

School Employees Benefits Board Meeting

June 2, 2022

School Employees Benefits Board

June 2, 2022

9:00 a.m. – 11:35 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
June 2, 2022
9:00 a.m. – 11:35 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: • June 24, 2021	TAB 3	Lou McDermott, Chair	Action
9:15 a.m.	Follow Up from May 5, 2022 Meeting		Dave Iseminger, Director ERB Division	Information/ Discussion
9:25 a.m.	2023 Annual Procurement Update	TAB 4	Lauren Johnston, SEBB Program Procurement Manager, ERB Division	Information/ Discussion
9:55 a.m.	Uniform Medical Plan (UMP) RFR 2022 for Benefit Year 2023	TAB 5	Christine Davis, UMP Account Manager, ERB Division	Information/ Discussion
10:10 a.m.	Public Comment			
10:25 a.m.	Closing			
10:30 a.m.	Transition to Executive Session			
10:35 a.m.	Executive Session			
11:35 a.m.	Adjourn		Lou McDermott, Chair	

***All Times Approximate**

The School Employees Benefits Board will meet Thursday, June 2, 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.

Pursuant to RCW 42.30.110(1)(l), the Board will meet 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. The Executive Session will begin at 10:35 a.m. and conclude no later than 11:35 a.m.

No “final action,” as defined in RCW 42.30.020(3), will be taken at the Executive Session.

This notice is pursuant to the requirements of the Open Public Meeting Act, Chapter 42.30 RCW.

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 May 31, 2022.

[Join Zoom Meeting](#)

Join Zoom Meeting

<https://us02web.zoom.us/j/85652867467?pwd=RTIkSHErVWFLNDM1THEycUdQSVRwZz09>

Meeting ID: 856 5286 7467

Passcode: 185574

One tap mobile

+12532158782,,85652867467#,,,,*185574# US (Tacoma)

+16699006833,,85652867467#,,,,*185574# US (San Jose)

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+1 253 215 8782 US (Tacoma)

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+1 312 626 6799 US (Chicago)

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Passcode: 185574

Find your local number: <https://us02web.zoom.us/j/85652867467?pwd=RTIkSHErVWFLNDM1THEycUdQSVRwZz09>

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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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

June 24, 2021
Health Care Authority
626 8th Avenue SE
Olympia, Washington
9:00 a.m. – 12:30 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/meetings-and-materials>

Members Present via Phone

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

Member Absent

Katy Henry

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 was telephonic only.

Meeting Overview

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

This Board season, we're highlighting the communities we serve. Today, our presenters have images from the lavender fields near Sequim in Clallam County as we go through the upper peninsula. I'm going to highlight Clallam and Jefferson Counties and the Kitsap Peninsula, as you head over the Tacoma Narrows Bridge, and head north to the Pacific Ocean.

Kitsap, Clallam, and Jefferson Counties have about 7% to 10% of each county's population within the PEBB and SEBB Programs. For Medicaid, it's about 20% to 25%, so on average, it's around 28% - 29% of the population between the three counties that are within the programs the Health Care Authority administers. I try to highlight things like unemployment, uninsured, poverty rates, and how they compare to the statewide averages. In general, Kitsap County has about the same average as the statewide average. Jefferson County issues go further out on the peninsula and are similar but slightly higher, but essentially equivalent. In Clallam County, there is higher unemployment, higher uninsured rates, and higher incidences of poverty compared to the statewide average. It's interesting to note that all three counties have significantly low rates of preventable hospital admissions, but they do have significantly higher rates of opioid prescriptions and overdose of opioid prescriptions.

The area is on par with primary care provider (PCP) availability, but there's a low access and utilization of those preferred providers. For example, in Clallam County, about 8% visit on PCP rates compared with peer groups that are about 20%. There is regional concern about the access and actual utilization of those PCPs, which may be in part related to the challenges of recruiting PCPs in more rural areas.

In Kitsap County in recent years, there have been a lot of mergers, acquisitions, and new affiliations. That's been very prevalent within the state market, but in Kitsap County in particular, there has been several changes and partnerships in recent years. A big part of that is CHI Franciscan expanding its footprint within Kitsap County. With that, there has been changes with payors, payment rates, and activity when it comes to the financial infrastructure of the health care setting in Kitsap County. Despite the mixture and change that's happening within Kitsap County, at this point we're not seeing changes in referral utilization patterns migrating to more urban areas for care, like Tacoma or Seattle.

I want to acknowledge our meeting is being supported physically in Olympia on the traditional territories of the Coast Salish people. This area was a primary portage way to and from Puget Sound, and these lands were shared by several tribes, including those we know 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.

Follow Up from June 3, 2021 Meeting

Dave Iseminger, Director, ERB Division. When Selena Davis shared the Uniform Medical Plan appeals process last month, there was a request for the percentage of appeals. I have PEBB data today to show more longitudinal information. I promise you one day we won't show you PEBB data as the sole source of data, but we are where we are today because we wanted historical, longitudinal information and, as we all know, 2020 is an interesting year and we're all skeptical of a lot of 2020 data.

Slide 2 – UMP PEBB Program Total Number of Non-Medicare Appeals shows the number of claims is ranging in that high four million, yet we're seeing a .02% to .03% appeal rate. There is a low volume of appeals considering the volume of claims activity with the Uniform Medical Plan. The numbers on this slide are the non-Medicare appeals, which means it includes non-Medicare retirees. In the PEBB Program there is

the Medicare pool and then non-Medicare pool, which has employees and early retirees. Whereas in the SEBB Program, we just call it the active employee risk pool, because it's just active employees.

Pete Cutler: I'm trying to confirm that I understand the math. Let's say for 2020 where we have about 4.5 million claims, I think that number indicates there is about .03 of 1% of those 4.5 million, so roughly about 1,360 appeals. Is that the right math? Because, if it's my other number, it would be up at 136,000, and I don't think you have that many claims – or appeals.

Dave Iseminger: You're doing the math correctly, Pete.

Pete Cutler: Okay. I've been away from it long enough that I'm having to double-check. Thanks.

2022 Annual Procurement Update and 2022 UMP Benefit Resolution

Lauren Johnston, SEBB Program Procurement Manager, ERB Division. Resolution SEBB 2021-14 UMP Accumulators is before the Board for action and a new resolution will be proposed due to an IRS notice for the UMP High Deductible. The benefit changes discussed at the June 3 meeting are included in the Appendix and those changes described in the Appendix are being included in the rate that will be presented at the next SEB Board meeting, and ultimately the Board approval of the premium resolutions includes the adoption of those underlying benefit designs.

Dave Iseminger: I'll just pause for a moment because the question of when does the Board vote on benefits and when do they vote on rates comes up a bit. It's not a completely clean line, but the way I'll describe it is, for the fully insured products, we typically bring you the rates, and it's the embodiment of the underlying benefit design. But because you have direct authority over the Uniform Medical Plan benefit design, when it's related to UMP benefit design that you have discretion on, and isn't a mandatory implementation, those we bring to you as standalone resolutions. That's the rough line to draw. I wanted to elucidate that, because I get the question often as to why is this one a resolution, but that one is not a resolution.

