

School Employees Benefits Board Meeting

April 7, 2022

School Employees Benefits Board

March 3, 2022

9:00 a.m. – 11:30 a.m.

Attendance by Zoom Only

Health Care Authority
Sue Crystal A & B
626 8th Avenue SE
Olympia, Washington

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TAB 1

School Employees Benefits Board
April 7, 2022
9:00 a.m. – 11:30 a.m.

**Aligning with [Governor's Proclamation 20-28](#),
all Board Members and public attendees
will only be able to attend virtually**

TO JOIN ZOOM MEETING – SEE INFORMATION BELOW

9:00 a.m.*	Welcome and Introductions		Lou McDermott, Chair	
9:05 a.m.	Meeting Overview		Dave Iseminger, Director Employees & Retirees Benefits (ERB) Division	Information
9:10 a.m.	Approval of Meeting Minutes: <ul style="list-style-type: none"> • May 5, 2021 • June 3, 2021 	TAB 3	Lou McDermott, Chair	Action
9:15 a.m.	Policy and Rules Development	TAB 4	Emily Duchaine, Regulatory Analyst Policy, Rules, & Compliance Section ERB Division	Action
9:25 a.m.	2022 Annual Rule Making	TAB 5	Stella Ng, Policy & Rules Coordinator Policy, Rules, & Compliance Section ERB Division	Information/ Discussion
9:40 a.m.	2022 Legislative Session Wrap-up	TAB 6	Cade Walker, Executive Special Assistant, ERB Division	Information/ Discussion
9:55 a.m.	2022 Supplemental Budget Update	TAB 7	Tanya Deuel, ERB Finance Manager Financial Services Division	Information/ Discussion
10:10 a.m.	Break			
10:20 a.m.	2024 Uniform Dental Plan (UDP) Dental Benefit Design Options	TAB 8	Ellen Wolfhagen, Senior Account Manager, Portfolio Management & Monitoring Section, ERB Division	Information/ Discussion
11:05 a.m.	Public Comment			
11:20 a.m.	Closing			
11:30 a.m.	Adjourn		Lou McDermott, Chair	

*All Times Approximate

The School Employees Benefits Board will meet Thursday, April 7, 2022. Due to COVID-19 and out of an abundance of caution, all Board Members and attendees will attend this meeting virtually.

The Board will consider all matters on the agenda plus any items that may normally come before them.

To provide public comment by email, direct e-mail to: board@hca.wa.gov.

Materials posted at: <https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program/meetings-and-materials> by close of business on April 4, 2022.

[Join Zoom Meeting](#)

Join Zoom Meeting

<https://us02web.zoom.us/j/85440649040?pwd=WjFTd3R0OVhaN25hNUthZjVXelArQT09>

Meeting ID: 854 4064 9040

Passcode: 510823

One tap mobile

+12532158782,,85440649040#,,,,*510823# US (Tacoma)

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+1 301 715 8592 US (Washington DC)

Meeting ID: 854 4064 9040

Passcode: 510823

Find your local number: <https://us02web.zoom.us/j/85440649040?pwd=WjFTd3R0OVhaN25hNUthZjVXelArQT09>

SEB Board Members

Name	Representing
Lou McDermott, Deputy Director Health Care Authority 626 8 th Ave SE PO Box 42720 Olympia, WA 98504-2720 V 360-725-0891 louis.mcdermott@hca.wa.gov	Chair
Kerry Schaefer 1405 N 10 th ST Tacoma, WA 98403 C 253-227-3439 SEBBoard@hca.wa.gov	Employee Health Benefits Policy and Administration
Pete Cutler 7605 Ostrich DR SE Olympia, WA 98513 C 360-789-2787 SEBBoard@hca.wa.gov	Employee Health Benefits Policy and Administration
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Dan Gossett 603 Veralene Way SW Everett, WA 98203 C 425-737-2983 SEBBoard@hca.wa.gov	Certificated Employees

SEB Board Members

Name

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4/1/22



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue SE • PO Box 45502 • Olympia, Washington 98504-5502

SEB BOARD MEETING SCHEDULE

2022 School Employees Benefits (SEB) Board Meeting Schedule

The SEB Board meetings will be held at the Health Care Authority, Sue Crystal Center, Rooms A & B, 626 8th Avenue SE, Olympia, WA 98501.

January 27, 2022 - 9:00 a.m. – 4:00 p.m.

March 3, 2022 - 9:00 a.m. – 2:00 p.m.

April 7, 2022 - 9:00 p.m. – 2:00 – p.m.

May 5, 2022 - 9:00 a.m. – 2:00 p.m.

June 2, 2022 - 9:00 a.m. – 2:00 p.m.

June 23, 2022 - 9:00 a.m. – 2:00 p.m.

July 7, 2022 - 9:00 a.m. – 2:00 p.m.

July 21 2022 - 9:00 a.m. – 2:00 p.m.

July 28, 2022 - 9:00 a.m. – 2:00 p.m.

*Meeting times are tentative

If you are a person with a disability and need a special accommodation, please contact Connie Bergener at 360-725-0856

7/16/21

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: July 16, 2021

TIME: 2:29 PM

WSR 21-15-080

TAB 2

SCHOOL EMPLOYEES BENEFITS BOARD BY-LAWS

ARTICLE I

The Board and Its Members

1. **Board Function**—The School Employees Benefits Board (hereinafter “the SEBB” or “Board”) is created pursuant to RCW 41.05.740 within the Health Care Authority; the SEBB’s function is to design and approve insurance benefit plans for school district, educational service district, and charter school employees, and to establish eligibility criteria for participation in insurance benefit plans.
2. **Staff**—Health Care Authority staff shall serve as staff to the Board.
3. **Appointment**—The members of the Board shall be appointed by the Governor in accordance with RCW 41.05.740. A Board member whose term has expired but whose successor has not been appointed by the Governor may continue to serve until replaced.
4. **Board Composition**—The composition of the nine-member Board shall be in accordance with RCW 41.05.740. All nine members may participate in discussions, make and second motions, and vote on motions.
5. **Board Compensation**—Members of the Board shall be compensated in accordance with RCW [43.03.250](#) and shall be reimbursed for their travel expenses while on official business in accordance with RCW [43.03.050](#) and [43.03.060](#).

ARTICLE II

Board Officers and Duties

1. **Chair of the Board**—The Health Care Authority Director or his or her designee shall serve as Chair of the Board and shall conduct meetings of the Board. The Chair shall have all powers and duties conferred by law and the Board’s By-laws. If the regular Chair cannot attend a regular or special meeting, the Health Care Authority Director may designate another person to serve as temporary Chair for that meeting. A temporary Chair designated for a single meeting has all of the rights and responsibilities of the regular Chair.
2. **Vice Chair of the Board**—In December 2017, and each January beginning in 2019, the Board shall select from among its members a Vice Chair. If the Vice Chair position becomes vacant for any reason, the Board shall select a new Vice Chair for the remainder of the year. The Vice Chair shall preside at any regular or special meeting of the Board in the absence of a regular or temporary Chair.

ARTICLE III

Board Committees **(RESERVED)**

ARTICLE IV
Board Meetings

1. Application of Open Public Meetings Act—Meetings of the Board shall be at the call of the Chair and shall be held at such time, place, and manner to efficiently carry out the Board’s duties. All Board meetings shall be conducted in accordance with the Open Public Meetings Act, Chapter 42.30 RCW, but the Board may enter into an executive session as permitted by the Open Public Meetings Act.
2. Regular and Special Board Meetings—The Chair shall propose an annual schedule of regular Board meetings for adoption by the Board. The schedule of regular Board meetings, and any changes to the schedule, shall be filed with the State Code Reviser’s Office in accordance with RCW 42.30.075. The Chair may cancel a regular Board meeting at his or her discretion, including the lack of sufficient agenda items. The Chair may call a special meeting of the Board at any time and proper notice must be given of a special meeting as provided by the Open Public Meetings Act, RCW 42.30.
3. No Conditions for Attendance—A member of the public is not required to register his or her name or provide other information as a condition of attendance at a Board meeting.
4. Public Access—Board meetings shall be held in a location that provides reasonable access to the public including the use of accessible facilities.
5. Meeting Minutes and Agendas—The agenda for an upcoming meeting shall be made available to the Board and the interested members of the public at least 24 hours prior to the meeting date or as otherwise required by the Open Public Meetings Act. Agendas may be sent by electronic mail and shall also be posted on the HCA website. An audio recording (or other generally-accepted electronic recording) shall be made of each meeting. HCA staff will provide minutes summarizing each meeting from the audio recording. Summary minutes shall be provided to the Board for review and adoption at a subsequent Board meeting.
6. Attendance—Board members shall inform the Chair with as much notice as possible if unable to attend a scheduled Board meeting. Board staff preparing the minutes shall record the attendance of Board members in the minutes.

ARTICLE V
Meeting Procedures

1. Quorum—Five voting members of the Board shall constitute a quorum for the transaction of business. No final action may be taken in the absence of a quorum. The Chair may declare a meeting adjourned in the absence of a quorum necessary to transact business.
2. Order of Business—The order of business shall be determined by the agenda.
3. Teleconference Permitted—A Board member may attend a meeting in person or, by special arrangement and advance notice to the Chair, by telephone conference call or video conference when in-person attendance is impracticable.

4. Public Testimony—The Board actively seeks input from the public at large, from enrollees served by the SEBB Program, and from other interested parties. Time is reserved for public testimony at each regular meeting, generally at the end of the agenda. At the direction of the Chair, public testimony at Board meetings may also occur in conjunction with a public hearing or during the Board’s consideration of a specific agenda item. The Chair has authority to limit the time for public testimony, including the time allotted to each speaker, depending on the time available and the number of persons wishing to speak.
5. Motions and Resolutions—All actions of the Board shall be expressed by motion or resolution. No motion or resolution shall have effect unless passed by the affirmative votes of a majority of the Board members present and eligible to vote, or in the case of a proposed amendment to the By-laws, a 2/3 majority of the Board .
6. Representing the Board’s Position on an Issue—No Board member may endorse or oppose an issue purporting to represent the Board or the opinion of the Board on the issue unless the majority of the Board approve of such position.
7. Manner of Voting—On motions, resolutions, or other matters a voice vote may be used. At the discretion of the Chair, or upon request of a Board member, a roll call vote may be conducted. Proxy votes are not permitted, but the prohibition of proxy votes does not prevent a temporary Chair designated by the Health Care Authority Director from voting.
8. State Ethics Law and Recusal—Board members are subject to the requirements of the Ethics in Public Service Act, Chapter 42.52 RCW. A Board member shall recuse himself or herself from casting a vote as necessary to comply with the Ethics in Public Service Act.
9. Parliamentary Procedure—All rules of order not provided for in these By-laws shall be determined in accordance with the most current edition of Robert’s Rules of Order Newly Revised. Board staff shall ensure a copy of *Robert’s Rules* is available at all Board meetings.
10. Civility—While engaged in Board duties, Board members conduct shall demonstrate civility, respect, and courtesy toward each other, HCA staff, and the public and shall be guided by fundamental tenets of integrity and fairness.

