overwhelming majority of dentists in all three plans are accepting new patients. We shouldn’t have an issue with SEBB Program members being able to find coverage.

There were a couple of supportive comments from stakeholder, no comments that disagreed or needed to be addressed. Our recommendation is to offer the fully insured dental plans as presented at the October 4 Board Meeting.

Lou McDermott: **Policy Resolution SEBB 2018-43 - Fully Insured Dental Plan - DeltaCare**

Resolved that, beginning January 1, 2020, the SEBB Program will offer a fully insured dental plan by Delta Dental, with the same coverage services and exclusions, same provider networks, same clinical policies, and same copays as the DeltaCare under the PEBB Program.

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

Pete Cutler: I just want to thank staff for pulling together the information in response to the questions from last meeting.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-43 passes.

Policy Resolution SEBB 2018-44 - Fully Insured Dental Plan – Willamette

Resolved that, beginning January 1, 2020, the SEBB Program will offer a fully insured dental plan by Willamette Dental Group, with the same coverage services and exclusions, same provider networks, same clinical policies, and same copays as the Willamette plan under the PEBB Program.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-44 passes.

Policy Resolutions

Barb Scott, Manager, Policy, Rules, and Compliance Section. There are two policy resolutions before you for action today. SEBB 2018-32, midyear hires anticipated to work 630 hours in the next school year and SEBB 2018-36, eligibility presumed based on hours worked the previous two school years, were both reintroduced at the October Board Meeting. The title was changed slightly in order to include the two-year requirement, which was a portion of the policy proposal itself when it was reintroduced to you. We've included versions of both of these policies as they were presented at the October meeting in the appendix.

Policy Resolution SEBB 2018-32 – Mid-year Hires Anticipated to Work 630 Hours in the Next School Year. This resolution will allow employees who are hired midyear to be eligible for the employer contribution toward SEBB benefits if they are anticipated to work at least 630 hours in the next school year and they are a nine- to ten-month employee anticipated to be compensated for at least 17.5 hours a week in six of the last eight weeks counting backwards from the week that contains the last day of school, or a 12-month employee who is anticipated to be compensated for at least 17.5 hours a week in six of the last eight weeks counting backwards from the week that contains August 31, the statutory last day of school.

I know this sounds really complicated, and so what you're going to find as we move through this, I'm going to talk to you about stakeholder feedback we've received. I've also had staff add some calendar charts to the examples for you so that we can see

how this plays out. This was shaped based on the feedback received from stakeholders in order to ensure we're clear. And we also covered what we'd been asked to consider.

Dave Iseminger: I want to level set. There are some changes on the page for clarity purposes, but substantively, this is the same resolution presented in October. There's been refinement on the substance prior to October. From October to today, there's more technical clarification, but substantively similar policies. Barb will go through feedback that requested substantive changes as well as clarification changes. We've only made the clarification changes and Barb will go through why.

Barb Scott: A lot of it had to do with clarity and trying to make sure we had a shared understanding of how this would function as far as, are we the 17.5 hours, versus a 3.5-hour, versus the 52-point-something that we came to you with originally. Really, what we've got it down to is this last set of revisions that had to do with adding some clarity on how we expect this to be administered based on the questions we received as we worked with stakeholders.

This policy was originally introduced to address stakeholder concerns that 12-month employees hired to work full time, beginning on July 1, would not become eligible for the employer contribution toward SEBB benefits until the beginning of the next school year. We believe this version of the policy addresses those concerns that we received from stakeholders. The feedback included one stakeholder requesting greater clarity regarding partial or full weeks and another stakeholder recommending we use full weeks and remove the word "partial." In this version, we removed both full weeks and partial and are now counting weeks. We also had a request to define the word "week." Although we're not going to bring a definition of the word "week" to the Board for action, we will make certain it is understood that "week" is Sunday through Saturday.

Dave Iseminger: We'll codify that in our rule making exercise in the definition section, but the Board doesn't need to take action to define the word "week."

Barb Scott: Correct. Another stakeholder supported the resolution as written, but requested that we have tools to assist staff in determining eligibility as it is becoming more complex. We agree. We're now into the eligibility that will be more complicated to administer. We did assure them that we plan to have worksheets and other tools to assist them in their eligibility decisions.

Dave Iseminger: We also have staff available here at HCA for questions, especially in complex eligibility situations. We do the “train the trainer” model where our centralized staff help local benefits officers understand the rules. But, if they come across something where they are uncertain how it fits, they have access to an in-person resource here to help them through those complex areas. This is in addition to tools that we create that are more self-service.

Barb Scott: Another suggestion was to replace this policy with one that would allow any employee hired as of April 1 that is anticipated to work 630 hours in the next school year to be eligible. A stakeholder requested that school employees, hired late in the school year and work 3.5 hours per day, receive benefits at the start of the next month.

We did not bring forward a resolution to the Board to consider allowing any employee hired as of April 1 to receive benefits because that was substantially much more generous than the policy we have been developing as far as eligibility is concerned. The 3.5 hours per day, as we worked through this with stakeholders, would be very difficult based on some of the employees that were trying to be addressed in this because not every employee might work 3.5 hours every day. They might work the full 17.5 hours within that work week, and so that's why we stayed with the 17.5 hours per week, which is before you today.

Dave Iseminger: Some people thought the standard should be about days, some thought about months, and weeks hits the average.

Barb Scott: Example #1. The only change was to remove the concept of full impartial weeks from the example itself. In addition, after the word "example" in that first sentence, staff inserted that these employees are coming from out of state. You'll see that pattern within all of the examples related to this particular policy resolution today. As we start to apply all of the Board's eligibility decisions made to date, and as we determine eligibility going forward into the future, whoever's doing that determination will walk through an exercise to evaluate each eligibility standard and decide whether or not the employee gains eligibility through any one of them. We wanted to make sure in these examples that we aren't trying to apply the eligibility that was already decided by this Board, which was if I am an employee who works in SEBB Organization A and I move to SEBB Organization B in the middle of the year, I get benefits under certain conditions. To take that complexity out of these examples, staff inserted states in the examples. For this example, this is a new employee coming from Oregon. They're hired as a principal. This person is not moving from one SEBB Organization to another. They're brand new.

In this case, the employee is not anticipated to work 630 hours during the current school year because of the time of year they're hired. Her first working day is July 1, 2020, and the current school year ends August 31, 2020. She is anticipated to work at least 17.5 hours per week for at least six weeks in the last eight weeks of July and August 2020. She becomes eligible for benefits July 1 and her coverage would actually begin August 1, 2020 based on Policy Resolution SEBB 2018-12, first of the month following the date of hire.

Slide 6 is a calendar to see how to apply eligibility. In Example #1, you start counting back from the end of the school year. Looking at the week that contains August 30 and 31, you count eight weeks back, which has been shaded back to the week of July 12 through July 18, and that's your eight weeks counted back. In this case, as long as the employee has six out of the eight of those weeks with 17.5 hours, the employee is eligible. If they were less than that, they would not be eligible. You'll see that pattern throughout these examples. This happened to be a 12-month employee example.

Example #2 is a bus driver coming from Idaho. Again, full and partial weeks is taken out and the language changed a bit based on that. Slide 8 is the chart on how this would play out for a nine- to ten-month employee. You count back from the week just before summer break. In this example, the last day of school was June 18, so you

count back from the week of June 14 through June 20. Eight weeks takes you all the way back to the last week of April. As long as the employee works six out of the eight weeks and has 17.5 hours in each of those weeks, and as long as the employee is anticipated to be at least 630 hours in the upcoming school year, they would meet the eligibility criteria.

Katy Hatfield: Barb, could you explain the difference between the resolution language "anticipated to be compensated" versus the example's use of "anticipated to work?"

Barb Scott: Yes. The last time I brought this proposed policy resolution to you, we talked about this being the one eligibility proposal I brought before you where it introduces the idea of compensated hours. Generally, the Board cannot be more restrictive in their eligibility, so you can't be more restrictive in the eligibility that you adopt, than to allow an employee who is anticipated to work 630 hours in a school year to be eligible. You couldn't say that those 630 hours have to be compensated because the RCW doesn't say they have to be compensated. It says, "anticipated to work." In this particular instance, though, with this policy you're being more generous than what is required by RCW. Because you are being more generous, you can apply the requirement that those be compensated hours. The difference that makes is that I cannot be someone hired on July 1, automatically put on leave without pay, and then come back in August with only four weeks of the school year remaining and still gain eligibility if they only work 17.5 hours in four out of the eight weeks. The policy before you to consider includes the idea of compensated hours. We've worked through this with different stakeholders. We've been clear that in this particular case, the Board's well within its authority to apply the concept of compensated hours rather than allowing something like I described.

Dave Iseminger: This is a very complex resolution, but at the same time, it treats all employees the same, regardless of whether they're a nine-month, ten-month, or twelve-month employee. When you look at the original resolution on the Slide 4, although you count backwards differently based on the last day before summer break, or the last day of the school year, structurally, it's the same hours, the same number of weeks across the same number of weeks.

One of the things we were trying to do for stakeholder feedback was, although this is a complex topic, not have separate rules for 12-month versus nine- and ten- month employees. There are definitely some stakeholder requests for an even more generous policy than an eight-week look back. But, when you look at the calendar, some of the reasons why there's only eight weeks and you look at all the ways the calendar falls. For example, August 31 can be on a Saturday. That means when you count back, you would start to straddle into June if you had a look back greater than eight weeks. Our experience and understanding is that many 12-month employees are hired around the month of July. We were trying not to straddle back into time before the bulk of individuals' typical hire date for a 12-month employee.

The other advantage, when you look at nine- and ten-month employees, as we looked at the current school calendars for the current summer breaks, and not knowing how many snow days there will be, and there's a lot of fluctuating in each calendar, we didn't

hit any scenario where eight weeks started to straddle back over spring breaks. If you evaluate more than an eight-week look back, you start to get really far back into the calendar year and you can start to get a lot more generous with this eligibility piece. You also have the problem of, “do you have the same look back for a 12-month employee or not.” We felt this was the right balance between all of the feedback proposals.

Barb Scott: Staff looked at seven or eight calendar years in order to see how the schools breaks and different things that might be falling. All of that was considered.

Slide 9 - Example #3. This example works much like the last few. This person is coming from Alaska and hired as a teacher. The calendar on Slide 10 will walk you through the same type of example as what you've seen before. It walks you through the calendar and it shows how we did that count. Slide 11 uses the same calendar and the same type of green lines that you've seen before, same concept.

Dave Iseminger: In this example, by having the concept of compensated hours, the last day of school is June 16, 2020, but there may be school employees who have compensated hours after the last day that students are in the building. By counting any hours in that entire week, an employee would be able to get credit for the hours compensated after students exit. It's the last day of school being the last day of students is the benchmark for counting week one back to week eight. I did want to draw attention to that. That compensated hour is also generous for the week that has the last day of school in it because it can capture work that happens after students leave.

Barb Scott: Correct. On Slide 11, the reason it's in here is we brought back example two that was used in the August 30 meeting. It was used in describing the effect of Policy Resolution SEBB 2018-34, school employees' eligibility when moving between SEBB Organizations. I wanted to bring it back because we wanted to note that it is no longer a usable example because of the changes that have been made to the proposed policy resolution SEBB 2018-32, which is before you today.