Lauren Johnston: Slide 2 – Resolution SEBB 2021-14 UMP Accumulators. After reviewing this resolution further since the last meeting, we felt some of the language needed to be clarified. The Appendix shows the changes for your reference. It is the amount the member has accrued toward their accumulators that follows the member over to their new Uniform Medical Plan, not the accumulator level itself. For example, if they started with a \$250 deductible plan and moved to a \$750 deductible plan, the \$250 deductible level would not be their deductible level at the new plan. It would be what they met toward that deductible so far. If they met \$175 towards the \$250, then the \$175 would carry over towards the new \$750 deductible.

During stakeholder review, in general the feedback received was positive. There was one question we get frequently, so we wanted to clarify that this resolution only addresses when a member stays within the SEBB Program. It does not include crossing programs currently. If somebody was moving from SEBB to PEBB, or PEBB to SEBB, this resolution would not apply to those individuals.

Dave Iseminger: We will look into bringing you and the PEB Board a resolution about cross program UMP switching in the future, but we aren't there today, so we encourage you to continue to act on at least the switching that happens within the program. Staff will work through the technical aspects of looking at the different risk pools, how risk is assessed for the two programs, etc. We have a similar resolution for switching within just the PEBB Program currently being considered by the PEB Board.

Lou McDermott: Vote – Resolution SEBB 2021-14 – UMP Accumulators

Resolved that, beginning January 1, 2022, when a subscriber enrolled in a SEBB Program Uniform Medical Plan (UMP) changes their enrollment to another SEBB Program UMP plan during the plan year (excluding Open Enrollment), the amounts accrued toward insurance accumulators (such as deductibles, out-of-pocket maximums, and benefit and visit limits) will transfer into their new UMP plan.

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

Voting to Approve: 8

Voting No: 0

Lou McDermott: Resolution SEBB 2021-14 passes.

Lauren Johnston: Slide 3 – Additional Proposed Change for Uniform Medical Plan. HCA evaluated this proposed benefit change and recently came to a decision for the UMP Medical Plan High Deductible. There are services the IRS said our plan can provide coverage for prior to a member meeting their deductible because the Treasury Department and the IRS are aware that some individuals diagnosed with certain chronic conditions were putting off care that can make their chronic condition worse due to high-cost barriers. It was determined, in consultation with Health and Human Services, that certain medical services and items purchased, including prescription drugs for these chronic conditions, do prevent consequences from putting off care, such as amputations, blindness, heart attacks, and strokes, that lead to significant higher levels of care and medical intervention. IRS Notice 2019-45 was released that expands the list of preventive care benefits that the Uniform Medical Plan High Deductible can cover before the member meets their deductible. The member would still pay their cost share, co-insurance amount, or copay amount. They don't have to meet their deductible prior to paying those cost shares. That's the change. Slides 4 and 5 – IRS Allowed Changes to UMP High Deductible, list the changes allowed starting January 1, 2022. Slide 6 – Proposed Resolution SEBB 2021-15 UMP High Deductible Preventive Care will be presented in July for Board action.

Dave Iseminger: I'm going to ask a question for the Board. Tanya, do we anticipate any impact on rates if the Board passes the new resolution about UMP High Deductible Preventive Care?

Tanya Deuel: The changes Lauren just walked through could be rolled into the rates, as is, and would not need additional adjustments to the rates. Meaning, no impact.

SEBB Continuation Coverage Policy Development

Emily Duchaine, Regulatory Analyst, Policy, Rules, and Compliance Section, ERB Division. Slide 2 – RCW 41.04.740(6)(d) provided for reference.

Slide 3 – SEBB 2021-16 SEBB Continuation Coverage Eligibility for School Employees' Dependents, addresses SEBB continuation coverage for dependents who lose SEBB dental, SEBB vision, or both because the school employee they were covered under was kept in PEBB medical and auto-disenrolled from SEBB dental and SEBB vision.

Slide 4 – Dual Enrollment Work Recap lists what we've done to date. Senate Bill 5322 prohibiting dual enrollment between School Employees Benefits Board and Public Employees Benefits Board Programs was signed into law by Governor Inslee on April 7, 2021 and goes into effect July 25, 2021. During Fall 2021 Open Enrollment for plan year 2022, school employees currently dual-enrolled can choose either the SEBB Program or the PEBB Program for their medical, dental, and vision plans for themselves and their covered dependents. School employees who become newly eligible for SEBB benefits, or who experience a special open enrollment and are already enrolled in PEBB benefits, can choose to enroll in SEBB benefits and drop their PEBB, or they can wave their enrollment in SEBB and maintain their enrollment in PEBB. The Board passed SEBB Resolutions 2021-02 through 2021-09 on April 7, 2021 to enable the SEBB Program to act on behalf of the school employee if the school employee does not resolve their dual enrollment on their own during open enrollment. The guidelines and principles followed for developing these resolutions are included in the Appendix.

Slide 5 - Resolution SEBB 2021-04 Resolving Dual Enrollment When a School Employee's Only Medical Enrollment is in PEBB (adopted April 7, 2021). In implementing this resolution, staff noted there is a chance the school employee may have dependents who will lose dental and vision benefits, so we are recommending an additional resolution today.

Slide 6 – Proposed Resolution SEBB 2021-16 SEBB Continuation Coverage Eligibility for School Employees' Dependents. This resolution is to allow dependents, or the school employee on behalf of the dependent, to continue SEBB dental, SEBB vision, or both on a self-pay basis for up to 36 months. The 36 months of self-pay aligns with federal requirements.

Slide 7 – Proposed Resolution SEBB 2021-16 - Example #1. In this example, although Maya is potentially a PEBB eligible dependent, she was not added to the PEBB subscriber's account.

Slide 8 – Proposed Resolution SEBB 2021-16 - Example #2. In this example, the school employee's dependent is an extended dependent, and the only legal guardian named in the court documents is the school employee. Regardless of whether the school employee was married to a PEBB employee, or a state-registered domestic partner of a PEBB employee, the extended dependent of the school employee would still not be eligible for the PEBB benefits.

Slide 9 – Federal COBRA Laws and Past Board Resolutions. The dependent in Example #2 is not considered a qualified beneficiary under the Public Health Services

Act. Only covered employees, federally recognized spouses, and dependent children of the covered employees are considered qualified beneficiaries. Although the dependent in Example #1 experienced a loss of coverage, losing coverage by itself is not considered a qualifying event under the Public Health Services Act. For children, the only qualifying events are the death of the employee or ceasing to satisfy the eligibility criteria under the plan. In Example #1, it's not that the child isn't going to be eligible under the SEBB plan, the SEBB employee didn't act to resolve their dual enrollment on their own and were auto-disenrolled from SEBB to be kept in PEBB, and the PEBB employee didn't take action to add the child to the plan. The Board does have the authority to permit the SEBB Program to expand the right to elect continuation coverage. The Board previously did this with Resolution SEBB 2018-58, when school district employees transitioned to SEBB benefits which extend a continuation of coverage to dependents not federally recognized, such as the dependent child of an employee. Resolution SEBB 2018-58 is in the Appendix for your reference.