ARTICLE VI
Amendments to the By-Laws and Rules of Construction

1. Two-thirds majority required to amend—The SEBB By-laws may be amended upon a two-thirds (2/3) majority vote of the Board.
2. Liberal construction—All rules and procedures in these By-laws shall be liberally construed so that the public’s health, safety, and welfare shall be secured in accordance with the intents and purposes of applicable State laws and regulations.

TAB 3

DRAFT
School Employees Benefits Board
Meeting Minutes

May 5, 2021
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 12:15 p.m.

The Briefing Book with the complete presentations can be found at:
<https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program>

Members Present via Phone

Lou McDermott, Chair
Dawna Hansen-Murray
Dan Gossett
Katy Henry
Terri House
Wayne Leonard
Kerry Schaefer
Pete Cutler
Alison Poulsen

Member Present

Alison Poulson

SEB Board Counsel

Katy Hatfield

Call to Order

Lou McDermott, Chair, called the meeting to order at 9:01 a.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting is via Zoom only and will address only those topics necessary and routine to complete the regular cycle of activity in our Board season.

Meeting Overview

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

Southwest Washington's Cowlitz County and Clark County were highlighted. Between the PEBB and SEBB Programs, 6% - 7% of each county's population is within the commercial part of the Health Care Authority's work. Another 33% of the population in

Cowlitz County is covered by Medicaid, and another 24% of Clark County is covered by Medicaid. At an aggregate level for PEBB, SEBB, and Medicaid in Cowlitz County, HCA covers 40% of the population in Cowlitz County with its programs. About 30% of the population for Clark County is covered.

The unemployment rate for Cowlitz County is higher than the statewide average but Clark County is the same as the statewide average. For uninsured rates, Cowlitz County has a higher-than-average uninsured rate compared to the state, whereas in Clark County, it has a lower-than-average uninsured rate. What's unique in this region is it is largely a commuter population, a suburb of Portland. There are a lot of additional health care infrastructures just across the river, more flexibility and accessibility for a wide range of services because of that access to another major metropolitan infrastructure for health care. There's a lot of cross pollination between Oregon and Washington at that part of the state.

We discussed some time ago the Live or Work criteria for being able to access health plans. I highlighted that somewhere between 750 to 1,000 school employees live in Multnomah County but come into the Vancouver School District or surrounding school districts in Clark County. There is a lot of cross pollination that happens at that border, which we see in the data.

I typically highlight things about opioid prescription, substance abuse disorder treatment, and other behavioral health numbers. Interestingly, in this region, compared to statewide average numbers, we see lower than average on all those typical metrics that I've reported about. Another insight about the health demographics of that part of the state.

I want to remind people and do an opening land acknowledgement statement. Our meeting here is being physically supported in Olympia on the traditional territories of the Coast Salish people, and specifically the Nisqually and Squaxin Island people. Olympia and the South Puget Sound region are covered by the Treaty of Medicine Creek signed under duress in 1854. We continue to acknowledge the tribal governments and their roles in taking care of the land that we're on today.

2021-23 Biennial Budget Update

Tanya Deuel, ERB Finance Manager, Financial Services Division. Today's update is on the final conference budget for the next biennium in the SEBB Program. Last month I updated the Board on a comparison between the Governor's proposed budget and the Senate and House proposed budgets. Both the Senate and the House were aligned in their budgets.

Slide 2 – Final Funding Rate. The school year funding rates are \$968 for 2021-22 and \$1,032 for the 2022-23. These numbers are the same that I presented last month and matched the proposed House and Senate budgets. We see no changes to any underlying assumptions and still feel comfortable with these proposed funding rates.

Slide 3 – Final Conference Budget Funding on our decision packages. For our Third-Party Administrator Fees, this is to provide the spending authority we need to be able to

spend out of a specific account to pay our administrators for our self-insured dental and medical plans.

For UMP Member Support we received one FTE to provide UMP specific support for member escalated issues to catch up with higher enrollment in our self-insured uniform medical plans.

The Scheduling Tool Replacement item received \$15,000, which is part of a larger decision package with the majority being attributable to the PEBB Program. Five percent of that decision package was for the SEBB Program to help support COBRA members.

Benefit Administrator Customer Support received two and half FTEs for the SEBB Program for our Outreach and Training Unit staff to help support our school districts. This helps with responding to members through the FUZE system. This was also a larger decision package with a total of three FTEs with half an FTE for the PEBB Program.

Slide 4 – Collective Bargaining. The items on this slide remain the same between the three proposed budgets.

Wayne Leonard: Last year, I asked a question if the board would be getting more financial information. I didn't have anything in mind per se because this is the same information we got last year, what the Legislature did and that it's sufficient to maintain current benefit levels. I emailed Megan questions and she got back to me with the answers to some of those. I'm wondering if you would mind sharing some information with other Board Members. I also had questions about the future and the overall operations of the plan. Will we get to see information like overall revenues, expenditures, administrative costs? Would we be able to see how much of the cost is being funded by the state allocations, as opposed to additional contributions from the local K-12 districts?

I had a chance to go through a statewide summary of the apportionment data. Just off the top of my head, it looks like the state formula funds about \$1.3 billion of the total SEBB Program costs, which I understand is about \$2 billion. If my estimate is close, that would mean about \$700 million is funded by the local K-12 school districts. I know even prior to SEBB, K-12 funded a lot of the medical benefits locally. I don't know if it was the same amount because we didn't have statewide data to look at. I think the difference under that old model is each individual district was setting eligibility criteria and now we, as a Board or the Legislature, is setting eligibility criteria. Under this pandemic, there's been a lot of additional requirements in terms of what is health coverage and that sort of thing. I was curious if we would ever get information like that or if that information is even available?

Tanya Deuel: Wayne, we received your email yesterday and we've gone through it. I think we do need to discuss internally what that presentation would look like. I'm not sure what crosses the line for a public meeting versus an Executive Session, because some of that would be deemed proprietary and confidential when we get into things like risk scores and trends of our fully insured carriers. We do acknowledge that is a

request and something we can provide. We need to just discuss logistics of how we would get that back to you.

Dave, Megan, and I will discuss when the best timing would be. Obviously, with the first year of the program being in a pandemic, things are a little hard to measure versus a baseline of what we projected versus what happened. This first year is a little harder to give you some of those responses. We can answer many of your questions. I do agree that it would be a good conversation.

Dave Iseminger: I do think there's a place for at least some of that to be a public Board presentation. I don't want to sound like we wouldn't discuss that with the public because obviously a lot of this is taxpayer funded dollars. There's certainly a portion of it that is clearly fair game for a public meeting. We can work on something that we can describe at a high level, like revenue and expenditures that talk about the status of building up the reserves. The Board will remember that piece was highlighted as part of the original funding rate setting needed to build up reserves.

There's the large administrative loan that needs to be repaid and the status of that repayment process. There are certainly some high-level pieces that would be amenable to a public session, and there would be some aspects that might squarely fall under Executive Session. Wayne, I want other Board Members to know that's some of what were in those questions along with other pieces. We can talk about the large program financial picture and work on a presentation for later this Board season.

Wayne Leonard: Thanks Dave and Tanya. I know that I neglected to follow up on my questions last year. I'm sorry for the last-minute email, but thanks for your information.

Dave Iseminger: We still have five more Board meetings this season. But this presentation at least covers what happens for the next biennial budget for that funding piece.

Pete Cutler: I just want to go on record also requesting the kind of broad financial overview analysis that Wayne has apparently been asking for. As such a time that you can pull that together, I'd second that request. The reason I put up my hand was I was curious what the employer contribution is for this upcoming school year.

Dave Iseminger: Do you mean the Employer Medical Contribution (EMC)?

Pete Cutler: Yes.

Tanya Deuel: Pete, I don't have what the EMC target would be handy. I can bring that back to the next meeting. As you know, we take that as a target and always try to meet or beat it. I'll get that back to you. We haven't gotten into procurement yet with rate development so it's not on the top of my mind.

Pete Cutler: Thank you.

Dave Iseminger: I want to tell the board that Tanya's presentation highlighted receiving several new staff positions. We are already in the hiring process and excited to bring on those resources. One has already been hired.

2021 Legislative Session

Cade Walker, Executive Special Assistant, ERB Division, provided the capstone of the 2021 legislative session. Slide 2 – Number of 2021 Bills Analyzed by ERB Division shows we completed 161 bills this year, with 55 being high priority and 106 being low priority. Thank you to all the analysts.

Slide 3 – 2021 Legislative Session - ERB High Lead Bills. Two high priority bills we were tracking made it through and were signed by the Governor.

Slide 4 – Upcoming Session – Agency Request Legislation. Senate Bill 5322 – Prohibiting dual enrollment between SEBB and PEBB Programs was signed by the Governor. Senate Bill 5169, the provider PPE reimbursement, was also signed by the Governor.

Slide 5 – House Bill 1052 – Group Insurance Contracts did not make it past cut off. It wasn't necessarily an issue with the bill topic, but a legislative timing issue. Dave is working with the Office of the Insurance Commissioner to determine what HCA will do during the interim on this topic.

Dave Iseminger: HCA will continue to track HB 1052 next year. Passing the bill won't fundamentally change anything we're doing at this point. It clarifies technical concerns with existing law that should be cleaned up in legislation. HCA will continue to muddle through for another year as needed. We will work hard to get this over the finish line next year.

Cade Walker: Slide 6 – Topical Areas of Introduced Legislation. The two pieces of legislation we were tracking related to Paid Family and Medical Leave, HB 1073 and SSB 5097, were signed by the Governor.

Senate Bill 5195 – Opioid Overdose Medication also passed but is yet to be signed by the Governor. This bill expands access to the medications that reverse opioid overdoses like Naloxone.

Slide 7 – Topical Areas of Introduced Legislation (*cont.*). Second Substitute Senate Bill 5313 - Health Insurance Discrimination passed and is awaiting the Governor's signature.

House Bill 1196 – Audio-only Telemedicine passed with minimal impact to the program.