Wayne Leonard: On Example 2, I'm confused. I don't know how to quite verbalize this correctly. The concept of a fiscal year, if someone were to not work 630 hours in a fiscal year, like this bus driver example, where they've been hired in April, and essentially work somewhere between 100 and 140 hours in that fiscal year, and then have a two-month break in service. They wouldn't be anticipated to work to meet the 630-hour eligibility criteria until the next fiscal year. I'm confused as to why they would become eligible on April 20 instead of the start of the next fiscal year, start of the next school year.

Dave Iseminger: Barb, I think there was an assumption that you didn’t say and I think that's where the disconnect is. On Slide 7, if you look at after “time of year they are hired” in bold, it says, "But are anticipated to work at least 630 hours the next school year." Wayne, your scenario, I believe, was that they *aren't* anticipated to work 630 hours in the next school year.

Wayne Leonard: No.

Dave Iseminger: Okay, I misunderstood.

Barb Scott: No, I believe what you said is that, in this particular example, the school bus driver is a nine- to ten-month employee. Based on when they're hired late in the current school year, they're going to become eligible for benefits on April 20 and their coverage will begin on May 1. The school year ends fairly quickly after that and then they're not going to be working for a number of months before the next school year begins. Your question was, "why are we allowing for that eligibility when they're not going to work the hours in the current school year even though they're anticipated to in the next school year?"
This is one place where what's being brought before the Board is more generous than the required eligibility. What you've described is generous eligibility being offered here. Does that answer your question? So, you're right. They're going to get coverage through the end of the school year, which is August 31 based on having worked for a short period of time during the actual nine- to ten-month employee work period that's associated with the current school year.

Dave Iseminger: Wayne, this resolution has had quite a journey. It started with a 12-month employee, a superintendent example hired and able to have benefits before September 1 under the eligibility framework of prior Board resolutions and statutory framework. As stakeholders asked more questions about treating all employees the same, we started addressing the two prongs of a nine- and ten-month employee versus a 12-month employee. To treat all employees the same, regardless of their classification or certification status, we got to a six- of eight-week look back for all employees. But you are correct that it is a generous eligibility requirement. Nothing like this exists in the PEBB world because there is no typical September 1 start cycle for state agencies.

Barb Scott: Probably the closest ones that you'll see would be maybe our academic year employees who are quarter to quarter, or maybe for PEBB, as far as other things we've looked at would be maybe seasonal employees. PEBB has an eligibility for seasonal employees that allows for coverage for a season that is as short as a season that spans three calendar months. PEBB has an interesting math used for determining coverage eligibility. This is complicated eligibility. We brought this forward because it is our understanding that in the current environment, folks hired July 1, like superintendents, principals, and others, are given benefits right away in today's environment. In order for districts to fulfill their business needs, they would want this eligibility within the SEBB Program. That's why it was brought forward originally. It's morphed in order to cover both 12-month and nine-to ten month employees as Dave described.

Dave Iseminger: I think it's important to remember that with the eight-week look back, the maximum amount of months an individual would get coverage is essentially May, June, and July. If there are questions about making that eight-week look back a 12-week look back, you start getting into April or possibly even March, depending on the scenario. This is generous, but it keeps it that you might get benefits May, June, July, and August when you otherwise would not get them in September.

Katy Hatfield: I'm not sure that's quite right.

Dave Iseminger: We don't have any examples that go further back with eligibility.

Katy Hatfield: But that's the look back period for eligibility. Someone might get benefits, I believe, as early as March.

Dave Iseminger: This one is just looking at the end of year hires that don't meet the other eligibility requirements of anticipated to work 630 hours. If I was hired early enough in the year and I got eligibility under that door, you wouldn't even look at this eligibility framework. This is just late-year hires.

Katy Hatfield: Right, but someone could be a late-year hire in March and not qualify for 630 hours and they could still qualify under this and they would get their benefits in March.

Barb Scott: As long as you could count back in doing the anticipation, you're correct, Katy. As long as you could count back from that last green line on the chart, into those eight weeks and say six out of the eight, they would've satisfied that anticipated eligibility, then you are correct. You could gain it earlier than that but this is the minimum standard under this eligibility.

Dave Iseminger: So, let's go through that one again because I didn't have an appreciation for that piece. I want to make sure everybody understands.

Katy Hatfield: In example 2, you could change the date to March 20 instead of April 20 in the example.

Barb Scott: If we change it to March 20, a month earlier, then their SEBB coverage would begin on April 1, 2020 based on Policy Resolution SEBB 2018-12. We would be counting back, still based on the resolution as it's presented to you today, from week one, which is the week of June 14 through the June 20. We would count back eight weeks and even though their SEBB coverage begins on April 1, you would really be counting back to the last week of April for the eight-week look back and they would definitely meet eligibility.

The example that Wayne's described is an employee who works more weeks at 17.5 hours probably, but still meets this eligibility standard. If I were determining eligibility, which is what SEBB Organizations will be doing in not too many months from now, they will have a worksheet that will cause them to look through multiple different eligibility decisions. If an employee fails to meet the condition of anticipated to be 630 hours within the current school year, I would move next to more generous eligibility that they might meet. Are they moving from one SEBB Oganization to the next? If they fail that one, then I need to move to the next eligibility they may meet, which might be this one. I would look at when the employee is hired and I would count back. If they met the eligibility under this, I would identify the date of eligibility. If they didn't meet the criteria, they would not be eligible. I would provide them with that information as well as appeal rights so that they would have the opportunity to appeal the eligibility decision I just

made. That is work that is downstream from all of these decisions you all are making today.

Pete Cutler: I guess more of a thought but it's related to Wayne's point. It's to acknowledge that much of what we've been asked to do is aligned with what is required by statute. In this case, we actually have a policy that says above and beyond what's required by statute. Let's provide medical coverage for the months of, let's just say somebody who starts in late April, for the months of May, June, July, and August for somebody who's going to work 17.5 hours a week for at least six of those last eight weeks of the school year. In this world, that's a very generous eligibility standard for what most working people would consider a very generous package of benefits. It is significant. But it does also promote the goal or the policy of promoting continuity of coverage, which is, in my opinion, much preferable to having people on coverage for a month or two, then off, then on, then off. It's better for everybody, both providers and the patients, if they have stability of coverage. But it is, admittedly, a very generous benefit, beyond what the statute actually requires.

Patty Estes: In the stakeholder feedback around these examples, did anything come through that this could possibly change some hiring practices?

Barb Scott: They may have talked about hiring practices. All the stakeholder feedback would be in your packets. But I think most of the feedback we received from the different groups is this is happening today and most of these positions the employers are recruiting at this late stage in the school year are employees that they're recruiting for positions they couldn't recruit for without being able to put benefits on the table.

Initially, that's where we started, but we worked through almost every example I could think of with stakeholders. We've looked at bus drivers who pick up different routes or they work during certain periods of time moving from one district to another because it happens that you have retirements a certain time of year. You're trying to recruit for those positions that you're securing for the next upcoming school year. We worked through a number of those examples with stakeholders. They don't all jump out in my mind, but for the most part, as we worked through them, they said they do this today.

Most often, we're not bringing them from Alaska, Idaho, or Oregon. They're going to come from the district next door. More than likely, they would meet the eligibility under the moving between SEBB Organizations. But stakeholders could see examples where they needed this one or they felt they had a need for this policy in order to recruit those people they might bring out of Oregon, California, or Idaho for specific positions. I don't know that some of them hit bus drivers so much as some of the other types of positions that are hired for, but I don't remember if they were bus drivers that they bring from out of state as well. Maybe if they're bordering districts.

Patty Estes: The only reason why I ask is because it creates a deadline, especially for nine- to ten-month employees on when they need to be hired and when they need to start working to be eligible for benefits.

Barb Scott: If they were brand new and not coming from another SEBB Organization within the state of Washington, yes. There were different conversations around drawing a line. One stakeholder said, "Let's just draw a line of April 1 and be done with it. Anybody hired April 1 or before you're in and anybody hired April 1 or after, you're out."

Wayne Leonard: I don't know if the practice of offering benefits like that is universal among school districts. Would there be a way to word this that would give some permissiveness, I guess, to districts if they wanted to interpret this less generously?

Barb Scott: My recommendation to the Board would be that this eligibility be standard across the SEBB Program so you don't have different treatment and don't set up anyone to cherry-pick who they give benefits to and who they don't because that would, I believe, create a legal risk for the Program.

Lou McDermott: I think that's Barb's nice way of saying no.

Wayne Leonard: In the other examples, you used in terms of a principal or a teacher, those are positions typically contracted out for a year and it was easy to anticipate they would work more than the additional hours in the future. But a lot of our bus drivers or classified groups are not necessarily contracted for a year. They're hourly employees and it's difficult to anticipate meeting that 630 hour criteria if they're hired late in the spring. And sometimes life changes happen and they don't show up in September. That's one of the big concerns I have with this. I don't have any concern at all if I have a bus driver or a classified employee that starts the school year on September 1 and they're anticipated to work 630 hours, offering them benefits the first day of school. I think that would be great. But I do have a lot of concern about offering benefits in the spring that are more generous than necessary to someone who works 100 or 150 hours and then may disappear in the summer and we may not have that employee to work in the fall.

Barb Scott: We worked very hard with WASBO on this and the bus driver. They were in on the thinking that they may be hiring bus drivers and it's a hard one for them to get sometimes. We did have those conversations with them and they did support this in this particular way. Rob meets with them significantly in order to get their feedback. We did walk through the bus driver scenario, the food service worker scenario, and a number of those. They felt they needed this in order to recruit positions they really needed to hire. Now if you have an employee who starts and then doesn't show up, if the employment relationship were terminated by the district, that would end benefits early based on an earlier resolution of when coverage ends that the Board has already passed. That would really be the only way to get out of paying for coverage through the end of the school year.

Dave Iseminger: The other piece I'm hearing is, if you hire a bus driver in May and you can't actually anticipate that they will meet the 630 hours the next year, that would be your basis for denying benefits under eligibility. If you've gone through the other pieces that Barb identified, you checked door A, no; door B, no. This is door C: you've hired them; you know they're going to work 17.5 hours in the timeframe, in the six out of eight weeks; but you can't actually anticipate 630 hours in the next school year. That is a

criteria to meet under this eligibility prong. If you say no to that, then you issue the benefits eligibility denial and the employee would have the opportunity to challenge that decision. On appeal, the employee could try to provide proof they met the 630 hours criteria. That's how that would work out. There are two requirements. It's the 17.5 hours in the six out of eight weeks counting backwards *and* anticipated to work 630 hours in the next school year. If you can't anticipate that, that could be a basis for denial of eligibility under this pathway.

Barb Scott: And then, they'll receive appeal rights and that can be reviewed if appealed. That helps to put checks and balances within the system. Did I get it wrong, Katy?

Katy Hatfield: No, I think that's right. I just wanted to give a slightly different response than Barb's response, which was right, but to answer Wayne's question. We have not talked about it very much yet, but there is language in the statute that allows individual SEBB Organizations to have the ability to locally negotiate eligibility criteria for a school employee who is anticipated to work less than 630 hours in the school year. There is a possibility that there could be a way to have discretion for that situation at the district levels. I wanted to point that out. The cart is before the horse a little bit, but I wanted to make sure you were aware of that statute. That could possibly be a different way to address this issue.