Therefore, we are asking the Board to pass a resolution allowing dependents to continue SEBB dental, SEBB vision, or both on a self-pay basis, only under the specific circumstance where we auto-disenroll a child to resolve dual enrollment.

Slide 10 – Next Steps - Bring proposed resolution to Board for action at next Board Meeting.

Dave Iseminger: I know this is a complicated resolution. We're basically asking the Board to allow these individuals the additional option to self-pay. There will be some instances, like Example #1, where eventually the individual could be an eligible dependent added to the PEBB dental plan, or enrolled in PEBB medical, and thus have vision coverage there. This is a stopgap, or another option, for this individual in this circumstance. Example #2 has no legal way for niece Bella to be on the PEBB account because Jennifer, the now stepmom, doesn't have a legal relationship to establish that eligibility. We want to make sure there is an opportunity for individuals to continue to have dental and vision coverage in this scenario.

You may wonder why, in these examples, would the subscriber be waiving their medical to be on PEBB but leave their kids on SEBB? We have 700,000 covered lives in both programs. There are many individual circumstances and every enrollment pattern one can imagine exists within the system. I also want to assure the Board that we've already done some data diving to identify how many people we think this could impact. Between the two programs, it's a couple dozen. We will also do a targeted outreach to these individuals to ensure they act so HCA doesn't have to implement automatic policies and so their dependent doesn't lose coverage. Hopefully an additional targeted outreach will alleviate the need to implement or act on this resolution, but we wanted your authority to offer them the self-pay option if this situation does materialize.

Pete Cutler: A technical question. As I understand it, this would not technically be a COBRA benefit, but it would be a state or HCA-provided continuation coverage benefit.

Dave Iseminger: You are correct, Pete. We call it continuation coverage at HCA and in our documentation because the continuation coverage bucket includes COBRA and things like this that aren't really COBRA, but we align it with COBRA rules. We call it

continuation coverage because it includes things like leave without pay. It includes federally qualified COBRA and then other self-pay instances like this.

Pete Cutler: Right. If the dependent had only signed up either for the dental or the vision, would they only have this continuation option for the benefits they signed up for? Or would it trigger an ability to sign up for both afterwards?

Emily Duchaine: They would only be able to sign up for continuation coverage for the benefit they lost.

SmartHealth Update

Kristen Stoimenoff, Washington Wellness Program Manager, ERB Division

Heidi Helsley, Washington Wellness Health Promotion Consultant, ERB Division

Slide 3 – SmartHealth Levels. SmartHealth is a voluntary wellness program that all SEBB and PEBB Program employees have access to as part of their benefits to enhance their well-being. There are intrinsic benefits: better quality of life, better employee engagement, better health, lots of intrinsic value that employees gain by participating in SmartHealth. They can also qualify for a \$125 wellness incentive if they get to Level 2 in SmartHealth. This slide shows the three levels and how to achieve those levels by the November 30 deadline. Employees whose medical effective date is October 1 through December 31 have until December 31 to reach their goals. The \$125 wellness incentive gets either applied to the following years' medical deductible or deposited into their Health Savings Account.

Slide 4 – SmartHealth Levels Completed 2019-2021. This table shows the percentage of SEBB Program employees who are registered for SmartHealth and got to Level 1 and Level 2. SEBB Program employees first became eligible in 2019 during open enrollment in October and November. They had the opportunity, if they did their well-being assessment and registered for SmartHealth by November 15, 2019, to qualify for \$50 toward their 2020 deductible, or get it deposited into their Health Savings Account. 2020 and 2021 numbers are also included on the table.

By the end of 2020, there is a potential financial impact of \$1.1 million potentially saved in out-of-pocket costs for SEBB Program employees. We are still gathering information on 2021.

Dave Iseminger: Kristen, you said, "In 2019, the vast majority of school employees only had access to earn a \$50 incentive." Kristen mentioned that there were some individuals who could access \$125. Those were only the individual school employees who were with school districts that had already been contracted with the PEBB Program, because before SEBB we had about 5% of school districts that were covered by PEBB benefits. If those school employees who were PEBBers before they were SEBBers completed their incentive as a PEBBer, it got honored in 2020 when SEBB launched. The ramp-up was a road through a \$50 incentive because of the abbreviated time frame. I wanted to provide that clarity because I don't want somebody to walk away thinking, "Wait, if I had engaged more, I would have been able to get another \$75?" That transition for \$125 was only PEBB Program K-12 employees who were moved over to SEBB benefits as part of the launch of the program.

Kristen Stoimenoff: Thank you making that clarification, Dave. Slide 5 – SEBB Program Level 2 Trends, 2020-2021, shows trends week-by-week for the number of people at Level 2 who earned the \$125 incentive. It starts in 2020, the first full year of the SEBB Program. It's common for people not to get to 2,000 points until late in the year. We've had a slower start in 2021 and we're working on messaging to remind people to complete their well-being assessment again, because they can't get to Level 2 until they do.

Slide 6 – SmartHealth by the Numbers. These numbers were compiled by Limeade, our SmartHealth vendor. For 2020, it represents all employees eligible for SmartHealth in both SEBB and PEBB Programs.

Pete Cutler: I'm curious by the numbers. How many PEBB and SEBB Program eligible persons? I don't remember whether this was only for employees or whether it was also for spouses. I'm trying to get a baseline.

Kristen Stoimenoff: Employees can qualify for the benefits. Spouses can participate in the program, but I'm only showing the people eligible for the benefits through SmartHealth. Pete, the numbers I showed you were the people who registered. I looked at the numbers again this morning and 145,719 SEBB Program members were eligible for the benefits as of today.

Pete Cutler: Great. That's what I was looking for.

Heidi Helsley: Slide 7 – Activities with the Most Participation shows activities school employees participated in the most in 2020, and so far in 2021. The top two activities were preventative dental visit, and then signing up for a primary care provider. In most cases, participants joined activities and tracked completion to earn points, but in these top two activities, these are verified by the plans before points are awarded. A custom activity can be created, like the walking challenge created for the Washington Association of Educational Office Professionals (WAEOP). A custom activity can be targeted to either a specific school district or to all SEBB Program employees.

Slides 8 – Enhancing Benefit Awareness shows examples of activities designed to support well-being. Activities can also help employees learn about their SEBB Benefits. When individuals log into SmartHealth, the activities align with their specific medical plan. For instance, the options for knee, hip, and spine care activity are for Uniform Medical Plan members so only they would see this specific activity. Employees can also connect with diabetes prevention, Living Tobacco-Free programs, and long-term disability decision tools their plan's offer. One of the activities I'm most proud of developing this last year has been the support for your mental and emotional well-being activity. It makes it easy for individuals to learn what their specific medical plan offers in these areas and helps reduce barriers to services, which is especially important during this challenging time.

Slide 9 – Connecting Members with Their Benefits. We've made it easier for employees to connect to their benefits by having one tile for each plan, which lists the activities for that plan. This slide shows examples of what those tiles would look like.