This session is over and sine die was April 25, 2021.

One last thing I want to mention is there was a new report. Dave, any other updates about that?

Dave Iseminger: There is a new report required on the PEBB side on impacts in the retiree setting. The report relates to this concept on the retiree window. I bring it up because we've had K-12 retirees in the PEBB Program for decades. The report will try to quantify what it would look like if eligibility were reopened for another opportunity for

former state and school employees who did not elect and sign up for PEBB retiree benefits at that initial opportunity. There have been various bills over the years potentially opening retiree eligibility for that population that hit different pension systems, sometimes all of them. There are parameters in those bills in the past and the agency will be working on this report.

ESSB 6189 Legislative Report: Variable Funding Rates

Molly Christie, Fiscal Information & Data Analyst, ERB Rates and Finance. Slide 2 – ESSB 6189 - Legislative Report, addresses a report due September 1, 2021, concerning a variable funding rate for waiving SEBB benefits. It asks HCA to analyze the estimated impacts to the projected future funding rates and the amounts billed to each school district allowing SEBB Organizations to pay variable funding rates based on benefits employees elect. For example, for employees waiving medical only, employees waiving coverage for employer-paid benefits, and other options considered by HCA or the SEB Board.

Slide 3 – Historical Pooling Arrangements provides a history of what districts or local bargaining units could do before the SEBB Program.

Slide 4 – The SEBB Program Approach redistributes funds for waived benefits through a single funding rate which is collected for every eligible employee, regardless of whether an individual employee waives benefits. The rate calculation includes an assumption for how many employees will waive based on historical trend. In the SEBB Program, the historical data used was from the PEBB Program. Moving forward, when there is data, SEBB Program historical trend will be used.

Slide 5 – Waiving Doesn't Mean Saving. The SEBB Program must collect enough revenue to insure everyone who enrolls. This slide walks through that process and shows why the formula HCA uses to establish the funding rate assumes a certain percentage of employees in the SEBB Program population will waive.

Slides 6 – 8 – Scenario A: Medical Waivers, walks through the approach, findings, and illustrations of medical waivers. The legislative report directs HCA to consider the estimated financial impacts of allowing districts to pay a lower funding rate for employees who waive medical.

Slides 9 and 10 – Scenario B: Employer-paid Benefits Waivers, walks through the approach and general findings. The Legislature asked HCA to look at what would happen if employees could waive any SEBB benefits, medical, dental, vision, life, AD&D, and LTD. It gets complicated quickly. Modeling these rates becomes more complex because we don't have historical data because it's not currently allowed.

HCA's approach was to interview carriers to estimate waiver rates for employer-paid benefits and any potential pricing impacts of waivers, then use this information to model two funding rates, one for medical only and one for full benefits. There is no financial credit for waiving fully employer-paid benefits because they are state paid benefits.

Dave Iseminger: Molly, I want to drive home one key point. The funding rate under the SEBB Program represents the *average* cost. It's not the *actual* cost attributed to *each*

individual member. That is a key difference between the pre and post SEBB funding models for K-12 benefits. The funding rate used by the state is *average*. The average person is a mythical person, and the money attributable to each person the Health Care Authority charges the district for is the average cost per employee. Waiving doesn't mean saving because it was part of the calculation of the funding rate up front.

Although we're saying we would anticipate a low waiver rate, that's not the same as saying we anticipate no waiver. Even though they're employer-paid benefits, we know the size of our program and we have estimates on the possible decisions that can be made within the Program on an individual and programmatic basis. Individuals will waive benefits for a variety of reasons. Some will believe if they waive benefits, somehow their local pooling arrangement they've had for decades will benefit their colleagues, coworker, or neighbor. Some will waive a government program because they don't want a government program even if it's through their employer, a governmental entity. If a waiver is allowed for each of the employer-based benefits, there will be people who waive it and the administrative complexities of 32 funding rates would be realized. We don't believe the waiver rate would be zero because we know our population is large enough that there will be reasons people waive benefits.

Pete Cutler: Having dealt with administrative simplification in the health care arena, the idea of having 32 funding rates sounds like an absolute nightmare to me. But be that as it may, I'm curious whether there's been any thought given to the *McCleary* court decision and the type of impacts on what the state would have to pay if it did go with this kind of structure, where some districts were funded at less than the level needed to pay for their employee contributions because the assumption of the example given prior was that dollar for dollar, every district got basically a windfall because they had more waivers than average or predicted would be offset by some other district having a dollar less than needed to pay for their state funded, presumably basic education employee insurance contributions. It would seem to me just off the top of my head, if I were one of those school districts, I would argue that the state was obligated under *McCleary* to provide whatever level of funding was going to be required for insurance benefits since I was mandated to get those benefits through the SEBB Program, something I suggest being considered in whatever discussion is presented to the Legislature.

Dave Iseminger: I think you're right, Pete. There are a lot of possible policy and/or legal debates to be had about this whole concept once our report is out. I'm sure we'll have a robust discussion in many circles for years to come.

Molly Christie: Slide 11 – Implementation & Other Considerations. These items will be considered in addition to the financial analysis for our report. Implementing this change would require both one-time and ongoing costs for actuarial assistance, retrofitting Pay1, updating SEBB My Account, preparing special communications to employees regarding this new policy, and costs to both HCA and the school districts to accommodate new billing procedures.

To Pete's point, HCA assumes the Office of Financial Management (OFM) would adjust the prototypical school funding model. These are assumptions. We don't know exactly how this would work to accommodate variable funding rates. OFM determines how much money each district needs for benefits for state funded positions and then distributes those funds to OSPI and then to districts. This would be challenging to do

prospectively because neither OFM nor OSPI will know how many employees in each district will waive benefits, what benefits they'll waive, and which of the 32 funding rates to apply for that employee. It gets very complicated.

If the Legislature decides, at some point, to consolidate the PEBB and SEBB Programs, this will present additional complexity. Today, the legislative report asks HCA to consider SEBB specifically.

Dave Iseminger: To be clear, these are the two approaches HCA is looking at. On Molly's original Slide 2 it had a third prong for other ideas. We don't intend to recommend a third scenario.

Wayne Leonard: I know from our discussions on the Board, various districts pre-SEBB had pooled health insurance dollars very differently. I think in most districts, even in the pooling scenarios you describe here, there wouldn't have been savings to the district. The primary savings, if people waived those benefit dollars, stayed in the pool and it was used by coworkers to lower premiums in certain groups as you mentioned. There was some pre-SEBB local pooling support in my district, and people appreciated helping their coworkers rather than the SEBB Program as a whole. I personally think the SEBB rates are very reasonable what I pay for out of pocket. But to some of our groups that was an increase if you can believe that.

Dave Iseminger: I appreciate that. HCA is aware of that dynamic. That's a piece Molly tried to emphasize at key points. This doesn't change the state or the employee costs, it's a different way of distributing money to the districts. Even here in this alternative scenario world with 2 or 32, or some other number beyond just a single funding rate, it does not trickle up to the overall state expenditure and it doesn't trickle down to the individual employee in the same way local pooling did pre-SEBB. That is an important point. This report will help level-set on understanding and knowing that this is one of the top three questions that comes in various forms from all stakeholders, whether it's an employee or a school district. They struggle through this concept because it is such a different way of thinking about program expenses and individual expenses pre-2020.

Pete Cutler: Thank you. Is the plan to include a full discussion of Pay1 impacts of trying to go to multiple premium contribution rates or funding rates? Am I correct that Pay1 is still written in Cobol or some other archeological type of computer coding?

Molly Christie: Yes, we are quantifying the cost impacts of retrofitting Pay1 because it would be complicated. They're currently working on a narrative for me in layman's terms, because I don't know Cobol. I should be able to explain at a high level what they would need to do in the program, what that would involve, and put some dollars to it.

Pete Cutler: I think there will be big dollars. Pay1 is a very, very complex and not a flexible system. Good luck on that.

Molly Christie: Thank you. I appreciate that.

Dave Iseminger: To those Board Members not familiar with Pay1, it's our accounting backend system that our eligibility and enrollment information flows into from SEBB My Account. The Pay1 accounting system is as old as the LTD benefits the Board just

changed. It was built roughly in 1977. Imagine a computer programming system whose foundation was built in 1977. You quickly start to imagine the complexities and risks associated with systemic changes to that accounting system. Pay1 was created before the personal computer was put on the market for purchase by anyone and everyone. You can start to get the idea of the system's functionality and limitations.

COBRA Subsidy Support for Benefits Administrators and Members

Jesse Paulsboe, Manager, Employer Outreach & Training Unit; **Stacy Grof-Tisza**, Manager, Customer Service Operations Unit provided a two-part presentation on COBRA subsidy implementation and support for both Benefits Administrators and assistance-eligible individuals.

Jesse Paulsboe: Slide 2 – Overview of the American Rescue Plan Act of 2021 which passed March 2021 by the federal government to provide almost two trillion dollars in Covid-19 relief funding, which includes provisions affecting health care coverage, including a 100% subsidy of the COBRA monthly premium for assistance-eligible individuals (AEIs) from April 1 through September 30, 2021. For these individuals, the federal government will pay their monthly premiums and applicable premium surcharges for up to six months of COBRA coverage.

Slide 3 – Outreach & Training (O&T). This Unit is the primary support resource for Benefits Administrators (BAs). It consists of a reactive customer service element to assist BAs when responding to employer questions and concerns that come to us via phone and FUZE, our secure online correspondence program. O&T also has a proactive service component comprised of staff who engage BAs by developing and delivering program training, webinars, materials, and guidance. Together, these efforts ensure employers achieve accurate eligibility and enrollment decisions for employee accounts.

Slide 4 – Implementation of the COBRA Subsidy. As administrators of this subsidy, HCA is required to send a letter notifying all AEIs of their eligibility no later than May 30, 2021, explaining both their options and how to apply for the subsidy if they choose. In the initial planning, we realized the information HCA's system of record does not offer the level of detail necessary to accurately reflect who is subsidy eligible versus who is not. In our day-to-day administrative practices, there's typically no operational need to ask employers whether an employee's termination was voluntary or involuntary. As such, to satisfy the federal requirements of this Act, the ERB Division partnered with employers to obtain this information.

SEBB Organizations received a pair of spreadsheets, one with a list of all former employees within our system of record listed as having lost benefits within the subsidy eligible window, which contained fields to help them determine whether the employee was voluntarily or involuntarily terminated. The Benefits Administrators were asked to complete the spreadsheets and return to the Health Care Authority via FUZE, our primary method of communicating with BAs. Once the spreadsheets were received, HCA completed the notification process.