Barb Scott: That's true. And staff have been working on the below 630 hour pieces for you, so you'll see that here within the next couple of months. I would say there's been probably at least six months of work just with legal and others trying to work through that for you. That's why you haven't seen it yet, including Katy.

Patty Estes: That brings up the question for me of how are we evaluating the anticipated to work? I know that some districts do a letter of intent for the next year saying, “we are anticipating that you are going to be in this school district next year for X amount of hours at this position.” They do that every year. However, I know some school districts do not do that. So, how are we, I don't want to say regulating, but how are we regulating the “anticipated to work?”

Barb Scott: I answered a question very similar to this when Rob and I were in Pasco on Tuesday meeting with WASBO folks. We talked about resolutions the Board has made, where we're at on HCA decisions that have been made, and how some of those are being rolled out into rules that are well through the process today. One of the reactions we saw from them was they may have to make some changes in their business processes as they implement the SEBB Program. They're recognizing that. I don't know if they've come to solid ideas as to how they will adjust. I don't know that I could answer those questions for you today because I don't think that I could predict that even based on conversations with them.

Based on what I did hear, they're trying to think about their current practices and how those practices might need to shift slightly based on the SEBB Program implementation. We will probably see after year one of the implementation how they've adjusted, and then this Board could reevaluate based on what we see. We'll be watching that for you

because we will be helping those SEBB Organizations to understand the eligibility and how to implement it. I would be wrong to sit before you today and think that we know how that's going to play out because I don't think we do, but we'll watch it for you.

Dave Iseminger: Patty, when the information is in our system as the golden record for who has eligibility for benefits, we'll be able to see if there are outliers in districts that have a lower proportion of individuals getting eligibility. If district A is only offering benefits to 50% of its employees, but everybody else in the state is more around 75%, we may need to talk about that. Is the Program being administered incorrectly and we need to provide more training? There will be ways to monitor that.

Lou McDermott: We also have the opportunity with appeals. As we see appeals come in, sometimes a rule change will take place because, during the appeal, it may be that we rule in favor of the member over, and over again on the same rule because there's an issue with the way it's being implemented. That's how some things come to light.

Dave Iseminger: We had that with PEBB Program where we see a pattern with an agency and then we have a training opportunity with that agency. Or, we see a pattern with a rule and we work to refine the rule and bring it to the Board. It works both ways.

Patty Estes: That's exactly what I was talking about so thank you.

Pete Cutler: I can't help when my budget analyst background pops up. Following up on Wayne's observation. I did a little quick math and if you work 17.5 hours a week for six weeks, it's about 105 hours. If you're paid $14 an hour, that gets you to roughly $1,500 that you would receive as your cash compensation. We're going to keep pension contributions or other issues out of this. And then, your health contribution as an employer would be roughly $3,800 for those two weeks, but because it would really be for four months. It would really be for May, June, July, and August. We know for sure it's at least $950+ a month in the first year, assuming the Collective Bargaining Agreements are ratified by the Legislature, because that's on the printed material showing for state employees.

While we see no specific number for K-12, we know the K-12 funding rate cannot be lower than the state number. I can understand if I were a business administrator at a school and I had somebody who was a college student saying, "I can drive your bus for the next two months. And sure, I'll continue to do that next year." But in reality, they're thinking, "I'm going to go to school full time next fall." They could get their four months of insurance coverage for pretty darn cheap and I could understand why a business manager at a school district might think that's awfully generous. But, there again, we have the statutory framework we have and the continuity of benefits is also important policy. So, all I can say is I have sympathy for business managers.

Alison Poulsen: I think you answered my question. It was really in the oversight and compliance portion. Where that line is. It seems like it's not a super sharp line and that you would start in a more passive way to say, “We've noticed this from your data. This could be a training opportunity." And then, the next step would be a policy change if it was actually not meeting the intent, which is, in my mind, we're trying to be generous

with coverage because having health insurance is an important part to starting to improve population-level health. Is that a correct assessment?

Barb Scott: I would say so. I know when we met with WASBO earlier this week, they did ask questions about being able to apply it differently. We cautioned them that they would not want to apply it differently. They will want to consistently apply the standards throughout their organization, not employee by employee, and that protects them too. Once you're in a bigger system, more people are looking at you. It's going to be important for them to be consistent in their application and we're going to do everything we can to help them get there. Watching the enrollment is one piece of that, providing them with worksheets, telling them how this is applied. It doesn't matter if it's a nine- to ten-month employee or a 12-month employee; this is how it's applied.

Lou McDermott: **Policy Resolution SEBB 2018-32 – Mid-year Hires Anticipated to Work 630 Hours in the Next School Year**

Resolved that, a school employee who is not anticipated to work 630 hours in the current school year because of when they are hired, but is anticipated to work at least 630 hours the next school year, establishes eligibility for the employer contribution toward SEBB benefits as of their first working day, if they are:

- A 9- to 10-month school employee anticipated to be compensated for at least 17.5 hours a week in six of the last eight weeks counting backwards from the week that contains the last day of school; or
- A 12-month school employee anticipated to be compensated for at least 17.5 hours a week in six of the last eight weeks, counting backwards from the week that contains August 31, the last day of the school year.

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

Pete Cutler: Once again, I want to thank staff for putting a ton of time into working with the school employers because this, I know from past work experience, is an incredibly complex setting in which to try and deal with eligibility issues. And so, I applaud you for all the work that went into it.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-32 passes.

Barb Scott: Slide 12 – Policy Resolution SEBB 2018-36 – Eligibility Presumed Based on Hours Worked the Previous Two School Years. This policy resolution requires eligibility be presumed for a school employee who worked at least 630 hours in each of the previous two school years if they are returning to the same type of position. For

example, a food service worker or combination of positions with the same SEBB Organization. A SEBB Organization rebuts this presumption by notifying the school employee in writing of the specific reasons why the employee is not anticipated to work at least 630 hours in the current school year and how to appeal the eligibility determination. Again, our worksheets that we develop will include walking through the eligibility and notifying the employee of their appeal rights. The employee signs it so they'll now they got their appeal rights. We really have a path to help make this fairly easy on the administrative side of it.

Stakeholder feedback on this policy had one stakeholder who didn't support the resolution because it included substitutes being eligible. This proposal was originally introduced to address eligibility for substitutes, as well as others that hovered near the 630-hour threshold. The same stakeholder asked if we will be providing worksheets, or other documents, to satisfy the notice requirement. I assured them we would. There is an example that is included in your packet, but there was no change to it from the last time we showed it to you. There was also no change to the two examples.

Pete Cutler: I'm curious. Right now, if I understand correctly, people retired under teacher Plan 2 can work up to 800+ hours a year as a substitute and still collect their retirement benefits and still be covered as a retiree in the PEBB Program. And the question is, how would this impact somebody who was a retiree and came back, retired under Plan 2 who was enrolled in the PEBB retiree benefits coverage, but then hit the 630 hours, and suddenly triggered eligibility under SEBB as an employee rather than a retiree. How will this deal with that context?

Barb Scott: There's nothing in place today that would prevent an employee who met the eligibility under this policy resolution to have eligibility under both SEBB Program eligibility and eligibility as a retiree under the PEBB Program. There's nothing in place today that would prevent that. There is, on my list of things to look at, is a question as to whether or not the PEB Board, or SEB Board as well, should look at a policy that addresses dual eligibility between those programs. It also may be that, as we move forward in seeing what the Legislature decides around retiree eligibility, that problem resolves itself. It's within the programs and the Boards of those programs to decide how they deal with eligibility within their own program. At this point, there is nothing that would prevent that.

Lou McDermott: **Policy Resolution SEBB 2018-36 - Eligibility Presumed Based on Hours Worked in the Previous Two School Years**

Resolved that, a school employee is presumed eligible if they:
- worked at least 630 hours in each of the previous two school years; and
- are returning to the same type of position (teacher, paraeducator, food service worker, custodian, etc.) or combination of positions with the same SEBB Organization.

The SEBB Organization rebuts this presumptions by notifying the school employee, in writing, of the specific reasons why the employee is not anticipated to work at least 630 hours in the current school year and how to appeal the eligibility determination.

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

Fred Yancey, Washington State School Retirees. Mr. Cutler's question is certainly germane. If I'm a substitute retiree, early retiree, or receiving a retirement and have insurance through the PEBB Program, the question is, if I qualified, does that mean the district will help pay the premiums on my existing plan or do I have to enroll in a second plan? It really is a question that needs answered. The easy thing would be the district would pay what they would pay for a regular employee that qualified would pay toward the premiums that I'm already paying. But it's an unresolved question that certainly needs resolved. You certainly can't expect me to have two insurances. One, my current Medicare insurance, plus another one because I qualify. So we're anxious to see that resolution.

Barb Scott: I can speak to that, Mr. Yancey. In answering Pete's question, there's nothing that prevents an individual today, without another policy passed, that would prevent a person from being eligible, as Pete described it, under both programs. In reality, if I were an employee eligible under both the SEBB and PEBB Programs, the PEB Board has put in place a number of policies that allow a retiree to defer their enrollment in the PEBB Program. They can defer during a period of time in which that person is eligible under K-12 school district coverage or under another employer program, whether I went to work for Boeing, Weyerhaeuser, or someone else. I could defer my enrollment, as long as during that time period, I am enrolled in qualified coverage, and that would include things like employer-based coverage, as well as Tricare and a number of other provisions the PEB Board has adopted over the years. But, I could defer my enrollment in that program while I'm covered under that other coverage.

If I were that person in that situation, I would defer my enrollment in my retiree coverage through the PEBB Program. I would take advantage of my coverage under my SEBB Organization employer. When I left SEBB Organization employment, I would re-enroll in my PEBB retiree coverage and take advantage of the subsidies available. Does that answer your question?

Fred Yancey: I think it does, assuming the transition between is seamless and allowed and I'm assuming they would be allowed. In other words, I could re-enroll in the PEBB plan upon the conclusion of the SEBB plan, regardless of when it happened during our calendar year.

Barb Scott: Absolutely. You would want to re-enroll in your PEBB retiree coverage immediately when your SEBB coverage ended. You wouldn't want to leave any gaps because you would lose your eligibility.

Fred Yancey: That does answer the question. And I do remember the discussion on the Tricare issue. But I just hadn't applied it to this. Thank you.

Barb Scott: Yes, and the PEB Board just passed an additional way to defer qualifying coverage this year.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-36 passes.

Eligibility & Enrolment Policy Devlopment

Barb Scott: I am introducing two policy resolutions today. They are Policy Resolution SEBB 2018-53 – School Employees May Waive Enrollment in Medical and Policy Resolution SEBB 2018-54 – Default Enrollment for a School Employee Who Fails to Make a Timely Election.

Dave Iseminger: There is the perennial question from employers, if someone is waiving benefits, why do I have to pass on that money? It's the way the funding rate is ultimately set in both the PEBB Program, and anticipated in the SEBB Program. The funding rate represents the average employee. The system already takes into account there will be waivers, but the average dollars needed for the program have to come to HCA whether the person enrolls in benefits or not.

Barb Scott: Proposed Policy Resolution SEBB 2018-53 would allow a school employee to waive enrollment in SEBB medical coverage if enrolled in medical through another employer-based group medical program. For example, a spouse's employer's coverage. The proposed policy would only allow employees enrolled in other medical to waive their enrollment in SEBB medical. It would not allow employees to waive enrollment in benefits that are 100% paid by the employer, which include SEBB dental, vision, basic life and accidental death and dismemberment, and basic long-term disability coverage.