Slide 10 – “SmartHealth for SEBB” Materials shows how we let employees know about SmartHealth. We include information in HCA newsletters, mailings from plans, our website, benefits fairs, and if employees have opted in to receive emails through SEBB My Account, then we can direct email to them as well. We primarily rely on SEBB Benefit Administrators and Wellness Coordinators to help inform employees about SmartHealth. We also have the help of our Well-being Champion Network, which is a group of school employees who have volunteered to help spread the message to their peers and encourage them to participate in SmartHealth. We offer flyers, articles, ready-made messages, and videos to help spread the word. These materials are on our website, or search “SmartHealth for SEBB,” and it will take you directly to the page.

Slide 11 – What’s Next? This is our plan for the next school year.

Slide 12 – Testimonial. When the pandemic hit, the world turned upside down. School employees continued to help their students learn and grow, while at the same time dealing with their own stress, anxiety, and isolation. SmartHealth is a tool to help employees take better care of themselves so they can be there for their students. This testimonial is from Dana who shared that she experienced the highest levels of stress in 20 years of teaching, and she told us how SmartHealth helped her.

Pete Cutler: I noticed a reference to long-term disability, and I assume that’s a tile for an activity that can earn points. As Board Members know, it’s a topic that’s near and dear to my heart, and I’m curious to hear a little more about that activity.

Kristen Stoimenoff: It’s learning about your long-term disability benefits. A lot of tiles end up connecting and giving people more information about their benefits. It really gives them a chance to do a deeper dive, understand all the details, and earn points for doing so. Sometimes when you see your list of benefits at an enrollment fair, or in your package when you first start, it’s hard to give it the full attention it deserves. This gives people detailed information and a chance to earn points.

Pete Cutler: I hope they get a lot of points for that.

Dave Iseminger: Pete, we also take the opportunity through these tiles to preview upcoming attractions! We dovetail with open enrollment and use this as another piece of marketing and encouragement materials, while incentivizing with SmartHealth and wellness incentive. We did that with life insurance when it was rebooted. We had a tile on how to calculate, and took you to a tool with MetLife, our life insurance benefit vendor, to help you calculate what your needs might be. We have things that help you understand and direct you to the resources to explain how you convey your election. It’s another opportunity to help people understand the benefit and then how they access the benefit. We are strategic in highlighting these topics when we’re making changes within that benefit portfolio.

Pete Cutler: Are you tracking data about the follow-up for those members that do that activity and now claim points for it? Do you track what their decisions are after that? How many sign up or how many don’t?

Kristen Stoimenoff: We can track participation, but it’s all de-identified, so we can’t make a one-to-one determination. We probably could do some comparisons about

whether there has been a spike in signups concurrent with a spike in activity participation, but it would never be a perfect one-to-one correlation.

Pete Cutler: Right. Just curious, but it seems worthwhile, in any case. Thank you.

Kristen Stoimenoff: Any other questions?

SEBB Program Financial Overview

Tanya Deuel, ERB Finance Manager, Financial Services Division. The goal of today's presentation is to introduce the SEBB Program financial picture and where we're at to date. Our goal is to make this presentation an annual discussion at the January retreat.

Slide 2 – SEBB Program Projection Model Overview. This is not our accounting tool or our formal accounting model, which is important to note when we walk through this presentation. That is done through the statewide system, and all our statewide financial reporting required of the agency is done outside of this model.

Slide 3 – SEBB Program Finance Terms. Listed as a reference are some of the SEBB Program finance terms used periodically. I want to point out three of them, specifically, that I don't think we usually focus on with the Board, the first one being "incurred but not paid (IBNP)," which is also sometimes referred to as incurred but not reported (IBNR). Those can be used interchangeably. It's one of our reserve requirements in the SEBB Program, which is an estimate of the amount of unpaid claims dollars for past claims that have not yet been paid. Meaning, we know there has been utilization and people going to the doctor utilizing services, we just haven't paid the bill yet. We have to hold money aside for those claims that we know have happened, and are going to happen, but we have not paid them yet.

Next, I want to talk about the net funding rate. You hear me come to the Board quite often talking about the funding rate, but when I'm talking about the funding rate with the Board, typically I'm referencing what we consider the gross funding rate. This is the funding rate the Legislature adopts and puts in the budget, and this is the amount we collect from districts per eligible employee/per month. That is different than the net funding rate. The net funding rate is the projected cost of benefits exclusive of any adjustments for either a surplus or a deficit. Meaning if the program were to accrue additional surplus within the program, the Legislature could artificially lower the funding rate to utilize some of that surplus, or vice versa. In the beginning of the program when the SEBB Program needed to build up reserves, the Legislature could have chosen to increase the funding rate even higher than what we needed from the net funding rate to help us build up that surplus.

Lastly, the second reserve we are required to keep is our premium stabilization reserve (PSR). This is the legislatively mandated funding reserve for both our self-insured medical and our self-insured dental. Throughout the next slides, I will talk more about both of those reserves.

Slide 4 – Program Startup. This is a refresher on some of the initial conversations we had with the Board early on. Before the program startup, in the 2019 legislative session, the first SEBB Program funding rate was based on a PEBB Program net

funding rate, which had PEBB Program specific assumptions. For instance, PEBB Program assumptions on waivers, enrollment, dependent load, and PEBB Program specific trends. It also didn't consider anything specific to the SEBB Program. In the beginning, the SEBB Program needed funding for building reserves, loan repayments, and an additional program startup that would not have existed within that PEBB Program net funding rate, which we knew would ultimately cause a deficit projection because we were projecting we needed a higher funding rate. Following that legislative session, we were able to finalize our first procurement within the program, and within that first procurement we were able to reduce the Employer Medical Contribution (EMC) drastically, enabling us to reduce some of that projected deficit within our first procurement.

In 2020, we were able to wrap up a second procurement which allowed us to have continued positive experience. Now we are at a point where we can build a fund rate projection based on actual SEBB Program experience and data. After the first open enrollment -- remember I told you in the past we had higher than expected waiver assumptions -- we had higher than projected enrollment in our self-insured product. All these things helped reduce that deficit we initially projected. At this point, we are happy to say we are no longer projecting to be in a deficit. We have fully funded our reserves and are on track to pay back both of our startup loans. We also feel great about our self-insured experience, as well as the procurements we've been able to do.

Slide 5 – Historical Funding Position shows how each of those points worked out. This bar chart is our historical funding position. I wanted to give a visual of when that funding position switched. On the bottom of the chart are the quarters, which are when we update our modeling. Spring and summer 2019 are based on projections because we had no actual data. It's not until spring 2020 that started to get real SEBB Program data that could roll into our projections. The green portion of the bar is the projected expenditures with the blue bar being projected revenue. What I really want to drive home is that with the start of spring of 2020 is when things flipped for the program. That's when we had our second procurement and had actual enrollment and data to look forward to. Through spring 2020 and spring 2021, things remained stable.