Slide 5 – Timeline of COBRA Subsidy Implementation. Our goal is to have 100% interaction with the SEBB Organizations to ensure the process is completed timely.

Dave Iseminger: This activity is happening for both the PEBB and SEBB Programs and with all state agencies and higher education institutions. There are roughly 750 employers between the two programs, all of whom have some level of work related to this because this data field, as Jesse indicated, isn't something that's been historically needed. It's not unique to SEBB Organizations.

Approximately 20,000 individuals need to be checked because the subsidy-eligible window goes back to November 2019 – that's about every month for the last 18 months, 800 employers in the two programs. It's a large volume of work.

Stacy Grof-Tisza: Slide 6 – COBRA Subsidy Readiness. I will share how the Customer Service Team plans to implement the COBRA subsidy portion of the American Rescue Plan Act. Jesse's team will work with the Benefits Administrators and my team will use that information to determine AEI eligibility. If individuals have further questions about their COBRA eligibility, they can reach out to our Customer Service Team at our 1-800 toll free line.

Slide 7 – COBRA Subsidy Customer Service Implementation. Customer Service Unit staff will process COBRA and continuation coverage forms, which is occurring outside our busier times of the year, so we don't expect delays in processing the applications.

Slide 8 – COBRA Subsidy Eligibility. Three scenarios have been identified of continuation coverage where individuals would be eligible for the subsidy: those currently enrolled, individuals eligible but not currently enrolled, and those newly eligible.

Slides 9 – 12 – COBRA Subsidy Eligibility Scenarios. These slides provide information for each scenario of COBRA subsidy.

Slide 13 – Deadlines. HCA must receive all required forms no later than 60 days from the date of the initial subsidy eligibility letter.

Public Comment

Fred Yancey: Thank you, I'll be brief. I always enjoy the opportunity of showing my ignorance. I appreciate the opportunity. First, I will make a comment if I could about the retiree window, a study that the Health Care Authority is going to do. It's important for Board Members to realize part of the impetus for this study is the fact that the Medicare Advantage plans came on, the United plans recently brought on through Health Care Authority were not options for many retirees in Eastern Washington where they only could choose Uniform, which they deemed potentially as too expensive. Now there are three plan options available throughout Washington State.

Anyway, two questions. Was there not a study and a conclusion to recommend moving retirees into SEBB? Is there any action on that issue?

And the last question, I'm a little confused. In the COBRA presentation, I would be covered in terms of the cost to be reimbursed for me, assuming I'm eligible. Would those same costs related to covering dependents be reimbursed too? I think there was an earlier slide that said they wouldn't but then the following slides kept talking about the

individual and dependents for reimbursement. Just not sure if my costs would be reimbursed for myself and dependent costs or just for me. And that's it.

Dave Iseminger: I can provide insight on the first question. Normally we don't do Q&A through public comment, but that first question is fairly easy to address quickly. In the April Board Meeting, I believe, we had a brief presentation that while we had intended to act and move K-12 non-Medicare retirees to the SEBB risk pool effective January 1, 2022, we identified that there's another statutory change needed before that move can happen. We anticipate discussing that in the next legislative session. There is an intent to continue moving that forward, but we need the statutory change first. It's on pause while we go back to the Legislature for the statutory fix necessary to implement that recommendation. So, status quo for now.

We will take your question on dependent subsidy coverage back and make sure that, as we finalize materials, it's clear and get back to you outside of the meeting.

Fred Yancey: Thank you.

Next Meeting

June 3, 2021

9:00 a.m. – 1:00 p.m.

Preview of June 3, 2021 SEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the April 7, 2021 Board Meeting.

Executive Session

Pursuant to RCW 42.30.110(1)(I), the Board met in Executive Session 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.

Meeting adjourned at 11:01 a.m.

Draft
School Employees Benefits Board
Meeting Minutes

June 3, 2021
Health Care Authority
Sue Crystal Rooms A & B
Olympia, Washington
9:00 a.m. – 1:30 p.m.

The Briefing Book with the complete presentations can be found at:
<https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program>

Lou McDermott, Chair
Dawna Hansen-Murray
Dan Gossett
Katy Henry
Terri House
Wayne Leonard
Alison Poulsen
Kerry Schaefer

Member Absent

Pete Cutler

SEB Board Counsel

Katy Hatfield

Call to Order

Lou McDermott, Chair, called the meeting to order at 9:03 a.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting is via Zoom only and will address only those topics necessary and routine to complete the regular cycle of activity in our Board season.

Meeting Overview

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

Today's Washington communities highlighted are Pend Oreille County, Stevens County, and Ferry County. Between the PEBB and SEBB Programs, in Pend Oreille we serve a little over 8% of the population; and similar levels, 8% and 7%, in neighboring Stevens and Ferry Counties. For Medicaid, it's roughly 30% to 32% of each county population

served. Roughly 40% of the residents in this three-county region are served by programs at the Health Care Authority.

Some of the demographic information in this region shows noticeably higher rates of the residents living in poverty in each county, generally somewhere between 20% to 25%, whereas the statewide average is 15%. There is a slightly lower than average rate of unemployment, so between 6% and 7% in each county, whereas the statewide average is around 8%. There are higher uninsured individuals in the region, between 7% and 7.5% in each county, whereas the statewide average is a little over 5%.

Approximately 60% to 65% of the entire population in the three-county region is covered in some way by either Medicare or Medicaid. A lot of provider rates are heavily drawn and influenced by those rates.

While all three counties are considered rural, there are noticeable referral and utilization patterns from Stevens County, in particular the Spokane region. We also see a lot of referral patterns in the Pend Oreille and Stevens County area over into the Idaho panhandle for non-primary care purposes.

A long-standing challenge in northeast Washington is the recruitment of physicians, Advanced Registered Nurse Practitioners (ARNP), and others that influence access to primary care causing lower access to primary care rates in that part of the state. It's estimated that roughly a third to a half of the population across that three-county region does not have easy access to grocery stores. This relates to food security, health, and the interrelationship between those various aspects of our lives.

We acknowledge our meeting is being supported physically here in Olympia on the traditional territory of the Coast Salish people. This area was a primary portage way to and from the Puget Sound. These lands were shared by several tribes, including the ones known today as the Squaxin Island Tribe and the Nisqually Tribe. HCA honors and thanks their ancestors and leaders who have been stewards of these lands and waters since time immemorial.

Approval of March 4, 2021 Meeting Minutes

Alison Poulsen moved, and Wayne Leonard seconded a motion to approve. Minutes approved as written by unanimous vote.

Follow Up of May 5, 2021 Meeting

Dave Iseminger, Director, ERB Division. There were two questions from our May meeting. One was a second request to have a presentation on program finances. Staff are anticipating bringing that presentation to a June meeting. Our goal is to incorporate a similar presentation annually at the retreat. We'll be looking for feedback at the next meeting on the structure of that presentations and other content Board Members would like for future iterations.

Pete asked the second question regarding a request for what the employer medical contribution financial budget target is in the operating budget that was passed by the legislature, because that employer medical contribution is the crux of how we do rate setting and comply with the collective bargaining agreements. The calendar year 2022

budget employer medical contribution (EMC) target is \$570. For context, the first two calendar years of the program, 2020 and 2021, the employer medical contribution target was \$555. It did not change from the first year to the second. During the initial financial modeling of the program, we indicated there would be some refinements. We would be right on some projections and off on others. The EMC was stable the first few years. Then the new budget target for the calendar year 2022 rates that we're setting now represents roughly a 3% increase in the EMC used for the rate setting process. Tanya will provide more insights when we have more financial information. That \$570 will be in subsequent presentations further in this season.

SEBB Medical Plan Appeals Process

Selena Davis, Senior Account Manager, ERB. Slide 2 – The General Appeals Process follows state and federal laws, so the medical appeals process is the same across all our carriers. Today I'm focusing on the appeals process specific to the Uniform Medical Plan.

Slide 3 – What is an Appeal? An appeal is a formal request to the health plan for reconsideration of a determination. It can be in writing or phone by the member or an authorized representative of the member. Due to privacy laws and regulations, unless the appealing member is a minor, the plan must have written authorization for a representative to advocate the appeal on the member's behalf. There are medical appeals and employee eligibility appeals. Medical appeals go directly to UMP (Regence). Employee eligibility appeals have a separate process that goes through the employer and HCA. Today's presentation will focus on the UMP medical appeals process.

Slide 4 – Medical Appeal Examples are situations where members may feel they had an authorization request denied, a denial of claims payment or reimbursement, a procedure or service ruled not medically necessary, health care setting denied, or a non-covered service.

Slide 5 – General Levels of Appeals. There are three levels of appeals, denial of request, internal appeal, or external appeal to an independent review organization.

Slides 6 – 8 defines the three levels of appeals, which are required by the Office of the Insurance Commissioner.

Slide 9 – Expedited Appeal has different circumstances and is on a case-by-case basis.

Slide 10 – UMP PEBB Non-Medicare Appeals. The number of appeals for 2018, 2019, and 2020 that UMP saw are listed. For 2020, the most recent information, had 1,805 appeals filed at the first level, which included expedited appeals. Of those, 266 went to a second level appeal, and only 71 went to a third level. The appeal was in favor of the member and overturned 645 times.

Slide 11 – UMP PEBB Retiree Medicare Appeals. In 2020, 202 Level 1 appeals were filed. Of those 48 reached Level 2, 20 went to Level 3. 81 were overturned or found in favor of the member. Expedited appeals were included in the totals.

Slide 12 – UMP SEBB Appeals. Only data for 2020 is available for the SEBB Program active population. Level 1 had 588 appeals filed with 91 going to Level 2. Of those, 16 went to Level 3 with 249 overturned or found in favor of the member.

Slides 13 – 14 – Regence: How to Submit an Appeal. UMP members with a Regence online account can submit an appeal by directly logging into their Regence account, or download the form online and submit by email, fax, or mail. An appeal can also be made by calling Regence Customer Service by phone.

Dave Iseminger: PEBB Program numbers were included to show a longitudinal history and a consistent trend. Eventually there will be enough historical knowledge when a program-to-program comparison won't be necessary. With 2020 being a unique year, we felt it would be helpful.

Members may have a perception the appeals process is futile. Selena's presentation shows otherwise. This data shows a hefty number of individuals whose appeal was overturned. The process creates a balance within the appeal process to ensure Regence and the carriers' own individual appeal processes learn along the way and can continue to refine a benchmark.