Staff looked at the benefit booklets for a number of districts and it looks like school employees are generally not required to have other coverage in order to waive their enrollment or opt out. They are used to an environment where some benefits are mandatory and others are optional, with medical typically being an optional enrollment. Administratively, in order to have the eligibility system function well, we need to have at least one benefit required that will allow the HCA to track and invoice SEBB Organizations for school employee benefits, even when a waiver is in place. The funding rate model that HCA delivered to OFM for development of the Governor's budget includes a medical waive rate similar to what is used for the PEBB Program population.

We recommend requiring employees to attest to being enrolled in other employer-based group medical in order to prevent adverse selection, which could impact bid rates. That's why you're seeing this policy brought to you in this way.

Proposed Policy SEBB 2018-54 would address whether an employee who fails to elect coverage within the required time period is defaulted into coverage versus no coverage. Staff looked at benefit booklets again, and it looks like school employees are used to an

environment where some benefits are mandatory and others are optional, typically medical being an optional choice. It also looks like some SEBB Organizations default employees to no coverage versus into coverage. The policy we're bringing to you would default them into coverage. Based on our experience, we know that employees do fail to make elections at times, and this would ensure employees are enrolled in coverage. If a school employee doesn't make the election in time, they would be defaulted into a coverage designated by the HCA, and that will be determined based on criteria used to make sure coverage is available to employees where they live.

Dave Iseminger: There is the question of which coverage. It's still too early to get into that granularity. There are 16 potential plans. We don't know exactly where they're going to land, what the employee premium contributions will be, and the overall service area to have a uniform default. There are too many variables, but we wanted to make sure the Board considered and took action on whether to default people into coverage or not, and have that be a foundational part of the rules codified in Barb's second rule making process.

Barb Scott: When you look at this policy proposal, you will see that the default would be enrollment in employee-only medical coverage and employee-only dental coverage, as well as vision. You're seeing this because we would not have information to enroll any dependents. We found this within the PEBB Program. You could only default them to the employee-only tier because you don't have any knowledge as to whether or not dependents exist. That's why you're seeing it presented in this way.

Pete Cutler: Would the plan then be to bring to the Board a proposed resolution regarding which specific medical coverage, dental coverage, or vision coverage once it's known what are the options, the coverage areas?

Dave Iseminger: We believe the setting of the default plan is within the agency's authority. We will bring this to the Board for their insight before making a final decision. It's an area the Board would have intense interest, but we don't believe it needs to come to the Board as a resolution.

Pete Cutler: Okay. My initial reaction is that it is a policy decision that the Board should have influence over, but we can save that for another day as long as it is going to be discussed with the Board.

Dave Iseminger: It absolutely will be discussed with the Board. We don't believe it's a resolution topic. But it is absolutely a discussion topic.

Pete Cutler: Thank you.

Patty Estes: Can we define "timely" again?

Barb Scott: Timely, 31 days. The election period for new enrollment is the 31 days, and that's a policy that the Board has already adopted. For special open enrollment, the employee will already be enrolled in order to exercise their right under a special open

enrollment unless it was to return from waiver, and they would have options based on that special open enrollment event specifically.

Katy Hatfield: Barb, could you give a little more context for SEBB 2018-53 in terms of whether or not as written, employer-based group medical would include retiree coverage, and talk about Medicare and Tricare?

Barb Scott: On the retiree coverage, it's not jumping into my head, Katy, so I'll start with the others. When we brief you on these rules being implemented, you'll see the rules will allow employees to waive medical based on the Board's policy, if you adopt it, that says they can as long as they're attesting to being enrolled in another employer-based group medical, for example, through a spouse. The rules will also allow them to defer coverage if they chose to enroll in Tricare coverage, based on the way the Department of Defense has implemented Tricare. Employers cannot put in place a barrier to a member who's eligible under Tricare being able to use Tricare as their coverage instead.

We also, based on Medicare rules, will allow employees to choose Medicare as their primary insurance. The rules will include that as well. The policies I'm bringing forward to you are those within your authority. I'm not bringing you those policies that are required under federal regulation or federal guidance from those agencies that govern those programs. And the retiree one, Katy, just doesn't jump into my head.

Katy Hatfield: I think maybe if we've had some scenarios where someone was perhaps enrolled, or they had the option to enroll, in their spouse's retiree Boeing coverage, for instance, or spouse's retiree Weyerhaeuser coverage. If someone had the ability to be enrolled in their spouse's retiree-based coverage, would that fall under this policy or not?

Barb Scott: I'm still not clicking on anything there. It may be that is related to work with the PEB Board on their deferral policy. The PEB Board's deferral policy doesn't allow a person to defer their enrollment in PEBB retiree coverage for enrollment in another employer's retiree coverage. That may be where that's coming from. As far as employees, other employer-based group medical, that could include, for example, if my husband worked for Weyerhaeuser, terminated employment with Weyerhaeuser, chose to enroll in COBRA coverage through Weyerhaeuser, and he wanted to keep the family on that coverage, we could pay to do that. It wouldn't be something we would do because, for us, we would do the math. The retiree one, though, Katy, it's just not getting there for me.

Dave Iseminger: That's an area we'll follow-up on at the next meeting. Katy and Barb know how to find each other.

Patty Estes: On that same one with the employer-based group medical, and this may be just some lack of knowledge for myself, if someone was on state assistance medical, would they be able to waive this in place of that?

Barb Scott: No. If someone were eligible for Medicaid (Apple Health), the Board would need a different policy that would allow them to waive their medical through the SEBB Program if they were enrolled in coverage under a state Medicaid plan. That's not a proposal I'm bringing before you today. That would be a very complicated proposal to navigate, because the Medicaid programs re-determine their eligibility at different times. Those folks who are eligible under those programs have a responsibility to report income. Trying to put in place a policy like that would be quite complex. It also would need to be evaluated regarding the funds that are being used and which state dollars to use.

We've had this same question under the PEBB Program and the PEB Board has not allowed for waiving of coverage in order to be enrolled under Medicaid.

Patty Estes: It makes for a very complicated situation because I know several school employees on state assistance, or their children are. I don't know that they waived their coverage.

Barb Scott: Children are different than the employee themselves. This is allowing the employee to waive their enrollment in a medical plan if they're enrolled in other employer-based group medical. There's nothing in the eligibility that exists that the Board's put in place as of today that would require an employee to enroll their dependent children even if they're eligible. Now, if there was a national medical support notice in place, court ordered, every employer would have to act on that.

Patty Estes: Right. I'm just trying to think of all the scenarios. Thank you.

Alison Poulsen: I'm curious, in that situation, wouldn't this be a more generous set of benefits than what someone would be eligible for in Medicaid?

Barb Scott: I don't know that it would be a more generous set of benefits. When I receive this question, it’s not necessarily because the employee has evaluated the benefits under each program, but they're evaluating the cost out of their monthly paycheck.

Wayne Leonard: A follow-up question to Patty's about time limits. You mentioned 31 days is the definition of that. Since our plan begins January 1, is that 31 days December 1 through December 31? Because there's a lot of holidays in there. There's non-business days, there's non-workdays. What would the 31 days be?

Barb Scott: When Patty asked that question, she was asking for the definition of timely. This applies to an employee who is making their initial election and new employees, based on Board policy, have 31 days in order to elect coverage when they first become eligible. That would count from, for example, if I was hired by a district effective July 1, then I would have 31 days from July 1 where my election form needs to be with my SEBB Organization employer by the 31st day. That policy was driven by cafeteria plan rules that allow an election window of 30 days, the 31st day being the date that the employer has it in hand in order to act on it.

If we were talking about annual open enrollment with the plan year that goes January through December, employees would make elections to change plans, enroll, or waive, during the open enrollment that precedes the beginning of the plan year. Year one, they'll have a little bit longer than the month of October. Years going forward, I don't know that it will be a month and a half, but for year one it will.

Wayne Leonard: Does it include Saturdays, Sundays, holidays? It's calendar days, it's not business days.

Barb Scott: Calendar days, not business days, yes.

Dave Iseminger: Wayne, that 31-day election period was part of Policy Resolution SEBB 2018-13 that passed in May. Katy Hatfield has a copy of all the resolutions if anybody needs to reference them.

Barb Scott: Slide 8 – Next Steps. If you have feedback for these policy proposals, we'll incorporate those. Otherwise, post today's meeting, staff will be sending these out to our stakeholders and then we'll bring recommended policy resolutions to the Board for action at the December meeting.

Lou McDermott: The Board will be 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 nonpublished information related to the development, acquisition, or implementation of state purchased health care services as provided in RCW 41.05.026.

[Lunch]

Centers of Excellence

Marty Thies, Account Manager. Today I'm presenting a policy resolution for action to adopt the Centers of Excellence Program. Slide 2 – Overview. This benefit option overlays the UMP Classic and CDHP plans in the PEBB Program. This is a voluntary program. It's about quality and incentivizing members toward facilities that have adopted best standards and have demonstrated optimal outcomes with regard to serious procedures. To date, we have a total joint replacement bundle. We are finishing our second year and have completed over 150 surgeries with great success and great member experience.

We are now implementing a spine care bundle, which will go live January 1, 2019. The contracts are signed for that bundle. This resolution today is to adopt this program for the SEBB Program. All future bundles that are a part of this program will follow.

Lou McDermott: Marty, I know the answer to this, but I love to ask it. How many readmissions have we had on those 150 surgeries?

Marty Thies: We've had no readmissions.

Lou McDermott: That's a great number.

Marty Thies: Full disclosure, we had a minor infection for one day.

Lou McDermott: Come on, man.

[laughter]

Marty Thies: It makes it more real.

Lou McDermott: Okay, one minor infection.

Marty Thies: And they went back to work. The recommendation is that the SEB Board adopt the Centers of Excellence Program in UMP on January 1, 2020, with implementation beginning in UMP Achieve 1, UMP Achieve 2, and the UMP High Deductible Plan.

Lou McDermott: **Policy Resolution SEBB 2018-51 - Centers of Excellence**

Resolved that, the SEBB Program will offer the Uniform Medical Plan Centers of Excellence Program (COE) starting in Plan Year 2020.

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

Dave Iseminger: This was one of the slides on the table in the hallway as an updated slide. We had copied the version that said it was proposed and didn't have the resolved language. It's actually the exact same thing, it's just the voting version of it.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-51 passes.

Fully Insured Medical Plan Resolutions

Lauren Johnston, SEBB Procurement Manager. Today's objective is to take action on the plans presented earlier today. Slide 3 – Recommendations. HCA recommends moving forward with the fully insured medical portfolio presented today for rate development to see where rates fall for different plans and AV levels. Once funding is set by the Legislature, next summer the Board will vote on 2020 employee premium contributions for the SEBB Program's offerings. Keep in mind that refinements to plan designs can continue until the Board votes on 2020 employee premium contributions.

Before taking action, I want to make some updates based on what you heard earlier. We did find a couple of inconsistencies in the information. On the SEBB benefits comparison chart, if you look at Premera's Plan 2 under emergency room says $150

plus 20%. That should be $150 plus 25% because it would be subject to the same coinsurance the rest of the plan is subject to.

TAB 4, Slide 8 of my fully insured presentation from earlier today, at the very bottom of the slide, for Providence HSA Plan, the drug deductible should say, "combined with the medical deductible". Right now it says $1,750 and $5,250. It should be combined with the medical.