Slide 6 – Initial Experience talks about volatility. Our initial experience was pretty volatile in both projections and actual experience. The SEBB Program is new, with a brand-new population, as well as a pandemic. The Board should be aware that the volatility will continue until we have a stable baseline to aid in our projections. I don't want you to panic when I say volatility, but to be comfortable knowing at any point, quarter-to-quarter, our projections may swing \$40 or \$50 million dollars because it's a new population. It can feel volatile but contrasting with the PEBB population who does have a very steady baseline, this type of quarterly swing is normal. Just to drive that home, the SEBB Program spends close to two billion dollars a year, so when we have a quarterly projection that can swing \$40 or \$50 million dollars, it's very small as a percentage. I bring that up because when we come back annually at the retreat you might see numbers change from quarter-to-quarter.

Slide 7 – Reserves. I'm referring to self-insured product reserves, the Uniform Medical Plan and Uniform Dental Plan. There are two types of reserves kept in the SEBB Program. Our reserves are restricted funds that ensure financial solvency for an insurer and can be used to offset temporary cash flow shortages. The SEBB Program is

legislatively mandated to maintain reserves for our self-insured benefits. That first fund is our premium stabilization reserves (PSR), where we're required to hold 7% of the prior 12 months' claims for medical and 4% of the prior 12 months' claims for dental. During the first year of the program, as that program built up claims, there wasn't a prior 12 months of experience to keep reserves. The PSR reserves are now fully built up since we've had 12 months of experience. Those reserves built up slowly in the program and Slide 8 shows how they built up.

Our second reserve is the Incurred But Not Paid (IBNP) reserve, which are those reserves kept for claims' payments for past periods that have not been paid yet, and those reserves are kept in a separate fund.

On top of both of those reserves kept by the program, we can start building surplus. Surplus are amounts created when our revenue is exceeding our expenditures, which can be used to offset future program costs, meaning the Legislature could adopt a funding rate that utilizes those reserves and artificially lower the funding rate.

That was just our self-insured reserves, but I want to point out that separate reserves are also built and maintained for our fully insured carriers. As some of those reserves fluctuate, we can see those play out in either future premium increases, or rate holidays, if we were able to accrue additional revenue. You might hear us mention that in the future years when we come to the Board on some of those optional benefits, that we're able to do either rate holidays or we must increase rates, because of those reserve requirements.

Slide 8 – Status of SEBB Program Reserves is a visual of how we built up our reserves from quarter to quarter. The quarters are listed on the bottom of the slide as well as a stacked bar with the green portion of the bar being our accrued surplus, the orange portion of the bar being the IBNP reserve, the blue portion being our PSR. The first bar includes a cash shortfall portion. At the very beginning of the program, you might remember we were worried about our cash flow situation due to the invoicing and timing structure of when we paid our carriers versus when we receive revenues from the districts. At the very beginning of the program, with the program not having sufficient funding for our reserves, we did not have enough money in our bank account to front paying those carrier invoices. I included that on the winter 2019 column so you could see how big that carrier payment really is, and what the cash shortfall was. However, we have since built up our reserves sufficiently enough that we can now float that payment, we have enough money in the bank, and don't have to go negative. The green bar has slowly increased over time. That is our surplus building up. The orange bar is our IBNP, which remains very steady throughout the year. Some seasonality comes into play in summer 2020 when many school employees utilize services, and they can get more things taken care of. This quarter sees more in claims fluctuation.

Dave Iseminger: Tanya, I want to talk about the cash flow piece. That jogged a lot of memories for me, and I wanted to take a moment to let the Board know and acknowledge that many of our carriers were very engaged with us about those initial payments and helped us manage those initial cash flow pieces with some additional flexibility in the initial payments for SEBB, knowing that we were going to have very long-standing partnerships. I want to take a moment to thank various carriers for engaging with the Health Care Authority on that cash flow situation and make the Board

aware because that was extraordinarily helpful. I almost forgot about that exercise, so I want to make sure others haven't!

Tanya Deuel: Thanks, Dave. That's a good reminder. Lastly, on Slide 8, the blue portion of the bar is our PSR. As mentioned on the previous reserve slide, the PSR was built up over time since it's based on a 12-month historical look back of claims. Until the program had 12 months of claims, we built it up slowly. In especially the last two quarters, you'll see the reserves remained fairly stable.

Slide 9 – Current Financial Position, is an attempt to give you a visual of what one of the financial statements within our model looks like. I don't expect the Board to understand each of these lines and I won't go through this line by line but will focus on two main items the Board has influence over. First one, are we hitting our procurement goals? Meaning when the Legislature adopts a funding rate, there's an underlying EMC that we budget to when we set procurement, and the Board adopts our premiums. Are we hitting those? Yes, we are. And, secondly, are we funding our reserve requirements? Are we making decisions that are driving us into a deficit? Are we managing those funds appropriately? And, yes, we are meeting our reserve requirements. We're happy to say the Board is doing well in managing procurement, and we are hitting both of those goals. The bottom line of this slide is to where our ending surplus position is projecting to be based on the last quarter we've updated, and this is the line that you will see swing quarter-to-quarter. This is where I was mentioning we can see this change at any quarter of \$40 million dollars, which is not shocking to us. I want the Board to be comfortable with that.

Slide 10 – Spending Breakdown FY21, is a visual of our spending breakdown. I wanted to show the Board the majority of our spending is on our medical benefits. The large blue section of the pie, that 82%, was spent on medical. We broke it down further to show how much of that medical is self-insured versus fully insured. Of the 82% of our total spending, approximately 30% is spent on our self-insured, and the remainder on our fully insured.

Slide 11 – Loan and Repayment Status, is an update on our loan repayment. The payments listed say approximate because the State Treasurer calculates interest for us, so those payments can change slightly.

Wayne Leonard: First of all, thank you for this information. It was very helpful. A couple questions. On the financial information, briefly, which line item would the loan repayment be on? Or would it be somewhere other than on this?

Tanya Deuel: The loan repayment is buried within the other financial activity where you see the \$14 million. There's one other item in there which is decreasing that slightly, but that's where that item would be.

Wayne Leonard: Thank you. One question I get from WASBO (Washington Association of School Business Officials) members goes back to the startup of our program. It would be helpful to try to determine how much of the program is funded through the state's basic education formula, and then how much is funded locally by school districts? I know at the implementation of our program K-12 was transitioning to new funding formula, and SEBB, I think, was part of that. A lot of districts around the

state were making budget cuts, and then some were using SEBB as an example in their communities about making budget cuts because of SEBB.

When I talk to my representatives, Senator Billig and Representative Ormsby, from a public policy standpoint they were really in favor of this. I don't know anybody really who wasn't in favor of this, in terms of making medical benefits more affordable. But the questions I get all the time is, "Yeah, we're fine with the public policy goal of providing medical as long as the state funds it," that old unfunded mandate kind of thing that we always talk about. I was just curious. At the risk of you having to ask WASBO members for a bunch more information, which they would probably not like to provide right now, I don't know how easily, or how difficult, that would be to get from people, just to have an estimate from a policy setting standpoint when we make decisions on eligibility and other kinds of things. How's that going to impact the local school district? I know this year I went through an audit where the auditors were looking specifically at, or starting to look at stuff specifically on how or what are we using our levy funds for? Was it outside the program of basic education? It's hard to pull that out from the sauce when it's all in there. But that was one thing I think for the future that would be very helpful to provide, just from a discussion point, from my WASBO members talking to their legislative staff about unfunded mandates and that kind of thing. But, otherwise, I thought the information was really good, Tanya, and thank you for that.