Dan Gossett: I appreciate this presentation. It would be nice to have the total number of claims and then the percentage that go to appeals. That could just be with the SEBB data. If it's possible, to also get information on the number of appeals, what percentage, were related to CAM (chiropractic, acupuncture, and message) therapy. Thank you.

Lou McDermott: As appeals go through the process, it can drive modifications we make to our own rules. HCA monitors appeals to see if there's a trend, a discrepancy, or confusion. We've refined our rules, on the PEBB side over the past 30 years. The appeals process drives some of that.

Wayne Leonard: I assume the reason, at least initially, that many of these appeals are a question about additional information or whether a procedure is medically necessary. Would that be safe to assume?

Dave Iseminger: Yes, I do think that's going to be the lion's share of it is medical necessity. Sometimes questions as to whether there's even a medical necessity override on that benefit. We've tried to highlight this before but the way the plan coverage works, certain parts of the plan design have strict limitations and there is no medical necessity override. And other plans do. Sometimes people want to question which parts of the benefit structure have a medical necessity override because sometimes there wasn't enough information with the original submission. They can supplement the record as they're going through certain levels of the appeal process.

Wayne Leonard: As a Board Member, when we receive letters in our Board materials from members who have probably been unsuccessful during the appeals process, that would be primarily for, as Lou mentioned, maybe planning potential future changes to the program. There's nothing the Board can do to overturn appeals. Is that correct?

Dave Iseminger: That is correct, Wayne. It does drive opportunity for benefit design changes. Sometimes we learn in the appeal process that maybe the pre-authorization

requirements being applied aren't as our team would expect. Sometimes, from the administrative hat, we're able to help dial those preauthorization criteria a little bit more without even needing to come to the Board because it's for the administrative aspect of it. For example, when it related to treatment limitations, that's the type of thing when the data is used to inform a benefit design discussion with the Board.

Wayne Leonard: Okay, thank you for this information. That was very helpful.

Dave Iseminger: You reminded me of another piece of information I wanted to share. This presentation has been about medical appeals. There's a separate appeal process when it comes to eligibility for benefits. Those determinations of who gets the employer contribution and whether they have access to the portfolio, start at the employer level, get elevated to the Health Care Authority legal team, and then can move to an Administrative Hearing under the Administrative Procedures Act. A very different process.

2022 Annual Procurement Update

Lauren Johnston, SEBB Program Procurement Manager, ERB Division. Slide 2 – Medical Procurement Plan includes the timeline for the Request for Renewal Process.

Slides 4 – 5 – Uniform Medical Plan (UMP) 2022 – Proposed Benefit Changes. This is ERB's self-funded plan, administered by Regence. There are proposed changes to mental health parity to ensure compliance with federal parity laws for mental health and substance use disorder benefits compared to medical and surgical benefits. It removes the coinsurance from mental health and substance use disorder inpatient professional services in UMP Achieve 1, UMP Achieve 2, UMP Plus Puget Sound High Value Network, and UMP Plus UW. It does not apply to facility fees of the inpatient stay. There are no changes needed for the UMP High Deductible Plan.

Change is being proposed for 2022 with UMP accumulators. Currently when a member switches plans during the plan year, their accumulators do not roll over when they switch to a different plan. HCA is recommending allowing accumulator rollovers between the UMP plans for member satisfaction and to align with how Kaiser and Premera's plans apply rollovers.

Dave Iseminger: As an example, an individual might be enrolled in the UMP High Deductible Plan, get married, and planning to start a family. Their circumstances are now different, and they want to be in UMP Achieve 1 or Achieve 2. If they already had services going toward meeting their deductible, having a special open enrollment related to that marriage and them switching plans, that deductible progress on their original plan election would be wiped away and they'd be back to zero in their new plan. This proposal would allow a midyear UMP plan switch during a special open enrollment to retain what they already accumulated towards their deductible. The progress on one UMP plan is retained and progress toward your deductible as well as all other accumulators when you switch within the carrier. That's how Kaiser and Premera work within their suite of offerings.

Lauren Johnston: Slide 6 – Proposed Resolution SEBB 2021-14 UMP Accumulators reads: Beginning January 1, 2022, when a subscriber enrolled in a Uniform Medical

Plan (UMP) changes their enrollment to another UMP plan during the plan year (excluding Open Enrollment), the insurance accumulators (such as deductibles, out-of-pocket maximums, and benefits and limit visits) will transfer into their new UMP plan. This resolution will be brought to the Board for action at a later meeting.

Dave Iseminger: This resolution will go through the stakeholder process before we bring it back for action.

Lauren Johnston: Slide 7 - Uniform Medical Plan (UMP) 2022 – Proposed Benefit Changes (*cont.*) This change with the UMP High Deductible Plan is due to an IRS change. The health savings account, which applies to the high deductible plan, will have an annual maximum contribution increased to \$3,650 for subscriber only and \$7,300 for all other tiers. That's a \$50 increase for the subscriber only and a \$100 increase for all the other tiers.

Dave Iseminger: This change is technically under the Cafeteria Plan the state runs that the agency has authority over. No Board action is needed because the authority to make these changes resides with the Health Care Authority. We anticipated bringing another change requiring Board action related to the high deductible plan, however, the change we anticipated did not occur. We had anticipated the IRS was going to increase the minimum deductible level necessary for the plan to be IRS qualified to have those tax advantage aspects of a health savings account. The IRS can increase this in \$50 increments each year, which they haven't done in the last few years. The IRS set the floor at \$1,400, which is exactly what the UMP High Deductible Plan deductible is. The current plan design complies with the IRS standard for 2022. We believe that signals next year will have enough inflationary pressures to prompt the IRS to raise it.

Lauren Johnston: Slides 8 – 9 – Proposed Change to UMP Plus – Puget Sound High Value Network. As of January 1, 2022, this network will no longer be offered in Thurston County in part due to provider contracting issues. There were adult primary care contracting challenges and recent ownership relationships that shifted towards UW Medicine, UMP's Plus network. This impacts 77 members. HCA and UMP will submit notifications to subscribers, as well as the Puget Sound High Value Network. Members can also see it through provider search and web notices.

Thurston County will still have 13 plans - four other UMP plans, three Premera plans, three Kaiser Washington plans, and three Kaiser Washington Options plans.

Slides 10 – 11 - 2022 UMP Plus Network Coverage and UMP Plan Coverage. The only change on these maps is that Thurston County went from purple to yellow on Slide 10 and from dark orange to medium orange on Slide 11 to reflect the Puget Sound High Value Network will no longer be offered in Thurston County.

The next set of slides will show proposed changes to the fully insured SEBB medical plans. HCA considers these proposed changes positive for the member. Slides 13 – 22 show Kaiser Permanente Proposed 2022 Benefit Changes. KPNW is proposing benefit changes to naturopathy, acupuncture, massage, rehabilitation services, and dental services for potential transplant recipient.

KPWA and KPWA Options, Inc. plans are proposing benefit changes to include home infusion therapy and removing cost shares for two urine drug screenings. KPWA Options, Inc. is proposing a benefit change to align with Premera and UMP by removing the annual out-of-network maximum out-of-pocket limit.

Slide 21 – Kaiser 2022 Service Areas – No Changes.

Slide 22 – KPNW and KPWA Provider Network Changes. KPNW is adding PeaceHealth Medical Center as a network provider. KP Washington’s contract with UW Medicine, used for their core and SoundChoice plans, expired on May 31, 2021. This does not impact KPWA Options, Inc. plans. The KPWA contract with Kittitas Valley Medical Center will end on December 31 of this year for all plans.

Dave Iseminger: KPWA and UW Medicine are still in active negotiations, but the contract did expire earlier this week. Staff looked at the data and understand around 500 members may be impacted in the SEBB Program. There are some protections that exist for individuals in the situation where they have primary contact with UW Medicine. Anything with a preauthorization already in place continues to be honored at the in-network rate, which covered about half the population. While there's no contract in place and because we're hopeful there will ultimately be agreements to bring them back into network status officially, emergency services are still covered. It does not impact the PPO Options product line at this point.

Lauren Johnston: Slides 24 – 26 – Premera 2022 Proposed Benefit Changes. Proposed changes include adding a Quit for Life Program with a zero cost to the member and service area expansion to include Kittitas County.

Dave Iseminger: I appreciate this response from Premera. It relates to our discussion when we highlighted that Kittitas Valley Health Care and Kaiser Washington will no longer have a network contract there by the end of this year. This will help alleviate some of the challenges the communities in Kittitas County feel with the change in the KPWA network status.

Lauren Johnston: Slide 28 – No Proposed Benefit Changes for 2022. There are no proposed changes to the dental and vision benefit offerings for 2022.

Dave Iseminger: We’ve described the benefit design pieces that are on the table. We'll discuss financial implications during our Executive Session. Staff will then move to the final rate setting process with the Board in public session.

Public Comment

No public comment.

Next Meeting

June 24, 2021

9:00 a.m. – 1:00 p.m.

Preview of June 24, 2021 SEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the June 24, 2021 Board Meeting.

Dave acknowledged Reimer Douglas, one of our longest standing partners on contracts with Uniform Dental Plan administration, as well as Delta Care. I want to acknowledge that his retirement is tomorrow and to take a moment to publicly thank him for his service to state employees and then school employees as the SEBB Program was formed. We wish him well in his retirement

Executive Session

The Board met in Executive session 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.

Meeting adjourned at 10:50 a.m.

TAB 4



Policy and Rules Development

Emily Duchaine, Regulatory Analyst
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
April 7, 2022

SEB Board Policy Resolutions

SEBB 2022-01 School Employees Returning
to Work From Active Duty

RCW 41.05.740(6)(c) & (d)

(6) The school employees' benefits board shall [...]