Dave Iseminger: For clarity, because this is one I noticed when Pete asked a question earlier, right now it says $5,250, but on your benefit comparison chart, that number says $3,500. It's really $3,500. And the shorter way is to say it's combined with the medical deductible. I wanted people to know that that $5,250 should have been $3,500, and even more streamlined, it should've just said, "combined with medical."

On Slide 9, the Premera Plan 1 and Premera Plan 2 has out-of-network coverage as 100%. It should be 50%.

Dave Iseminger: We'll get all of these updated and provide an updated version of the briefing book online so only the correct version is posted.

Patty Estes: When you say refinements we can make later on, I want to make sure I'm understanding, and the public understands, how we're moving forward with these. Just because these are on here does not mean that these are what we are going to launch. These are just what we're proposing to go forward for rates. We don't necessarily have to offer all the carriers. Is that correct?

Lauren Johnston: Correct.

Dave Iseminger: Patty, right now there are 16 fully insured plans and the four UMP plans. This represents the maximum high water mark that the Board's looking at. As time goes by, either a carrier might find a reason that they no longer want to offer something in the SEBB Program, or the Board could identify that they want even fewer plans or fewer carriers. The rate development process will just give another layer of information and the Board will have its final decision about what exactly will be offered when setting the employee premium contribution in the summer. But, I do think what we're asking the Board to buy into is these are potentially reasonable type of plan designs and the right direction, but you still have those refinements and those final decisions. And you're not 100% endorsing any one plan or carrier at this point.

Lou McDermott: **Policy Resolution SEBB 2018-45 - Fully Insured Medical Plans (Aetna)**

Resolved that, the SEB Board endorses Aetna's proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-45 passes.

Policy Resolution SEBB 2018-46 - Fully Insured Medical Plans (Kaiser Foundation Health Plan of the Northwest)

Resolved that, the SEB Board endorses Kaiser Foundation Health Plan of the Northwest's (KPNW) proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.PO

Alison Poulsen moved and Dan Gossett seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-46 passes.

Policy Resolution SEBB 2018-47 - Fully Insured Medical Plans (Kaiser Foundation Health Plan of Washington)

Resolved that, the SEB Board endorses Kaiser Foundation Health Plan of Washington's (KPWA) proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

Wayne Leonard moved and Katy Henry seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-47 passes.

Policy Resolution SEBB 2018-48 - Fully Insured Medical Plans (Kaiser Foundation Health Plan of Washington Options, Inc.)

Resolved that, the SEB Board endorses Kaiser Foundation Health Plan of Washington Options, Inc. (KPWAO) proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-48 passes.

Policy Resolution SEBB 2018-49 – Fully Insured Medical Plans (Premera)

Resolved that, the SEB Board endorses Premera Blue Cross' proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting and an additional plan design with a separate drug deductible that does not exceed that of UMP Achieve 1 for the purposes of rate development.

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

Jim Grazko, Chief Underwriting Officer for Premera Blue Cross. I'd like to introduce a recommendation that, for pricing, the Board consider not just the two options you've seen so far, and I guess we've added a third with the drug deductible, but another option to what you've seen already, which would basically place us with an actuarial value range of 0.78% to 0.81%. So the additional one we're proposing that we introduce for pricing purposes is a 0.78% AV benefit design that basically is a $1,250 deductible major medical PPO. And the reason we are proposing this is because we have a long history with the school districts in Washington, going back over 60 years, either under the WEA Program, and most recently now with school districts on their own. But we have about 85,000 members and I think at the peak we had 104,000.

So, we essentially understand the benefits very, very well and we know that in the past that two of the three plan designs that we're proposing to price have become the most popular. And over time, to keep the plans affordable, we've been asked by the districts to come up with actuarial values that are slightly lower than those that are proposed. So those that are proposed are 80% to 91%. We're proposing 81% and 84%, which are the two plans you've seen so far and then introducing the 78% as a way to reach a price point that we feel is going to be competitive.

What this would do is it would allow us, just again, for pricing purposes, to create a little bit of runway. I think folks know that just in general, when you set an actuarial value, if those benefits stay static, that actuarial value starts to go down over time. The percentage of member cost share drops and the percent that the plan pays goes up over time just naturally the way the math works. This would do is it would create a little bit of runway so that you could leave the benefit design roughly static and keep that AV within a tolerance range because you're pricing it slightly below the 80%. We think that, if that were to be offered, we could probably, in the market, attract up to 30,000 school district members on a plan based on how people have enrolled in the past through WEA and through the regular district plans.

Also, I think it's important that teachers be given a choice. I think that this would allow us for about a $15 per member per month premium drop just to go from 80% down to 78%, so that roughly three percentage point AV difference would be worth about $30 per employee per month on the premium rates, again, making it more affordable.

And the last consideration is just that, when you're looking at how the overall business is priced, this is really a private exchange. We have experience with a couple private exchanges. They can be very volatile and you want to make sure that you have enough choice and a range that allows people to select within that tight range. And adding this option we believe would help create that range. Also, there's a little bit of a difference now between the fully insured versus the self-funded plans. So, there's premium taxes, insurer tax that go with the fully insured options that add about another 5% to the overall cost, as well as the UMP underlying reimbursement design that goes with the self-funded. So, we're talking really a 5% to 10% differential between the fully insured plans and the self-funded plans just out of the gate, apples to apples on benefits.

What this does is, again, allows the price point to come down somewhat for purposes of setting price tags in the initial round. That's really what we're asking for. So, we're proposing that Premera basically provide pricing for the two benefits that you've seen today. And I guess the third with the drug deductibles that have been normalized to the UMP plans and then adding in this 78% major medical plan that's also a $1,250 deductible.

Pete Cutler: Mr. Grazko, two questions. One is my understanding is, if you have a health plan design that has a lower actuarial value; and therefore lower cost, the general dynamic would be that you'd get your healthiest population, people who don't think they're going to use health services, would be attracted to that plan design compared to one with greater coverage. And so, I'd just like to hear your thoughts on that. And the other topic is does this include a separate prescription drug deductible like the other two Premera proposed plans?

Jim Grazko: It does not. No, this is just drugs subject to major medical -- the medical deductible.

Pete Cutler: Okay and on that question, if you have any comments, explain why Premera believes a separate prescription drug deductible is a good plan design in terms of the interests of individuals. I'd be interested in hearing about that, too.

Jim Grazko: Absolutely. So, the first question relative to the risk selection, I guess is what you're referring to on that. That is absolutely true. Within a private exchange setting where everyone's making a decision based on their own economic circumstances, people that have health conditions are going to want to probably stick with what they have now, and generally speaking, choose much richer plan designs relative to lower deductible, lower out-of-pockets. If you introduce a range of product designs that have a very wide range of actuarial values, you will absolutely see what you just described, Pete, in terms of adverse selection.

I think if you're looking at 78% and we're looking at right now 78% to 81%, that's tight enough that really what you're doing is just basically addressing affordability. You shouldn't see in such a tight range adverse selection going into plans other than this lower 78% because that's really what that would be implying is that you're going to be pushing some of the higher risk off of that plan. But I think they're close enough with the

highest and the lowest being 78% and 81% that they're pretty much within range. I don't think you really see that adverse selection.

In terms of the drug deductible, the reason we did that was because that is the plan that we currently have in the market that's the most popular. People are very used to that now. And, really, within a private exchange-type selection setting, every penny counts. I think that it's really a price point issue. It's a way to keep continuity of benefits because that's what they have today. That's what they know. They're buying it, they're choosing that plan design, and if we were to go with a lower deductible or eliminate the pharmacy deductible, it's really a pure price point issue so the price would need to go up by that amount. So, it's a way to keep the costs down in short.

Pete Cutler: My question, thank you for your responses, is why, because you could get a lower cost point, a lower actuarial value by just having a larger overall medical expense deductible and just say it's all lumped together. I don't really quite understand what are considered the policy advantages or the benefit designed advantages of having a separate deductible for prescription drugs versus other medical expenses.

Jim Grazko: You're absolutely right on that, too. There is a way to do that. I mean, there's a lot of ways to get the price point down or the actuarial value down. Again, it had more to do with this is what we have in place today. We have about 85,000 members under coverage with the districts around the state, and just continuing with what they know and what they are currently selecting is a way to hit that price point. But you're right. If we theoretically eliminated that altogether, there'd be a way to get back to that same set of price points on the actuarial values, a number of other ways.

Pete Cutler: Thank you very much.

Wayne Leonard: When you said your most popular plan, are you referring to one of your Easy Choice options?

Jim Grazko: Yes, they're within the range of those Easy Choice. So, when we first had the WEA, going back over a year, we priced out a range of, and I brought that, about 73% to 90%. Over time, we were asked to price in the 73% to 84% so really to sort of shift the range down a little bit. And that became, by far, the most popular set of plans in the program, the Easy Choice plans. That's where the bulk of the enrollment sat until the time when the WEA went to that other structure about a year ago. And now, it's the plans that we're offering today that we have about 85,000 members under coverage are very similar to those Easy Choice plans. And two of the three AVs that we're proposing are largely like those plans.

Dave Iseminger: So, before Jim leaves, in case there's something to follow up on, I do want to assure the Board that as we go through the rate development process, if the rates come in and it looks like there's affordability concerns, I'm not going to wait until the next Board Meeting to ask if you want other options. We'll go back to all the carriers and treat all potential players equally, and ask them to bring us an AV plan that is less than 80%. There are a couple of reasons that the agency has explained to you that we believe all roads lead towards 80% being the lower point before there's a negative

employee contribution. And a couple of those, just to remind you of some of the terms of the Collective Bargaining Agreement that Megan and I described last month, is the employer medical contribution under the tentative agreement is 85% of the premium of an 88% AV plan. That's fixed so if you're buying a plan that's below 88%, then more than 85% of that total premium or bid rate would be paid by the employer. The way that employer medical contribution is set up for the launch of the SEBB Program under the tentative agreement is a fixed 85% of an 88% plan. And so, that will provide some upward pressure because of that contribution.

The second piece is under the Collective Bargaining Agreement. Don't forget that there is an agreed upon minimum employee contribution that represents at least 2% of the employer medical contribution. So for example, if the employer medical contribution ends up being $600, and I'm just using that as an example, then the minimum employee premium per month would be $12 per month. Those two factors have led the projections within the agency to believe that 80% AV is going to be the lower end tolerance whenever you look at those financial factors. But if that turns out wrong, as we go through the rate bill process, we would certainly open up to all the carriers an opportunity to bring additional plans. And then, we will bring you that information in addition to all of the information that would be requested under all the resolutions today.

Patty Estes: Dave, that was actually my question.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-49 passes.

Policy Resolution SEBB 2018-50, Fully Insured Medical Plans (Providence Health Plan)

Resolved that, the SEB Board endorses Providence Health Plan's proposed fully insured medical plan designs presented at the November 8, 2018 Board Meeting for the purposes of rate development.

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

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-50 passes.

Self-Insured Plans Treatment Limits

Kim Wallace, SEBB Finance Manager. This presentation is focused on giving you an opportunity to vote on a change to certain treatment limits in the self-insured medical plans.