Tanya Deuel: I can address a portion of that now. On Slide 9, the very top line K-12 Revenue says \$1.746. That is funding rate revenue we received. We do not know when we get that money what color of money it is. We don't know if it's General Fund. We don't know if it's local dollars. We don't have a way to tell how that's being funded. What I did do with one of your previous questions is reach out to our Office of Financial Management to figure out how much General Fund was sent out for that specific period. So, of that approximately \$1.7 billion that we received in revenue, about \$1.3 billion of that was General Fund. At this point, we can assume the remainder of that was local dollars, but we would have to do some partnering with our other partners, because we're not quite experts on how much is local and how much is General Fund. We only need the one bucket of money.

Wayne Leonard: Some of that would be on federal grant programs that the district runs, as well, and then the rest would be on local dollars.

Tanya Deuel: We can explore that offline, if that's something we can do, or how we could answer that question, but that's where we're at now. Of that \$1.7 billion, we know about \$1.3 billion was sent out in General Fund.

Wayne Leonard: Thank you, Tanya. That's very helpful.

Dave Iseminger: Also, I want to put out a reminder that there is a JLARC study, I believe, that comes out later this year that might also shed some light on the specific topics. I think it's October, November-ish. Just like everything else, we'll have the pandemic year influences, but I do think it's an important reminder that there are some JLARC insights that might be related to this topic as well.

Dan Gossett: This is more out of curiosity, but on Slide 10 where we have the pie charts. Would it be possible with the smaller of the pies to break that down so, you have prescription drug costs and then other medical costs?

Tanya Deuel: I could find a creative way to break down of medical how much is prescriptions. One thing that is in medical is our self-insured products are reserve requirements. So, certain things like that, and administering our self-insured products, are within our self-insured expenditures, so I can break those down categorically. What I probably cannot do is on our fully insured products, break that down by medical versus pharmacy, but on our self-insured products I can.

Pete Cutler: Just quick question on that same slide and the other category it has on it. I'm curious, can you name some of the components that go into that 7% of the pie?

Tanya Deuel: The largest majority of that is the K-12 remittance, which is considered an expenditure to the SEBB Program because we have to transfer it to the PEBB Program.

Public Comment

No public comment.

Next Meeting

July 15, 2021

9:00 a.m. – 12:15 p.m.

Preview of July 15, 2021 SEB Board Meeting

Dave Iseminger, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the July 15, 2021 Board Meeting.

Executive Session

Pursuant to RCW 42.30.110(1)(I), the Board met in Executive Session to consider proprietary or confidential non-published information related to the development and acquisition or implementation of state-purchased healthcare services as provided in RCW 41.05.026.

Meeting adjourned at 11:20 a.m.

TAB 4



2023 Annual Procurement Update

Lauren Johnston
SEBB Program Procurement Manager
Employees and Retirees Benefits (ERB) Division
June 2, 2022

Medical Procurement Work Plan

- Request for Renewal Released
 - February 25, 2022
- Responses Received from Carriers
 - April 8, 2022
- Negotiations Began
 - April 11, 2022
- Board Presentation of Negotiated Results
 - June and July Board Meetings
- Final Vote
 - July 2022 (employee premium resolutions)

Compliance with SB 5564

- Legislation caps insulin at \$35/month
- All SEBB medical plans will comply with WA SB 5564

Kaiser Foundation Health Plan of the Northwest (KPNW) & Kaiser Foundation Health Plan of Washington (KPWA) Proposed Changes

KPNW 2023 Proposed Benefit Changes

Maximum Out-of-pocket Changes:

- KPNW 1:
 - Increased from \$4,000 to \$4,500 and \$8,000 to \$9,000
- KPNW 2:
 - Increased from \$3,500 to \$4,000 and \$7,000 to \$8,000
- KPNW 3:
 - Increased from \$2,000 to \$2,500 and \$4,000 to \$5,000

KPNW 2023 Proposed Benefit Changes (*cont.*)

Book of Business Changes:

- Advanced Care at Home (ACAH)
 - When clinically appropriate, the option to be treated and recuperate at home.
- Naturopathic services for dependents who live outside of plan service area

KPNW and KPWA Accumulator Transfers

- Effective January 1, 2023
- Subscriber changes from between the SEBB and PEBB Programs and stays within the same carrier (except into/out of the PEBB KPNW CDHP plan)
- Medical and pharmacy cost-share accumulators (deductibles and out-of-pocket limits) for all members will transfer over
- Does not include when a spouse or dependent child becomes the subscriber on their own account

Note: Does not apply to KPWA Options because KPWA Options is not in PEBB

KPWA and KPWA Options

First Fill Program:

- For maintenance drugs only
- First prescription can be filled at any in-network pharmacy
- Subsequent refills must be filled via mail order or at a Kaiser Permanente retail pharmacy¹
- Safety: pharmacists can ensure members avoid negative drug interactions and other risks
- More cost effective to members
 - Use of generics when medically appropriate
 - Can negotiate better drug prices

¹Does not apply to medications for sudden conditions or to drugs Kaiser cannot mail.

KPWA and KPWAO 2023 Book of Business (BoB) Changes

- Advanced Care at Home (ACAH)
 - When clinically appropriate, the option to be treated and recuperate at home
- Subject to Deductible Changes
 - Surgeries received during an office visit will not be subject to deductible or coinsurance
 - Labs/diagnostics for the same visit will apply to the deductible and have applicable cost shares

KPWA and KPWAO 2023 BoB Changes (*cont.*)

- Well Care Service Codes
 - Covering codes as preventive that are not required
 - Codes will have cost shares going forward
 - Most of the codes are lab and radiology services that are considered medically necessary to diagnose or treat condition and not considered preventive

Premera Blue Cross Proposed Changes

Premera 2023 Proposed Benefit Changes

Pharmacy Cost shares for 30-day Supply

Pharmacy Tier	<i>Premera HMO</i>	Premera High PPO	Premera Standard PPO
Preferred Generic	<u>\$7 to \$9</u>	\$7 to <u>\$9</u>	\$7 to <u>\$9</u>
Preferred Brand	<u>\$30 to \$40</u>	\$30 to <u>\$40</u>	No change
Non-Preferred	<u>30% to 50%</u>	30% to <u>50%</u>	No change
Preferred Specialty	<u>\$50 to \$75</u>	\$50 to <u>\$75</u>	No change

Note: Cost shares are not prorated based on length of treatment. If the actual cost of the drug is less than the stated cost share, the member is only responsible for the lesser of the two amounts.