(c) Authorize premium contributions for a school employee and the employee's dependents in a manner that encourages the use of cost-efficient health care systems. For participating school employees, the required school employee share of the cost for family coverage premiums may not exceed three times the premiums for a school employee purchasing single coverage for the same coverage plan;

(d) Determine the terms and conditions of school employee and dependent eligibility criteria, enrollment policies, and scope of coverage. At a minimum, the eligibility criteria established by the school employees' benefits board shall address the following:

(i) The effective date of coverage following hire;

(ii) The benefits eligibility criteria, but the school employees' benefits board's criteria shall be no more restrictive than requiring that a school employee be anticipated to work at least six hundred thirty hours per school year to be benefits eligible; and

(iii) Coverage for dependents, including criteria for legal spouses; children up to age twenty-six; children of any age with disabilities, mental illness, or intellectual or other developmental disabilities; and state registered domestic partners, as defined in RCW [26.60.020](#), and others authorized by the legislature;

RCW 41.05.050(4)(d)(i)

Beginning January 1, 2020, all school districts, represented employees of educational service districts, and charter schools shall commence participation in the school employees' benefits board program established under RCW [41.05.740](#). All school districts, represented employees of educational service districts, charter schools, and all school district employee groups participating in the public employees' benefits board plans before January 1, 2020, shall thereafter participate in the school employees' benefits board program administered by the authority. All school districts, represented employees of educational service districts, and charter schools shall provide contributions to the authority for insurance and health care plans for school employees and their dependents. These contributions must be provided to the authority for all eligible school employees eligible for benefits under RCW [41.05.740\(6\)\(d\)](#), including school employees who have waived their coverage; contributions to the authority are not required for individuals eligible for benefits under RCW [41.05.740\(6\)\(e\)](#) who waive their coverage.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Title 20 Chapter IX Part 1002 Subpart D Health Plan Coverage § 1002.168

If the employee's coverage was terminated at the beginning of or during service, does his or her coverage have to be reinstated upon reemployment?

(a) If health plan coverage for the employee or a dependent was terminated by reason of service in the uniformed services, that coverage must be reinstated upon reemployment. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment, if an exclusion or waiting period would not have been imposed had coverage not been terminated by reason of such service.

Board Follow Up

At the March 3, 2022 SEB Board Meeting, the Board asked a question involving a scenario of “a full-time teacher who would have benefits, but they left in November before they could get their benefits.”

Resolution SEBB 2022-01

School Employees Returning to Work From Active Duty (Revised)

Resolved that, when a school employee who is called to active duty in the uniformed services under USERRA loses eligibility for the employer contribution toward SEBB benefits, they regain eligibility for the employer contribution toward SEBB benefits the day they return from active duty. Employer-paid SEBB benefits will begin the first day of the month in which they return from active duty.

Resolution SEBB 2022-01 School Employees Returning to Work From Active Duty

Resolved that, when a school employee who is called to active duty in the uniformed services under USERRA loses eligibility for the employer contribution toward SEBB benefits, they regain eligibility for the employer contribution toward SEBB benefits the day they return from active duty. Employer-paid SEBB benefits will begin the first day of the month in which they return from active duty.

Next Steps

- Issue guidance to SEBB Organizations on this resolution
- Incorporate resolution into SEBB Program rules

Questions?

Emily Duchaine, Regulatory Analyst
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division

Emily.Duchaine@hca.wa.gov

Appendix

Resolutions Revised Since the March 4, 2022 Board Meeting

Resolution SEBB 2022-01 School Employees Returning to Work From Active Duty (Revised Proposed Resolution SEBB 2022-01 After Stakeholder Review)

Resolved that, when a school employee who is called to active duty in the uniformed services under USERRA loses eligibility for the employer contribution toward SEBB benefits, they regain eligibility for the employer contribution toward SEBB benefits the day they return from active duty. Employer-paid SEBB benefits will begin the first day of the month in which they return from active duty.

Original March 3, 2022 Board Materials



Eligibility and Enrollment Policy Development

Emily Duchaine, Regulatory Analyst
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
March 3, 2022

RCW 41.05.740(6)(c) & (d)

(6) The school employees' benefits board shall [...]

(c) Authorize premium contributions for a school employee and the employee's dependents in a manner that encourages the use of cost-efficient health care systems. For participating school employees, the required school employee share of the cost for family coverage premiums may not exceed three times the premiums for a school employee purchasing single coverage for the same coverage plan;

(d) Determine the terms and conditions of school employee and dependent eligibility criteria, enrollment policies, and scope of coverage. At a minimum, the eligibility criteria established by the school employees' benefits board shall address the following:

(i) The effective date of coverage following hire;

(ii) The benefits eligibility criteria, but the school employees' benefits board's criteria shall be no more restrictive than requiring that a school employee be anticipated to work at least six hundred thirty hours per school year to be benefits eligible; and

(iii) Coverage for dependents, including criteria for legal spouses; children up to age twenty-six; children of any age with disabilities, mental illness, or intellectual or other developmental disabilities; and state registered domestic partners, as defined in RCW [26.60.020](#), and others authorized by the legislature;

RCW 41.05.050(4)(d)(i)

Beginning January 1, 2020, all school districts, represented employees of educational service districts, and charter schools shall commence participation in the school employees' benefits board program established under RCW [41.05.740](#). All school districts, represented employees of educational service districts, charter schools, and all school district employee groups participating in the public employees' benefits board plans before January 1, 2020, shall thereafter participate in the school employees' benefits board program administered by the authority. All school districts, represented employees of educational service districts, and charter schools shall provide contributions to the authority for insurance and health care plans for school employees and their dependents. These contributions must be provided to the authority for all eligible school employees eligible for benefits under RCW [41.05.740\(6\)\(d\)](#), including school employees who have waived their coverage; contributions to the authority are not required for individuals eligible for benefits under RCW [41.05.740\(6\)\(e\)](#) who waive their coverage.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Title 20 Chapter IX Part 1002 Subpart D Health Plan Coverage § 1002.168

If the employee's coverage was terminated at the beginning of or during service, does his or her coverage have to be reinstated upon reemployment?

(a) If health plan coverage for the employee or a dependent was terminated by reason of service in the uniformed services, that coverage must be reinstated upon reemployment. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment, if an exclusion or waiting period would not have been imposed had coverage not been terminated by reason of such service.

Introduction of Proposed Resolution

SEBB 2022-01 School Employees Returning to
Work From Active Duty

Proposed Resolution SEBB 2022-01

School Employees Returning to Work From Active Duty (As Presented on March 3, 2022)

When a school employee who is called to active duty in the uniformed services under USERRA loses eligibility for the employer contribution toward SEBB benefits, they regain eligibility for the employer contribution toward SEBB benefits the day they return from active duty. Health plan coverage will begin the first day of the month in which they return from active duty.

Proposed Resolution SEBB 2022-01

Example #1

(As Presented on March 3, 2022)

Example: Steve works at Roosevelt Middle School. He returned to his job on May 11, 2022, after six months of active duty. When Steve went on active duty, he was eligible for the employer contribution toward SEBB benefits.

- When are employer paid coverages reinstated?
Employer paid coverages are reinstated May 1.

Proposed Resolution SEBB 2022-01

Example #2

(As Presented on March 3, 2022)

Example: Penny works at Olympia High School. She returns to her job on Monday, April 25, after eighteen months of active duty. When Penny went on active duty, she was eligible for the employer contribution toward SEBB benefits.

- When are employer paid coverages reinstated?
Employer paid coverages are reinstated April 1.

Next Steps

- Incorporate Board feedback in the proposed policies
- Submit feedback by March 18, 2022
- Bring recommended proposed policy resolution to the Board for action at the April 7, 2022 Board Meeting

Questions?

Emily Duchaine, Regulatory Analyst
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
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TAB 5



2022 Annual Rule Making

Stella Ng, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
Employees and Retirees Benefits Division
April 7, 2022

Rule Making Timeline

May 2022	File proposed amendments (CR-102) and distribute new rules for public comments
June 2022	Conduct public hearing and adopt final rules (CR-103)
January 2023	Permanent rules effective

Focus of Rule Making

- Administration and benefits management
- Regulatory alignment
- Implement SEB Board policy resolution

Administration and Benefits Management

- Make global changes to include the addition of Limited Purpose Flexible Spending Arrangement
- Include information on the methods to use when a subscriber wishes to cancel supplemental dependent life insurance and accidental death and dismemberment (AD&D) insurance coverage

Administration and Benefits Management (*cont.*)

- The premiums for employee-paid LTD insurance will be waived for the first 90 days for a school employee who is on a leave of absence and maintains eligibility for the employer contribution
- Clarify a school employee's employee-paid LTD insurance will be automatically reinstated effective the first day of the month following the date they regain eligibility for the employer contribution toward SEBB benefits

Administration and Benefits Management (*cont.*)

- Amend SEBB Program appeal rules related to brief adjudicative proceedings and formal administrative hearings

Regulatory Alignment

- Clarify school employees cannot enroll in a medical FSA and a limited purpose FSA in the same plan year
- Clarify the special open enrollment applies when a school employee's dependent has a change in their own employment status that affects their (the dependent's) eligibility or another dependent's eligibility (such as a dependent child) for the employer contribution toward the dependent's employer-based group health plan

Questions?

Stella Ng, Policy and Rules Coordinator
Policy, Rules, and Compliance Section
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TAB 6