Slide 2 – Recommendation – Align with Current State for 2020. The Health Care Authorities recommendation was to align the chiropractic, acupuncture, massage, (CAM) and therapy visit limits to the current state that matches the PEBB UMP plan treatment limits. We've walked through this data before on Option #1, Option #2, Option #3, and Option #4. The dollar values and figures in this table, at the lower rows, show an increase in plan paid PSPM and increase in plan paid per year. Those dollar values were based on analysis done on the PEBB population, essentially saying, "what would be the increase in plan paid on a total paid basis if the PEBB Program population in 2017 had the increased limits?" It was a way for us to see the order of magnitude change that could be reasonably expected on a statewide population of this size under the SEBB Programthat would be likely similar as seen under the PEBB Program. The resolution before you, if passed, would change from the current state to a different level of treatment limitations.

Lou McDermott: **Policy Resolution SEBB 2018-52 - Self-insured Plans Treatment Limitations**

Amending Policy Resolutions SEBB 2018-20, SEBB 2018-21, and SEBB 2018-22 to change the treatment limitations as follows:

- Chiropractic visits are limited to 52 per calendar year
- Acupuncture visits are limited to 52 per calendar year
- Massage visits are limited to 52 per calendar year

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

Pete Cutler: I have to admit, this is a huge increase, a huge disparity compared to what state employees have as coverage and not an insignificant cost increase. I guess I'd be interested in hearing from the sponsors a little bit more in the rationale, but at this point, my inclination is to think this is a reach too far given that the state is about to spend a ton more money on extending health benefits and increasing funding for health benefits for school employees.

Wayne Leonard: The last time we went through this, it seemed like not a lot of people got to even the state limits, or a smaller limit like maybe Option #1 would have covered the vast majority of all visits, or of all claims. Is that correct?

Kim Wallace: Yes, you are remembering correctly.

Dave Iseminger: Just to reiterate that. I think the point was the claims data that the agency and Milliman received back in April, shows that most people wouldn't hit the treatment limits that are the 10, 16, 16, 60 that is the current starting point based on the Board's June decisions.

Kim Wallace: That statement actually holds true for both PEBB Program state employees, active employees in UMP, and current K-12 employees enrolled in plans

with various treatment limits. When we reviewed the utilization to help predict what raising the limitations would mean, and how much benefit-induced utilization there would be, we believe that there does not appear to be a significant number of people who would automatically reach or utilize the limit, or anywhere close to it, actually.

Dave Iseminger: At the same time, Kim, the numbers that are on the prior chart with the options represents an estimate of the total liability the plan could incur. That is a factor. It doesn't seem like there's a rush and you might ask why this number matters. It's the potential plan liability that would exist.

Wayne Leonard: Right. I was just wondering about that because, especially with the chiropractic, I wouldn't mind increasing that a little bit. I would agree with Pete. 52 seems like quite a large jump and quite a big additional cost potential and not even covering many people.

Alison Poulsen: I had a question, which I think is what you just said about the plan liability. Is that what this increase in plan paid per year line is or is that something different?

Kim Wallace: It is different. The total plan liability, essentially, how much money could the plan actually pay out, would mean you would take every single eligible covered member and give 52 visits to every single person. That would be the total possible liability. That is not what's reported here. These numbers are specifically an assessment of how much more would it cost if PEBB Program members that were enrolled in UMP Classic had higher treatment limits for these services. That's what this is reporting. It is taking into account an assessment of how many people would use the full number because it was offered to them, close to the full number but not the full number, likely to use zero. As you can imagine, there are lots of different factors and assumptions to be made. We did this in consultation with our actuarial consultants.

Katy Henry: Part of the thinking around this was based on feedback both Dan and I received from members who were concerned that it was a significant decrease in plans they already had access to. I think we are definitely open at looking at another option on here. The current one just seems very low to us. And that was the feedback we got from members. To Pete's point, it might be a way to distinguish us a little bit from PEBB that we don't have to look exactly the same. This might be a way to do that.

Terri House: The $1.7 million. If we voted for this, where would that come from? What would we sacrifice to have this benefit?

Kim Wallace: I don't know that I would say something will be sacrificed, but what I would say is that the self-insured plan designs that are endorsed will, over the next few months, will undergo rate development. All of the factors and features in the plan design, the treatment limits, the coinsurance, the copays, all of those factors will be taken into account in predicting what the costs are likely to be in 2020 for people who enroll in the UMP plans. If that sounds like a big guess, it is.

Lou McDermott: As we talk about modifying previous resolutions, this can be modified as well. As rate development, as we just had the conversation about Premera and the 78% actuarial value, that can be changed as well. This is informing rate development. It's not a final decision, it's just a piece. The question is whether the Board wants to continue on with a vote. We can just see where the chips fall.

Dave Iseminger: We brought information to the Board. This has been June, July, August, October, November, I think it would be good at some point for the Board to give direction. Is this a topic for continued discussion on future agendas? We're presenting the same information over and over again, quite honestly at this point.

Kim Wallace: I'd like to add that I used a casual term and I'd like to caveat that a bit. I talked about it being a guess.

Lou McDermott: Educated guess.

Kim Wallace: Yes, as the Finance Manager, rest assured, we will take great care in making as clear and as reasonable assumptions as possible, using all the data we have available. But, to your question, Terri, the rate development will be informed by many, many factors. One of which are these treatment limits listed here. These treatment limits will not be a major driver of the rate development, but they will be factored in.

Lou McDermott: Dave and I have a meeting to attend from 2:00 p.m. to 2:10 p.m. We will hold the vote after the meeting. It will give everyone a chance to reflect on what they want to do. If they have questions, we'll continue the comment phase from the Board. We will take a ten minute break.

Dave Iseminger: Board Members are also welcome to ask Katy Hatfield for advice if you have amendments you want to consider and the process. It'll be another opportunity for that. I just want to assure the public that the meeting Lou and I have has absolutely nothing to do with this resolution or the SEBB Program. It's absolutely unrelated.

[Break]

Lou McDermott: Thank you for your patience.

Patty Estes: Is it possible for us to only do the 52 limitations in just one of the UMP Plans and not all three? I know we've had some discussion behind that before.

Kim Wallace: We also talked about the necessary alignment. We use the phrase "substantially similar." How substantially similar the SEBB UMP plans are to the PEBB UMP plans is you could increase the treatment limits on one of the UMP Achieve plans, like UMP Achieve 2 but not UMP Achieve 1, or HDHP, or Plus. The question would be, does that still meet the criteria of standard of substantially similar in terms of how we would set up the administration and work with our current TPA contract, etc. That's essentially the heart of the question. I don't know if we have that answer.

Dave Iseminger: We've talked with Regence and there is that level of flexibility. I think our recommendation would be if you're looking for variability across plans, you have a fully insured book of business and we've provided the information about the variability they're proposing. There's 12, 16, 20, 50, and 52. When we talk about uniformity, consistency, and member experience in the complexity of the benefit designs to be able to say UMP looks like this or the UMP benefits that are statewide have these same benefit pieces that helps reduce some of the complexity and that the members would still have other opportunities for other levels and other benefits. Our recommendation would be to go with all three plans versus fragmenting the plans themselves. We've just gone through an exercise with the fully insured carriers to try to get them more aligned. And moving everything would be consistent with that approach.

Patty Estes: I think the point behind this resolution was to be able to offer something for those members who want something more. I think as long as we have something within the breadth of what we're offering that offers choice, I think that'll be attractive to those members. I just have a really big problem with $1.7 million. It's a lot.

Terri House: I'd like to make a motion to amend 2018-52 to reflect Option 1.

Dave Iseminger: Terri, just for confirmation, all of Option 1? So 16, 16, 16, 80?

Terri House: Correct.

Dave Iseminger: Okay. Let's see if there's a second.

Pete Cutler: I would second that motion.

Dave Iseminger: I anticipated this was going to be an interesting event. I have an alternate slide.

Lou McDermott: Katy, a technical question. We had a motion on the first one, we had a second on the first one. Then we had a motion to amend the first one and we had a second for the second one. Does that mean the first one's gone?

Katy Hatfield: No. What that means is we will discuss the motion to amend and vote on it. If the motion to amend fails, we go back to the original. And, if the motion to amend passes, we amend it and go back and vote on the original with the amendment. You could vote that you want to amend and then still vote no on the original after it's been amended.

Lou McDermott: Okay, we're at the point of public comment.

Katy Hatfield: Yes, we can have public comment and/or Board discussion on the amendment only.

Dave Iseminger: For clarity, we have on the screen the version I just handed out, which basically had all options with blanks. Because acupuncture and massage is currently set at 16 based on the June Board decision, technically, Terri's motion is

amending Policy Resolution 2018-52, the opening clause, first bullet, chiropractic visits are limited to 16 per calendar year and then the fourth bullet that's on the screen, which is combined PT/OT/ST/NDT are limited to 80. There's no acupuncture or massage bullet because there's no change that's moved by that option. The amendment is changing chiropractic from 10 visits to 16 visits and combine PT/OT/ST/NDT visits to 80.

Lou McDermott: So, leave the first bullet and the last bullet.

Dave Iseminger: Yes.

Pete Cutler: I think a slightly more generous set of visit limitations would be appropriate and I think the cost involved is, I'm not supposed to say de minimis, but it is still a reasonable balance and I think a fiscally prudent one, so thank you.

Wayne Leonard: I would second Pete's comments. I think that offering slightly more generous chiropractic benefit would be good without going too far up the scale in terms of cost.

Lou McDermott: I will re-read the resolution and then we'll take a vote.

Katy Hatfield: You're going to read the amendment. You are voting on the amendment. Do you want me to say it?

Dave Iseminger: Let me try it. **Amending Policy Resolution SEBB 2018-52 – Self-Insured Plans Treatment Limitations to read:**

Amending Policy Resolutions SEBB 2018-20, SEBB 2018-21, and SEBB 2018-22 to change the treatment limitations as follows:

- Chiropractic visits are limited to 16 per calendar year
- The combined physical therapy, occupational therapy, speech therapy, and neurodevelopmental therapy visits are limited to 80 per calendar year

Katy Hatfield: That's not accurate. Sorry, but it’s not correct.

Dave Iseminger: I opened it by saying you're amending it and it reads as follows so that I didn't have to say deleting, deleting, adding, deleting.

Katy Hatfield: Okay. The most important thing is that everyone understands rather than we get it technically right. Does everyone have clear understanding on what we're doing?

Patty Estes: Yes. [And others nodding yes.]

Voting to Approve: 8
Voting No: 0

Lou McDermott: The amendment to Policy Resolution SEBB 2018-52 passes.

Katy Hatfield: Yes. Now we need to vote on the resolution as amended.

Dave Iseminger: Let me make a suggestion, Chair McDermott. You are asking the Board to now vote on Policy Resolution SEBB 2018-52 as amended, which now reads:

Policy Resolution SEBB 2018-52 – Self-insured Plans Treatment Limitations

Amending Policy Resolutions SEBB 2018-20, SEBB 2018-21, and SEBB 2018-22 to change the treatment limitations as follows:

- Chiropractic visits are limited to 16 per calendar year
- The combined physical therapy, occupational therapy, speech therapy, and neurodevelopmental therapy visits are limited to 80 per calendar year

Lou McDermott: What Dave said. Let's go ahead and take a roll call vote. Does everybody understand?

All: Yes.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-52 passes as amended.

We've got to figure that out better for the future.

Katy Hatfield: That was really good, actually. It was great. Everybody knew what they were voting on! That's the most important thing.