Italics/Underline indicates a change from 2022

Premera 2023 Proposed Benefit Changes

Acupuncture, Chiropractic, Massage, and Therapies

Service	Visit Limitations	<u>Premera HMO</u>	Premera High PPO	Premera Standard PPO
Acupuncture	12 to <u>24</u>	<u>\$10*</u>	25% to <u>\$25*</u>	25% to <u>\$25*</u>
Chiropractic (spinal manipulations)	12 to <u>24</u>	<u>\$10*</u>	25% to <u>\$25*</u>	25% to <u>\$25*</u>
Massage Therapy	12 to <u>24</u>	<u>\$10*</u>	25% to <u>\$25*</u>	25% to <u>\$25*</u>
Rehab Therapies (NDT, PT, OT, ST)	No change	<u>\$40</u>	\$40 to <u>\$50</u>	\$40 to <u>\$50</u>

*With this change, CAM services will no longer apply to deductible.

Italics/Underline indicates a change from 2022

Premera 2023 Proposed Benefit Changes

Office Visits

Service	<u>Premera HMO</u>	Premera High PPO	Premera Standard PPO
Office and Clinic Visits	<u>Non-specialist:</u> <u>\$10</u> <u>Specialist:</u> <u>\$40</u>	Non-specialist: \$20 to <u>\$25</u> Specialist: \$40 to <u>\$50</u>	Non-specialist: \$20 to <u>\$25</u> Specialist: \$40 to <u>\$50</u>
Mental Health Office and Clinic Visits	<u>\$10</u>	\$20 to <u>\$25</u>	\$20 to <u>\$25</u>
Naturopathic Physician Services	<u>\$10</u>	\$20 to <u>\$25</u>	\$20 to <u>\$25</u>

Italics/Underline indicates a change from 2022

Premera 2023 Proposed Benefit Changes

Service	<u>Premera HMO</u>	Premera High PPO	Premera Standard PPO
Telemedicine	<u>Non-specialist:</u> <u>\$10</u> <u>Specialist:</u> <u>\$40</u>	Non-specialist: \$20 to <u>\$25</u> Specialist: \$40 to <u>\$50</u>	Non-specialist: \$20 to <u>\$25</u> Specialist: \$40 to <u>\$50</u>
Virtual Care: Behavioral Health	<u>\$10</u>	\$20 to <u>\$25</u>	\$20 to <u>\$25</u>

Italics/Underline indicates a change from 2022

Premera Proposed Plan Changes

- Retiring Peak Care Exclusive Provider Organization (EPO)
- Introducing Premera Health Maintenance Organization (HMO)
 - Same three county service area: Pierce, Thurston, Spokane
 - Provider Network: revolves around MultiCare
 - No out-of-network coverage, except for emergency care and hearing hardware
 - Referrals required

Premera Proposed Plan Changes (*cont.*)

Why is Premera proposing this change?

- Working towards more affordable, higher quality care
- Offers a streamlined digital experience

What should members expect?

- Continued access to MultiCare Health Systems, MultiCare Connected Care providers and hospitals, Mary Bridge Children's Hospital, plus Premera's affiliated provider partner, Kinwell (exclusive to Premera members), etc.

Premiera Proposed Plan Changes (*cont.*)

What should members expect? (*cont.*)

- Members will be assigned a primary care provider (PCP)
- PCPs will be responsible for coordinating and providing referrals for all specialty care
- No pharmacy deductible
- Lower cost shares

Premera Proposed Plan Changes

Premera HMO

	Medical			
Deductible (single/family)	\$750/\$1,500			
Coinsurance	20%			
Maximum OOP* (single/family)	\$3,500/\$7,000			
	Pharmacy			
Deductible (single/family)	No Pharmacy Deductible			
Coinsurance	Generic: \$9	Preferred: \$40	Non-Preferred: 50%	Specialty: \$75
Maximum OOP* (single/family)	Accumulates to Medical Maximum OOP*			
	Copay	Coinsurance	Subject to Deductible?	
Emergency Room	\$150	20%	Yes	
Hospital: Inpatient		20%	Yes	
Hospital: Outpatient		20%	Yes	
Office Visits: Primary Care	\$10		No	
Office Visits: Specialist	\$40		No	
Urgent Care		\$25	Yes	

*OOO – Out-of-pocket

Plan Cost-Shares Overview

What You Pay	Managed Care and Health Maintenance Organization Plans							
	Kaiser Foundation Health Plan of the Northwest			Kaiser Foundation Health Plan of Washington				Premera Blue Cross
	KPNW 1	KPNW 2	KPNW 3	Core 1	Core 2	Core 3	SoundChoice	<u>HMO</u>
Annual Costs								
Medical Deductible	\$1,250/ person \$2,500/ family	\$750/ person \$1,500/ family	\$125/ person \$250/ family	\$1,250/ person \$3,750/ family	\$750/ person \$2,250/ family	\$250/ person \$750/ family	\$125/ person \$375/ family	<u>\$750/ person</u> <u>\$1,500/ family</u>
Medical Out-of-pocket Limit	<u>\$4,500/ person</u> <u>\$9,000/ family</u>	<u>\$4,000/ person</u> <u>\$8,000/ family</u>	<u>\$2,500/ person</u> <u>\$5,000/ family</u>	\$4,000/ person \$8,000/ family	\$3,000/ person \$6,000/ family	\$2,000/ person \$4,000/ family	\$2,000/ person \$4,000/ family	<u>\$3,500/ person</u> <u>\$7,000/ family</u>

Italics/Underline indicates a change from 2022

Plan Cost-Shares Overview (*cont.*)

What You Pay	Preferred Provider Organization (PPO) Plans								
	Kaiser Foundation Health Plan of Washington Options			Premera Blue Cross		Uniform Medical Plan (administered by Regence BlueShield)			
	Access PPO 1	Access PPO 2	Access PPO 3	High PPO	Standard PPO	Achieve 1	Achieve 2	UMP Plus	High Deductible
Annual Costs									
Medical Deductible	\$1,250/ person \$3,750/ family	\$750/ person \$2,250/ family	\$250/ person \$750/ family	\$750/ person \$1,875/ family	\$1,250/ person \$3,125/ family	\$750/ person \$2,250/ family	\$250/ person \$750/ family	\$125/ person \$375/ family	<u>\$1,500/ person</u> <u>\$3,000/ family</u>
Medical Out-of-pocket Limit	\$4,500/ person \$9,000/ family	\$3,500/ person \$7,000/ family	\$2,500/ person \$5,000/ family	\$3,500/ person \$7,000/ family	\$5,000/ person \$10,000/ family	\$3,500/ person \$7,000/ family	\$2,000/ person \$4,000/ family		\$4,200/ person \$8,400/ family