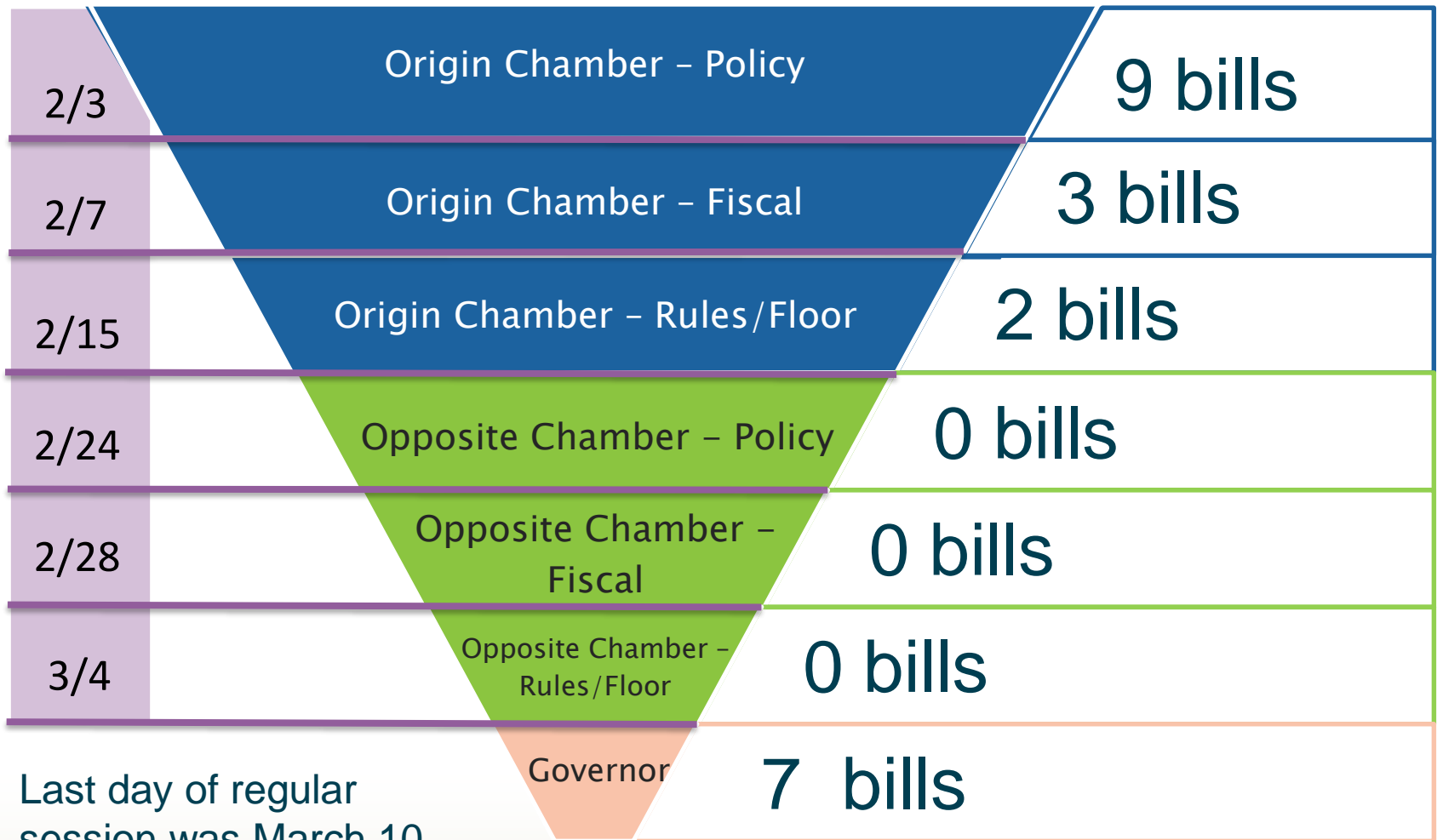
2022 Legislative Session Wrap-up

Cade Walker, Executive Special Assistant
Employees & Retirees Benefits (ERB) Division
April 7, 2022

Number of 2022 Bills Analyzed by ERB Division

	ERB Lead	ERB Support	
High Priority	31	24	55
Low Priority	17	97	114
	48	121	169
Fiscal Notes	38	32	

2022 Legislative Session – ERB High Lead Bills



ERB High Priority Lead Bills - Passed

- 1052 – Group insurance contracts
 - Signed
- 1688 – Out-of-network health care
 - Delivered to Governor
- 1689 – Biomarker testing prior authorization
 - Signed
- 5532 – Rx drug affordability board
 - Signed



ERB High Priority Lead Bills – Passed (*cont.*)

- 5546 – Insulin affordability
 - Signed
- 5610 – Rx drug cost sharing
 - Signed
- 5702 – Donor human milk coverage
 - Signed



Other Passed Legislation

- 1329 – Public meetings
- 1651 – Postpartum contraception
- 1675 – Dialysate & dialysis devices
- 1728 – Insulin work group reauthorization
- 1761 – Opioid reversal by Emergency Department (ED) nurses
- 1851 – Abortion care
- 1881 – Birth doulas



Other Passed Legislation (*cont.*)

- 1893 – EMTs/public health
- 5508 – Insurance guaranty fund
- 5518 – OT licensure compact
- 5539 – ESD funding
- 5765 – Midwifery
- 5793 – State boards, etc./stipends



Questions?

Cade Walker, Executive Special Assistant
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TAB 7



2022 Supplemental Budget Update

Tanya Deuel
ERB Finance Manager
Financial Services Division
April 7, 2022

Final Funding Rate

School Year 2021-22: \$968*
School Year 2022-23: **\$1,026**

Per employee per month

Adequate to maintain current level of
benefits

No significant concerns with funding
rates and underlying assumptions

**Remains unchanged*

Final Conference Budget Funding

\$600K

Customer Service Staff - Funding for 4.5 FTEs requested to address customer service responsiveness and program complexity within Portfolio Management.

\$1.4M

Procurement Resources - Funds requested to maintain, enhance, and replace contracts with the SEBB Program.

\$350K

Mental Health Parity - Funding to complete an analysis of mental health benefits in the Uniform Medical Plan and implement necessary changes to comply with federal requirements.

\$970K

IT Maintenance and Operations - 5.0 FTEs to support basic maintenance and operations and capacity for future enhancements to the SEBB My Account system.

New Proviso Language

\$250,000 is provided for HCA to conduct a study of the Uniform Medical Plan administration. By June 30, 2023, the HCA must prepare a report that includes:

- Administrative services provided prior to 2010, those that have been procured since, and what elements could be provided by HCA or through discrete provider contracts
- Compare the administrative costs before and after the use of the current contract
- Assumptions on claims' impacts and performance guarantees
- An implementation plan for the HCA to resume administration of all or some of the administrative services at the end of the current contract

Questions?

Tanya Deuel, ERB Finance Manager
Financial Services Division
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TAB 8



2024 Uniform Dental Plan (UDP) Dental Benefit Design Options

Ellen Wolfhagen
Senior Account Manager
Employees and Retirees Benefits Division
April 7, 2022

Objectives

- Present specific proposals of benefit design enhancements for the Uniform Dental Plan (UDP)
- Have an initial prioritization discussion
- Explain how prioritization relates to the decision package process

Current UDP Plan Design

- Deductible - \$50/person – up to \$150/family
- Class I (preventive services) – 100% coverage
- Class II (fillings) – 80% coverage
- Class III (crowns, bridges, etc.) – 50% coverage
- TMJ – 70% coverage and \$500 lifetime limit
- Annual *plan* payment - \$1,750

2024 UDP Options

- Annual plan maximum adjustment
- Composite posterior fillings
- Incentive plan design promoting preventive services
- No deductible for children's benefits
- TMJ lifetime benefit limit adjustment

Annual Plan Maximum

Current UDP Annual Plan Maximum Details

- \$1,750 annually
- This is the amount that *plan* pays; the member must pay any amount over that
- UDP has different coverage percentages depending on whether provider is Premier or Preferred

Current UDP Annual Plan Maximum Details (*cont.*)

- While preventive services are covered at 100%, they currently count towards the plan maximum; this could have a big impact if one were to use more expensive services earlier in the year and then has preventive visits later in the year.

Preventive Service Visits

- Cleanings
- Exams
- X-rays
- Periodontal maintenance
- Fluoride application

Currently covered at 100%

Current UDP Annual Plan Maximum Example

Katy needs extensive dental work done. She has a series of appointments for X-rays and oral surgery in January. The total *allowed amount* bill is \$3,500.

In April, Katy returns for periodontal maintenance (deep cleaning). She must pay the full \$200 allowed amount out-of-pocket.

Example of Katy's Claims

Service	Allowed Amount	UDP % of Allowed Amount	UDP Paid	Member Pays
January				
X-rays	\$100	100% (Class I)	\$100	\$0
Oral Surgery	\$3,400	50% (Class III)	\$1,650 (remainder of \$1,750)	\$1,750 (50%, includes \$50 deductible)
April				
Periodontal Maintenance	\$200	100% (Class I)	\$0	\$200

Proposed Annual Plan Maximum Benefit Change

Remove **preventive services** from the annual plan maximum.

- Continue annual plan maximum at \$1,750 level
- Create incentive for using preventive services
- Improve overall health by establishing good oral health routines
- Improve health equity by treating dental preventive services the same as medical preventive services

Example of Katy's Claims Under Proposed Change

Service	Allowed Amount	UDP % of Allowed Amount	UDP Paid	Member Pays
January				
X-rays	\$100	100% (Class I)	\$100	\$0
Oral Surgery	\$3,400	50% (Class III)	\$1,675 (50%) (\$75 plan max remaining)	\$1,725 (50%, includes \$50 deductible)
April				
Periodontal Maintenance	\$200	100% (Class I)	\$200	\$0

Comparing Katy's Out-of-Pocket Costs

	Annual Plan Maximum Used	Annual Plan Maximum Remaining	Katy's Member Costs To Date
Current Benefit Design	\$1750	\$0	\$1,950
Proposed Benefit Design	\$1675	\$75	\$1,725

It is April in the scenario and those having periodontal maintenance are typically recommended to have 3-4 visits per year; Katy can pursue those visits without a concern about paying \$400-\$600 additional out-of-pocket costs.

UDP Annual Plan Maximum Benefit Change Insights

Specific Proposed UDP Benefit Design Change	2021 SEBB Program Utilization of Class I
Provide 100% coverage for Class I (preventive) services and <i>exclude</i> them from the annual Plan Maximum	200,393 members had a Class I visit in 2021, which reduced their available Plan Maximum 57,860 members were not seen in 2021

Composite Posterior Fillings

Current UDP Composite Posterior Fillings Coverage Details

- Considered an elective procedure; coverage limited to percentage of **amalgam** allowed amount
- Depending on the number of surfaces filled, posterior fillings are generally Class II services
 - Class II services currently covered at 80%
- Crowns are Class III
 - Class III services currently covered at 50%

Current UDP Posterior Composite Fillings Coverage Example

- Joe requires a filling for a back molar
- Joe's out-of-pocket costs, if his dentist provides both amalgam and composite options:

	Billed Amount	Network Allowed Amount	SEBB Program Plan Allowed Amount	Plan Payment (80% of \$125)	Joe's Out-of-Pocket Amount
Amalgam Filling	\$200	\$125	\$125	\$100	\$25
Composite Filling	\$200	\$150	\$125	\$100	\$50

Proposed Composite Filling Benefit Change

- Change Class II coverage to include 80% plan coverage for posterior composite fillings
 - In the prior example, Joe's out-of-pocket amount would change to \$30 (based on the plan paying 80% of the Network Allowed Amount of \$150)
- Class II coverage at 80% would also remain for posterior amalgam fillings

UDP Composite Fillings Benefit Change Insights

Specific Proposed UDP Benefit Design Change	2021 SEBB Program Utilization of Composite Fillings (Procedure Numbers)
Provide 80% of the network allowed amount coverage for posterior composite fillings (Class II)	68,609 members had Class II fillings 2,321 posterior amalgam fillings 94,937 posterior composite fillings

Incentive Plan Design Promoting Preventive Services

Current UDP Coverage Limits

- Class I (preventive) 100%
- Class II (fillings) 80%
- Class III (crowns, etc.) 50%