Disability Benefits

Betsy Cottle, Contract Manager. Today's objective is to take action on the disability plan designs presented at the September 17 Board Meeting.

Slide 3 – September 17, 2018 Board Follow Up. The Board had a couple questions about clarifying the disability insurance taxation issue, the Washington Paid Family and Medical Leave qualifying period, and the utilization of disability insurance in general.

Slide 4 – Taxability of Disability Benefits. Taxability is relatively simple. Disability benefits are either taxed as you pay for it or as you receive it. I've provided two different examples and it can show either you pay your tax when you purchase it or you pay your tax when you receive your benefit. The PEB Board's employer-paid long-term disability benefits are taxed at the time of claim.

Pete Cutler: I have to admit, I'm confused. Under example one, the first sentence says, "The employer-paid basic disability insurance as a taxable benefit for the employee." And that is my understanding of the rule. But then under example two, the last bullet says, "Employer-paid basic disability insurance is not a taxable benefit for the employee." And I'm not seeing why they're saying different things.

Betsy Cottle: I made the example to show either/or. You can design a plan to do it one way the other.

Pete Cutler: But if the employer pays it, are you saying there's a way for the employer to pay on an after-tax basis so that then it would not be taxable when received by the employee?

Dave Iseminger: Pete, there are ways in which you can structure it so that an employer pays in a way that makes the claim paid tax-free. The more common way is the way the state does it, but there are scenarios and structures in which you could craft it so that you impute the dollars that are paid so they're paid on a pre-tax basis even though they're coming out of the employer's pocket. There are structures that can result in example two where the claim is paid tax-free, but it is not as prominent in the market. It's possible it's not well utilized.

Pete Cutler: Okay, thank you.

Dave Iseminger: We can follow up. At one point, there was a very complex slide that went through the taxing structure. We thought it was too detailed for here. But it sounds like you may personally be more interested and we may follow up with that slide. It doesn't show how you get there. It just shows that it exists.

Pete Cutler: Okay. And, actually, I was involved with IRS taxation of benefits quite a bit before, so I probably would be interested in the details. Thank you.

Dave Iseminger: We'll go through the weeds with Pete and anybody else who wants. I'm not seeing any other head nods on that one so you might be on that journey alone, Pete, but we will certainly follow up with you.

Betsy Cottle: There was a question about how the qualifying period works for the Washington Paid Family and Medical Leave. We confirmed that Katy was absolutely correct. An individual must work a continuous four quarters in the past five quarters. So, you cannot work the first two quarters, skip a quarter, and work two quarters. It's the first four or the last four of the last five quarters. So that does mean that the SEBB Program employees who work more than 630 hours per school year but less than 820 will not will not qualify for the Washington Paid Family and Medical Leave Program unless they accrue additional hours with another employer.

Dave Iseminger: The Employment Security Department (ESD) is presenting at our December Board Meeting. Our recommendation is to not go forward with a short-term supplemental employee paid disability benefit as Betsy will describe in a minute. But,

after further conversation with ESD, if there's continued questions about that from the Board, we can continue the discussion,

Wayne Leonard: Would that potentially change our decision about not offering a short-term disability plan if we felt like a lot of our employees wouldn't be covered by this state family paid medical leave?

Dave Iseminger: I think the Board is asking how large of a population is it that could be between 630 hours and 820 hours. In the context of getting you more information about the paid family and medical leave piece, we'll also work to describe the part of the population that could fall in that area. But whether there is a short-term disability benefit that is established by this Board as an employee paid benefit that supplements the portfolio really shouldn't change the bulk of the recommendation, which is that the paid family and medical leave new state program should dovetail with the long-term disability benefit for the vast majority of school employees. I think your question is how big of a gap is it for 630 hours to 820 hours and is there a benefit offering that should this portion authorize for employees to be able to opt into?

Wayne Leonard: Yes. That's the essential idea. But also, since the last discussion, I've gotten a lot of feedback in terms of the dollar amount that's paid for under the state family and medical leave act being a pretty small amount relative.

Dave Iseminger: If you would hold that question for ESD to answer. Small and large is in the eye of the beholder, but they will be able to describe, and we'll make sure to have them prepared to talk about examples of different income sizes, and what a payout would be. And everyone here can individually, subjectively decide what's small and large.

Betsy Cottle: The last question was whether we could find a way to compare the K-12 school population's utilization of disability compared to the PEBB Program. Our vendor, The Standard, was able to do so. This is a representation of Washington PEBB, K-12 school districts of their book of business, and their national group. You can see how the PEBB Program, the existing K-12 school districts that purchase disability insurance from The Standard, and then The Standard's national book of business. In general, school district employees do not appear to access disability benefits at the same frequency as PEBB Program members. Other than that, I'm not sure that we can extrapolate a lot of specific meaning from here.

Dave Iseminger: We were trying to give you general utilization information, differences that we have. I want to be clear that the blue bar is Washington PEBB Program, which includes 71 school districts, and the green bar does not include those 71 districts. That's Standard's separate book of business, but it doesn't have the K-12 districts that are included in the PEBB Program.

Betsy Cottle: For disability insurance, there is much less specific detail. We do end up having to do some interpretations.

Slides 7 and 8 are Stakeholder Feedback that we received after our September meeting. We presented at a couple of meetings and these are the reactions. Two responses were that the basic long-term disability amount is too low to be useful to most school employees and is lower than what most school employees currently receive. Another comment was to recommend offering a supplemental long-term disability benefit only and putting the funds for the basic LTD toward increasing life insurance or another benefit. We made the clarifying statement here, and responded to the stakeholders when they called out this question that, if this Board does not offer an employer-paid long-term disability benefit, the school districts do not have the authority to offer one.

Dave Iseminger: Just a general reminder about the inner play of the authority, remember, you have the exclusive authority for the benefits that are in your jurisdiction. If you don't offer something, there is no alternative authority.

Pete Cutler: To be clear, school districts do not have the authority to offer one, period. It doesn't matter whether the SEB Board decides to offer one or not. Because it's within the SEB Board's purview of authority, school districts do not have the authority to pay for one. Okay.

Betsy Cottle: Exactly.

There was also concern expressed about sick leave being used prior to the waiting period beginning, forcing members to experience a period of no income. This comment was made for both the employer-paid and the employee-paid disability products. We reminded stakeholders the benefit waiting period begins the day of the incident that requires a disability claim, not after a member has used all their sick leave. A member who has accrued more sick leave than their waiting period will be required to exhaust their sick leave balance. But they will, in general, not end up with $0 income by using sick leave. If you have less sick leave than your waiting period, you obviously have a gap for income.

Participants do support choice for pension because it allows a member the best option to manage their income during a disability. We told them the reason we recommend choice for pension is that, if you are disabled at a very young age, your pension could be negatively impacted.

Slide 9 – Short-Term Disability Insurance Recommendation. The Health Care Authority continues to recommend that the SEBB Program not offer a short-term disability benefit. Offering a short-term disability benefit would likely lead to confusion and redundancy. The Washington Paid Family and Medical Leave is a required program that employees will already be paying for. Offering a short-term disability insurance would be duplicative. We believe there will be minimal gaps in coverage for employees who are either just starting employment in the state or exceed the maximum weekly salary. As a result of the Washington Paid Family and Medical Leave, it is assumed the commercial short-term disability market is going to constrict. Enrollment in short-term disability insurance has also historically been very low.

Dave Iseminger: We will continue to scope what we believe is the size of the population that falls in the 630 hours and 820 hours. But, with what we know today, this is the recommendation. If there are more questions that come up after learning more about paid family and medical leave from the Employment Security Department next month, we will continue to have this discussion. You don't have to take an affirmative vote to not offer the benefit. If you have continued questions on this topic, we can continue working on this area.

Betsy Cottle: Policy Resolution SEBB 2018-38 – Employer-Paid Basic Long-Term Disability is before you for action.

Dave Iseminger: As we are about to move into the voting cadence, I want to discuss this because I know the Board is probably not particularly excited about a benefit starting level of $400. So far the agency has provided about four or five different examples of potential horse trades that could be made to reduce a benefit somewhere else and raise this benefit. There haven't been amendments to the other benefit resolutions, and this is the last one of the suite of benefits that's presented to the Board and I designed it that way in case there was a horse trade made in other meetings or at this meeting. There would have been that opportunity to make that trade and then, consequently, immediately amend this resolution to reflect the changes of the horse trade.

I'll go back to my 90% of your homework today, 10% of your homework after the funding comes in. If you're not happy with this piece, I think it is important to be able to describe that there is an intent to have an employer-paid long-term disability benefit and that is something that you want in the portfolio. As the final numbers come in, there could be some refinement and maybe more amenable horse trades. The agency is more than willing to work with Board Members about other alternatives that you're interested in seeing as potential horse trades.

We've shown one on life insurance. You either take some of that money or you don't. There's not as many variables as there are in vision, dental, or in the medical area.

If there are ideas and specific pieces you want costed out as a potential horse trade, we can bring that information to you. We brought orthodontia information because of a Board request. I'm not sure there was a majority of the Board that was particularly interested in that horse trade, but you wanted to know what the numbers looked like. We'll go through any and all exercises to describe potential horse trades. For today, you could view this as showing that there is an intent to have an employer long-term disability benefit in the suite and that this is a starting point.

Lou McDermott: **Policy Resolution SEBB 2018-38 – Employer-Paid Basic Long-Term Disability**

Resolved that, the SEBB Program will offer the following Employer-Paid LTD Plan to subscribers beginning January 1, 2020:

- Later of 90 days or the End of the State Paid Family and Medical Leave Benefit
- No Choice Sick Leave
- Choice Pension
- Maximum Monthly Benefit $400 (60% of $667)

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

Pete Cutler: I'll just start out by saying this is an issue that I feel very strongly about, whereas I tend to feel pretty flexible about most of the other issues we've been dealing with. In my opinion, this $400 maximum benefit is worse than no benefit at all, because frankly, I know in the state employee context, it leads many employees into a false sense that the employer provides something, they don't pay close attention, and when they have a disability, they realize they can't begin to cover their costs. In my opinion, it would be better to put the money into marketing, and really stress very strongly with employees, this is a much more likely occurrence to impact your life while you're working than a life insurance benefit.

I think a $2,000 minimum benefit or maximum benefit would be much more appropriate. I also, under the Collective Bargaining Agreement, for whatever reason, it did not actually lock in a dollar amount for the SEB Board to work with. We really don't have an idea of what the proposed funding for SEBB benefits is on a per member rate. But it clearly states that whatever this Board adopts as an employer-paid benefit, which would include this benefit, would be funded by the employer. It will not involve some kind of trade-off or cost sharing. So, I'm going to vote no on this resolution. Thank you.

Alison Poulsen: Can you remind me how this compares to a PEBB benefit?

Dave Iseminger: Alison, the PEBB benefit, is a maximum monthly benefit of $240 or 60% of $400. It's a $240 benefit. The difference you see here is reflective of the risk corridor and the risk differences associated with the job classifications that predominate within the SEBB Program population compared with the PEBB Program population.

Betsy Cottle: The utilization slide actually does exactly that.

Terri House: You had mentioned horse trading. Could you trade on life insurance somewhat to, like Pete suggested, make this a little more robust?