Incentivize Preventive Services

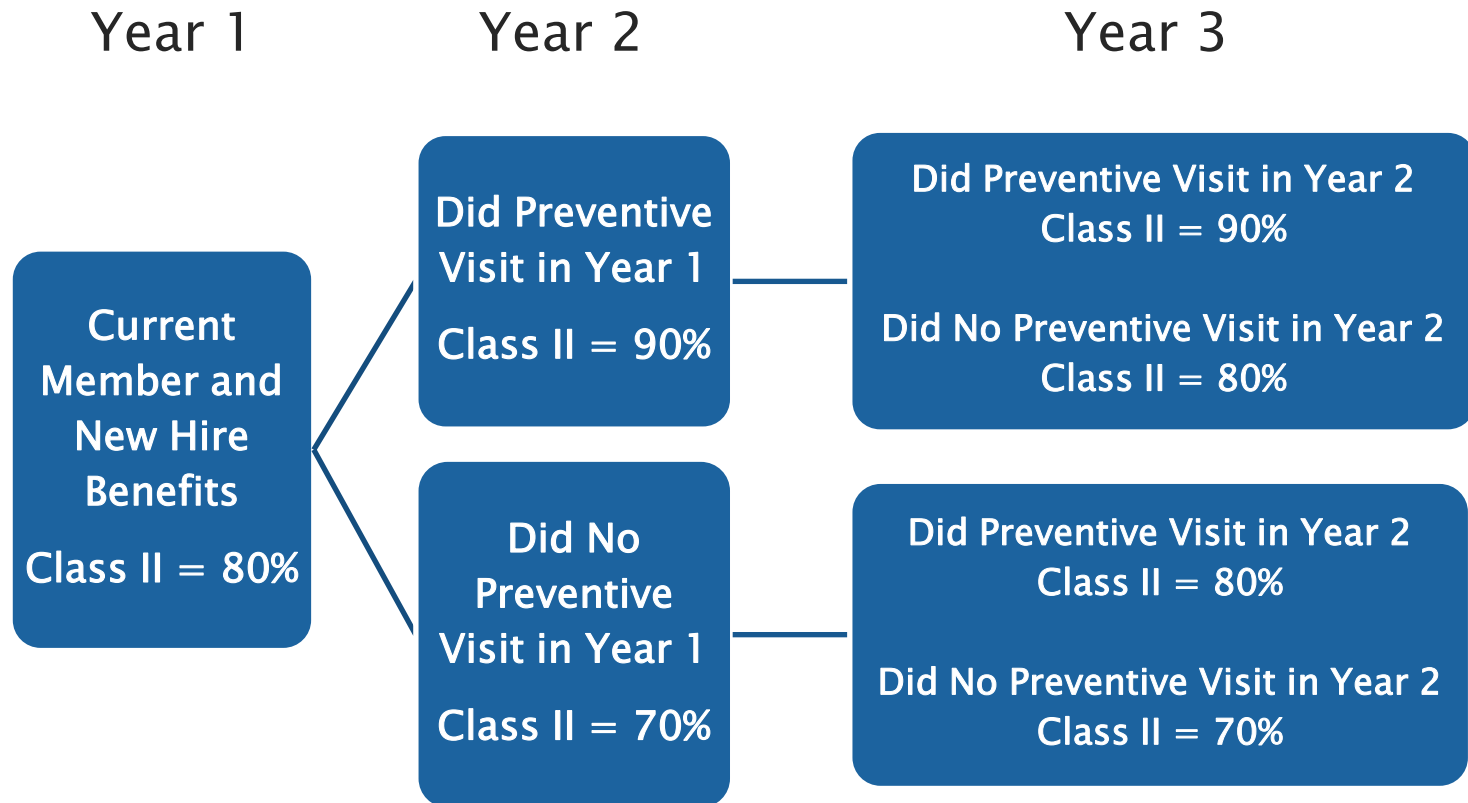
Concept	2021 Utilization
Use preventive services and increase coverage for Class II benefits in the <i>following year</i>	There were 199,226 members who had at least one Class I visit in 2021
Have no preventive visit and <i>decrease</i> coverage for Class II benefits in the following year	57,860 out of 257,086 members were not seen at all in 2021

Preventive Service Visits

- Cleanings
- Exams
- X-rays
- Periodontal maintenance
- Fluoride application

Currently covered at 100%

Incentive Plan Example



- Class I always covered at 100%; Class III always covered at 50%
- New Hires always start Class II coverage at 80%

Child Deductibles

Current UDP Deductibles

- Every member is subject to the \$50 deductible (which does not apply to preventive services)
- If there are 4 or more individuals covered together, the maximum overall family deductible is \$150

Proposed Child Deductible Benefit Change

- Eliminate the \$50 deductible for children up to the age of 15
- Family deductible would remain at \$50 per person up to \$150/year; but an account with a subscriber, spouse, and one child under age 15 would have only a \$100/year overall deductible

UDP Child Deductible Benefit Change Insights

Specific Proposed UDP Benefit Design Change	2021 SEBB Program Utilization of Deductible
Eliminate \$50 deductible for children (up to age 15)	12,267 out of total 53,494

Ages of Members	Class I Preventive	Class II Fillings	Class III Crowns, etc.	TMJ
0-15	44,766	12,083	171	13

Temporomandibular Joint (TMJ) Limit

Current UDP TMJ Coverage

- Non-surgical TMJ benefits (e.g., spacers, retainers) are covered at 70%
- There is a *lifetime* limit of \$500

Proposed UDP TMJ Benefit Change

- Increase the lifetime non-surgical TMJ member benefit from \$500 to \$5,000
- Set an annual member benefit limit of \$1,000

UDP TMJ Benefit Change Insights

Specific Proposed UDP Benefit Design Change	2021 SEBB Program Utilization
Provide 70% coverage for non-surgical TMJ treatment, with an annual maximum of \$1,000 and a <i>lifetime</i> maximum of \$5,000	531

Prioritization Discussion

Prioritization: Using Population Impacts

Proposed Benefit Change	2021 SEBB Program Population Impacts
Exclude Preventive visits from Annual Plan Maximum	208,240 (81%)
Cover Composite fillings same as Amalgam	97,692 (38%)
Incentive Plan for Class II changes based on prior year Class I utilization	57,860 (29%)
Eliminate Children's Deductible (up to age 15)	48,223 (19%)
TMJ Annual and Lifetime Increase	531 (0.2%)

Prioritization: Using Estimated Premium Impacts (lowest impact to highest impact)

In PEBB Program	In SEBB Program
TMJ Annual and Lifetime Increase	TMJ Annual and Lifetime Increase
Eliminate Children's Deductible (up to age 15)	Eliminate Children's Deductible (up to age 15)
Cover Composite fillings same as Amalgam	Incentive Plan for Class II changes based on prior year Class I utilization
Incentive Plan for Class II changes based on prior year Class I utilization	Cover Composite fillings same as Amalgam
Exclude Preventive visits from Annual Plan Maximum	Exclude Preventive visits from Annual Plan Maximum

Who Pays Premiums Reminder

- For employees, 100% employer paid
 - Any increase in state costs requires a decision package, even if in isolation a single change may not change the funding rate, because the cumulative effect of benefit changes could change the funding rate
- For retirees, COBRA, and other self-pay members, premium impacts would be borne by the member

Funding For All Five Benefit Proposals

- Overall *estimated* PSPM* increase for each program of ~\$5-\$7
- Reminders
 - Estimates based on 2021 pandemic period utilization
 - Actual premium increases may vary
 - As a self-insured plan, ultimately the State has claims liability

Initial Premium Insights on TMJ & Child Deductible Proposals

- The combined premium impacts of these two benefit change proposals are estimated as:
 - under \$0.50 PSPM for the SEBB Program
 - under \$0.25 PSPM for the PEBB Program
- For the State and SEBB Organizations from a budget funding rate perspective, these two changes combined are unlikely to impact the funding rate

Initial Premium Insights on Incentive, Composite Fillings, & Annual Plan Maximum

- The premium impacts of *each* of these three benefit change proposals, for *each* of the PEBB & SEBB Programs, is estimated as:
 - Between \$1.25 and \$2.25 PSPM
- For the State and SEBB Organizations from a budget funding rate perspective, any of these changes individually would impact the funding rate

Prioritization Discussion

- Any proposed options that Board Members think should not be further evaluated?
- Which proposed options do Board Members think should be prioritized the most and why?

Next Steps

- May Meeting
 - Board consensus on recommendations
 - Additional information as requested

Questions?

Ellen Wolfhagen, Senior Account Manager
Employees and Retirees Benefits Division

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Appendix

Market Comparison - Annual Plan Max

Annual Plan Maximum	Uniform Dental Plan	Delta Book of Business	WEA Plan (Pre-SEBB)
<p>The most the Plan will pay during a coverage period, at which point the member will assume the full responsibility for payment of covered services.</p>	<p>\$1,750 regardless of network status (PPO, Premier, and Out-of-Network)</p>	<p>43% of Book of Business has a \$2,000 maximum</p>	<p>\$2,000 PPO, \$1,750 Premier, and Out-of-Network</p>

Market Comparison – Composite Fillings

- UDP: Currently considered elective in posterior teeth (stainless steel or prefabricated crowns are covered under Class II)
- Large employers
 - Included in smaller fully insured groups
 - Not included in larger self-insured plans
- WEA (Pre-SEBB): covers posterior composite fillings (base 70%, subject to increase in incentive plan to 100%); crowns and onlays were covered under Class II

Market Comparison – Plan Coverage

Coverage Amount	Uniform Dental Plan	Delta Book of Business	WEA Plan (Pre-SEBB)
The amount that the Plan pays towards the covered service.	Class I – Preventive Services 100%	Class I – Preventive Services 100%	Class I – Preventive Services 70% - 100%
	Class II – Restorative (Fillings) 80%	Class II – Restorative (Fillings) 80%	Class II – Restorative (Fillings, Crowns) 70% - 100%
	Class III – Major (Crowns, Bridges, Implants) 50%	Class III – Major (Crowns, Bridges, Implants) 50%	Class III – Major (Bridges, Implants) 50%

Market Comparison – Child Deductibles

Annual Deductible	Uniform Dental Plan	Delta Book of Business	WEA Plan (Pre-SEBB)
The amount the member must pay before the plan begins to pay for covered services.	No deductible for preventive services \$50/individual \$150/family	Industry standard - \$50/\$150 (Waived for Preventive services)	No deductible

Market Comparison - TMJ

Uniform Dental Plan	Delta Book of Business	WEA Plan (Pre-SEBB)
70% up to \$500 Lifetime maximum	50% up to \$1,000 annual maximum; \$5,000 Lifetime maximum Boeing and Alaska Airlines have NO coverage	50% up to \$1,000 annual maximum; \$5,000 Lifetime maximum