Dave Iseminger: The answer to that is yes. When we brought up the life insurance resolutions for consideration by the Board at the October meeting, one of the benefit horse trades we described was decreasing the basic life insurance benefit from $35,000 to $25,000. That would allow you to generate annual premium dollars to support increasing the basic LTD benefit from $400 to $600. That is one of the horse trade ideas. To make sure the Board has an appreciation for why that could be one of the more tolerable types of trades you might lean towards, when you go into the employee-paid supplemental life insurance benefits, the employee can elect more coverage in $10,000 increments.

There's a lot of flexibility in what the employee can get on the life insurance side that tailors to their personal financial situations that they want to insure. On the LTD side, it's more of a pass/fail test. There's the basic benefit that goes to a certain level and then, when you want to elect a supplemental benefit, you have to make the complete jump up to 60%. There's no gradation. So, by raising the basic LTD benefit, you're leveraging that people have flexibility on life insurance. If they need that extra $10,000, they can elect that in a $10,000 increment, but you're enhancing and lowering the big jump they have to make to get up to 60% in LTD.

If this Board wants today to convey that they want a resolution brought in December to do the horse trade in life insurance, we can certainly tee it up that way. If that is the consensus with the Board, and I'd want more people to chime in that is a trade you want to acknowledge, you could amend this resolution to be $600 and then we would bring the second resolution to amend life insurance down to $25,000 for you in December.

Alternatively, you can know that's on the table, and do that during the refinement process and see what other ideas your fellow Board Members have about other potential horse trades while waiting until the funding dollar comes in. I would recommend the Board not engage in trying to do false precision over January, February, March, April, but if you want to convey a horse trade before going into the legislative session and then wait until after the legislative session to do the rest, that would be one way you could proceed.

Terri House: If others are interested, I'm interested in doing that today.

Lou McDermott: Dave, wouldn't we want to vote this in and then in December bring one that switches both of them at the same time?

Dave Iseminger: We can do it that way, too. That may be clearer because it shows the horse trade.

Lou McDermott: Yes, because if we get to the second one and they vote no, it's problematic.

Dave Iseminger: I agree with your suggestive strategy, Chair McDermott.

Lou McDermott: Okay. I would say we vote on this one now and then in December, we'll bring that trade if other members of the Board are also interested in that trade. So, other members are interested? I see heads nodding. Okay.

Pete Cutler: I'm sorry. I'm not interested in the trade because I don't think going to a $600 a month maximum benefit is going to fundamentally change the dynamic that people are going to have the accident and are disabled before they realize they don't begin to have enough money to cover even rent, much less other expenses. So, no thank you.

Alison Poulsen: Yes, I think the trade would be a good option.

Patty Estes: I have to agree with Pete.

Katy Henry: I agree with Pete.

Wayne Leonard: I agree with Pete. Our district's current LTD is 60% of base salary up to maximum $2,000.

Dave Iseminger: That was a nice straw poll for whether to tee something up at the next meeting or not.

Lou McDermott: More deliberation.

Dave Iseminger: Yes, more deliberation. To me, that's signaling that there's a fundamental question about LTD that I think it will be best to engage with the Board about other opportunities for horse trades. We identify other areas that you want the agency to cost out. You're focused on waiting until after legislative session to see if there's any relief that comes in the legislative process.

Wayne Leonard: Just for clarification, though, you indicated that we had to offer a plan. If we don't offer a plan, then school districts aren't able to offer a plan. I will support this resolution today just in that context that we want to offer a plan, not necessarily at this level.

Dave Iseminger: And you do have a correct understanding, Wayne.

Patty Estes: Could we possibly amend the resolution to take out the maximum monthly benefit until a further subsequent meeting to show our intent of offering something but not setting that dollar amount yet?

Lou McDermott: So, my two cents. For rate-setting purposes, you have to have something. You have to put something in and then the horse trading is more real because you'd have to put in a placeholder. You've got to stick a number in anyway. At the end of the day, back to Pete's comment of it's better to offer nothing and let them know that they need to go and get their supplemental, we can also do a resolution to end it.

Dave Iseminger: You could ultimately come back and repeal Policy Resolution SEBB-38 and say there is no basic long-term disability benefit, and use those funds to do something else.

Lou McDermott: But this would give us a starting point.

Pete Cutler: With all due respect, it seems to me that the Board could make a motion to strike the last bullet about the maximum monthly benefit, go on record in favor of having a long-term disability benefit, and then in terms of rate setting, you'd be dealing with the carriers or the insurance company. You'd come back with dollar amounts and essentially punt the decision of that level of benefit until further down the road. In my view, it is quite feasible, unlike health care, the negotiations with the health plans, you're

going to a set market with a set company. The cost is what it is. Making the decision five months from now is not going to materially impact the cost or the opportunities, whereas it would have a huge impact if you tried to make the same kind of delay in decision making for the health benefit, or probably even the dental benefit, or vision benefits. I would definitely support a motion to amend the resolution to delete the final bullet. Thank you.

Lou McDermott: I guess my perspective, I'm not sure if I see the point of the resolution then. I don't know what it would do.

Betsy Cottle: It would give everything except the value.

Dave Iseminger: It conveys an intent.

Lou McDermott: But we already have that intent.

Dave Iseminger: Not in a formal action by the Board.

Lou McDermott: No, not in a formal action by the Board. I guess I'm not seeing. If we don't have a number then I don't know what it does.

Pete Cutler: From my view, as Wayne said, it would get us on record that we definitely believe this is an important benefit and there is intent by the Board to offer it. Going on record for those parts and leaving undefined what the level of benefit will be until later in the process.

Lou McDermott: I guess I'm thinking everything that we say during the meeting is on record. So, we have expressed our intent. That's what we want. It's up to you, Dave.

Dave Iseminger: I'll just say, typically, OFM and legislative staffers, if they're not in the audience, they're on the phone, and they're hearing the Board's struggle with this piece. It been a longstanding struggle, both on the PEBB side, and with the level of this benefit for you. I do think it's important to be able to describe to the Legislature, here is the preliminary suite of benefits in its totality. I think there is value to showing people that there is the full suite of benefits, even though it's preliminary. It will have the same asterisk that was at the top of the comparison chart subject to legislative funding and final Board determinations. Showing everyone that there is this preliminary consensus, although not complete consensus, on all aspects of the benefit design. There is a way to thread this needle and show that this program can launch with a full suite of benefits. I think there is an inherent value being able to go into the legislative session that way.

Alison Poulsen: I would support keeping the dollar amount in there so that we have some good parameters to work and then allow the process to play out over the next period of time.

Terri House: I just have one more question. Can we take out the word "maximum" and put "minimum?" That's the bottom where we're starting. We horse trade up. Can we do that?

Dave Iseminger: Interestingly, Terri, in my mind I was wondering about the value of the word "maximum" or "minimum" because the reality is that would be the benefit. Upon reflection, as soon as you asked that question, I thought there's no value to that adjective either way.

Katy Hatfield: If somebody's salary is less than $667.

Dave Iseminger: So, there is value to the maximum side.

Lou McDermott: Yes, depending on how many people would fall underneath that threshold and receive less than $400. If they receive other money, too, that's counted against that. There is a chance that they would receive less than $400.

Betsy Cottle: Same problem with the word "minimum."

Lou McDermott: It would cost more to say $400 period. We would have to recalculate.

Dave Iseminger: I think we're in the middle of Board discussion but I don't know if there's more Board discussion or public comment about it that may have come up.

You do have a motion and a second on the table right now.

Katy Hatfield: Patty made a motion to amend so I don't know if that is resolved.

Patty Estes: I didn't make a motion, I just asked.

Katy Hatfield: Okay.

Dave Iseminger: I was listening very carefully. Nobody made any motions to amend the main motion at this point. There was just lots of hypotheticals.

Voting to Approve: 7
Voting No: 1

<u>Voting to Approve:</u>
Wayne Leonard
Terri House
Alison Poulsen
Katy Henry
Patty Estes
Dan Gosset
Lou McDermott

Voting No:
Pete Cutler

Lou McDermott: Policy Resolution SEBB 2018-38 passes.

Dave Iseminger: I know this is a very difficult resolution for folks. It is not the end of the journey on that benefit. I want to reassure you of that. I appreciate being able to have a full suite of benefits at the end of the day to go into legislative session. That is not the end of the journey.

Lou McDermott: **Policy Resolution SEBB 2018-39 – Employee-Paid Supplemental Long-Term disability**

Resolved that, the SEBB Program will offer the following Employee-Paid Supplemental LTD Plan Design:

- Waiting Period - Later of 90 days or End of the State Paid Family and Medical Leave Benefit
- No Choice Sick Leave,
- Choice Pension
- Maximum Monthly Benefit $10,000 (60% of $16,667)

Alison Poulsen moved and Katy Henry seconded a motion to adopt.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-39 passes.

[Break]

Dual Enrolment

Kim Wallace, SEBB Finance Manager. The objective of this agenda item is to take action on Policy Resolution SEBB 2018-15 regarding dual enrollment in SEBB benefits. We do have a little bit of information regarding stakeholder feedback before we ask for your vote.

Slide 3 – Stakeholder Feedback. One stakeholder did not support the policy of prohibiting dual enrollment because it is significantly different from what employees in some districts have currently. They went on to describe the two sub-bullets on this slide and asked the Board to consider a separate policy for medical versus dental and vision benefits.

Slide 4 - We received a comment from one stakeholder who supported prohibiting dual enrollment for medical benefits, but not for dental or vision.

Slide 5 – Recommendation. The Heath Care Authority's recommendation is to prohibit dual enrollment in SEBB benefits, to limit enrollment in SEBB medical, dental, and vision coverage to a single enrollment per individual.

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

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

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

Fred Yancey: Thank you, Mr. Chair. My name is Fred Yancey and now I'm wearing the Washington Association School Administrator hat. And they are very much in support of this policy. It is very expensive for districts to double cover employees, and as much as there's an advantage to it and I've been a beneficiary of such a practice in the past, there's a financial cost that is just, you know, we're already looking at a substantial financial cost. So, they're very much in favor of passage of this resolution. Thank you.

Voting to Approve: 8
Voting No: 0

Lou McDermott: Policy Resolution SEBB 2018-15 passes.

Next Meeting

December 13, 2018
8:30 a.m. to 2:00 p.m.

Preview of December 13, 2018 SEB Board Meeting

Dave Iseminger: First I just want to thank the Board for your 18 votes today.

We've just ended Chapter Three of our journey. Chapter One was orientation and procurement resolution, Chapter Two was self-insured medical, and Chapter Three was a preliminary suite of benefits. We'll talk about the next coming chapters and the work to come for the Board between January and July.

In December, we'll do some myth busting. There are numbers out there that people are asking about. "What exactly is that $1,174 number?" "How is this going to work?"

We'll start a multi-month journey talking about pharmacy, pharmacy trends, and ways you might want to think about modifying a pharmacy benefit going forward. The Employee Security Department will present on Paid Family and Medical Leave. We'll bring back Policy Resolutions for action.

We'll discuss wellness and tee up resolutions related to decisions you have to make related to the wellness program authorized under the Collective Bargaining Agreement.

Lou McDermott: Dave, I want to thank you and your staff for doing a great job. Katy, thanks for helping us through the amendment process. I appreciate the Board for devoting their whole day to this endeavor. It is important and I appreciate your candor and speaking your mind and allowing each other the space to do that. These are hard topics. Nothing is straightforward. There's a hundred ways of looking at it and I appreciate you. So, thank you.

Meeting adjourned at 3:21 p.m