Italics/Underline indicates a change from 2022

Chiropractic, Acupuncture, and Massage (CAM) Services by Plan

What You Pay	Managed Care and Health Maintenance Organization Plans							
	Kaiser Foundation Health Plan of the Northwest			Kaiser Foundation Health Plan of Washington				Premera Blue Cross
	KPNW 1	KPNW 2	KPNW 3	Core 1	Core 2	Core 3	SoundChoice	<u>HMO</u>
Annual Costs								
CAM Visit Limits	Chiropractic: No limit Acupuncture: 20/yr Massage: 20/yr			Chiropractic: 20/yr Acupuncture: 20/yr Massage: 20/yr				<u>Chiropractic: 24/yr</u> <u>Acupuncture: 24/yr</u> <u>Massage: 24/yr</u>
CAM Cost Shares	C: \$40 A: \$40 M: \$25	C: \$35 A: \$35 M: \$25	C: \$30 A: \$30 M: \$25	C: \$30 A: \$30 M: \$40	C: \$25 A: \$25 M: \$35	C: \$20 A: \$20 M: \$30	C: \$0 A: \$0 M: \$30	<u>C: \$10</u> <u>A: \$10</u> <u>M: \$10</u>

Italics/Underline indicates a change from 2022

CAM Services by Plan (*cont.*)

What You Pay	Preferred Provider Organization (PPO) Plans								
	Kaiser Foundation Health Plan of Washington Options			Premera Blue Cross		Uniform Medical Plan (administered by Regence BlueShield)			
	Access PPO 1	Access PPO 2	Access PPO 3	High PPO	Standard PPO	Achieve 1	Achieve 2	UMP Plus	High Deductible
Annual Costs									
CAM Visit Limits	Chiropractic: 20/yr Acupuncture: 20/yr Massage: 20/yr			<u>Chiropractic: 24/yr</u> <u>Acupuncture: 24/yr</u> <u>Massage: 24/yr</u>		Chiropractic: 24/yr Acupuncture: 24/yr Massage: 24/yr			
CAM Cost Shares	C: \$30 A: \$30 M: \$40	C: \$25 A: \$25 M: \$35	C: \$20 A: \$20 M: \$30	<u>C: \$25</u> <u>A: \$25</u> <u>M: \$25</u>		C: \$15 A: \$15 M: \$15			C: \$15 A: \$15 M: \$15 After deductible

Italics/Underline indicates a change from 2022

Dental & Vision Benefit Offerings

2023 DeltaCare Proposed Benefit Changes

- Pediatric care for children through age 19 will be covered at 100%, less applicable copays
- Coverage for composite fillings for posterior (rear) teeth
- Providers will be paid a \$25 Preventive Care Incentive

No Proposed Benefit Changes for 2023

- Dental
 - Uniform Dental Plan
 - Willamette Dental of WA
- Vision
 - Davis Vision
 - EyeMed Vision Care
 - MetLife Vision

Questions?

Lauren Johnston

SEBB Program Procurement Manager

Portfolio Management and Monitoring Section

Employees and Retirees Benefits Division

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TAB 5



Uniform Medical Plan (UMP) RFR 2022 Benefit Year 2023

Christine Davis, UMP Account Manager
Portfolio Management & Monitoring Section
Employees and Retirees Benefits Division
June 2, 2022

App-based Behavioral Health Program

- HCA requested information on available app-based behavioral health program options for SEBB and PEBB Program members
- Regence providing details on offerings for app-based behavioral health programs that could be offered to PEBB and SEBB Program UMP members for a January 1, 2023 implementation

Costco Mail Order Pharmacy

- Adding Costco as additional mail order pharmacy beginning in 2023
- Member experience will be similar to current offerings

HSA Qualified High Deductible Plan

IRS minimum deductible was derived April 29, 2022 from Revenue Procedure 2022-24.

	2022	2023
Single Subscriber	\$1,400	\$1,500
All Other Tiers	\$2,800	\$3,000

Proposed Resolution SEBB 2022-02 IRS Minimum Deductible for High Deductible Health Plan

Beginning January 1, 2023, the deductible in the UMP High Deductible plan will be increased to \$1,500 for single subscribers and \$3,000 for all other tiers.

IRS Notice 2019-45

- Internal Revenue Service Notice 2019-45 expands the list of preventive care benefits the Uniform Medical Plan High Deductible can cover before a member meets their deductible. Although these services and items are classified as preventive care for purposes of section 223(c)(2)(C), these services and items can still be subject to cost sharing (coinsurance, copayment, etc.).
- Board voted on medical components of the notice last year (SEBB 2021-15) included in the Appendix.

Pharmacy Aspects of IRS Notice 2019-45

APPENDIX

Preventive Care for Specified Conditions	For Individuals Diagnosed with
Angiotensin Converting Enzyme (ACE) inhibitors	Congestive heart failure, diabetes, and/or coronary artery disease
Anti-resorptive therapy	Osteoporosis and/or osteopenia
Beta-blockers	Congestive heart failure and/or coronary artery disease
Blood pressure monitor	Hypertension
Inhaled corticosteroids	Asthma
Insulin and other glucose lowering agents	Diabetes
Retinopathy screening	Diabetes
Peak flow meter	Asthma
Glucometer	Diabetes
Hemoglobin A1c testing	Diabetes
International Normalized Ratio (INR) testing	Liver disease and/or bleeding disorders
Low-density Lipoprotein (LDL) testing	Heart disease
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression
Statins	Heart disease and/or diabetes

IRS Notice 2019-45

HCA recommends the UMP High Deductible plan provide pre-deductible coverage (15% cost share) for certain high value drugs within each drug class specified in IRS notice 2019-45.

Preventive Care for Specified Conditions (Pharmacy)	For Individuals Diagnosed With	Drugs UMP CDHP/HDHP Will Cover Before Deductible in 2023 (15% cost share)
Angiotensin Converting Enzyme (ACE) Inhibitors	Heart failure, diabetes, and/or coronary artery disease	Enalapril/hydrochlorothiazide, enalapril, lisinopril, lisinopril/hydrochlorothiazide
Anti-resorptive Therapy	Osteoporosis or osteopenia	alendronate
Beta-blockers	Heart failure, coronary artery disease	Atenolol, bisoprolol/hydrochlorothiazide, carvedilol, metoprolol succinate, metoprolol tartrate

Preventive Care for Specified Conditions (Pharmacy)	For Individuals Diagnosed With	Drugs UMP CDHP/HDHP Will Cover Before Deductible in 2023 (15% cost share)
Inhaled Corticosteroids	Asthma	Budesonide suspension, Flovent Diskus, Flovent HFA
Insulin and Other Glucose Lowering Agents	Diabetes	Insulin: all insulin Non-insulin: Glimepiride, glipizide, glyburide, glyburide/metformin, metformin

Preventive Care for Specified Conditions (Pharmacy)	For Individuals Diagnosed With	Drugs UMP CDHP/HDHP Will Cover Before Deductible in 2023 (15% cost share)
Selective Serotonin Reuptake Inhibitors (SSRIs)	Depression	Citalopram, escitalopram, fluoxetine, sertraline
Statins	Heart disease, diabetes	Deductible is already waived and covered as Preventive for members aged 40 and above.

Proposed Resolution SEBB 2022-03 UMP High Deductible Plan Preventive Care

Beginning January 1, 2023, the UMP High Deductible plan will cover the drug list, presented to the Board on June 2, 2022, prior to meeting the plan deductible. Thereafter, HCA may alter this drug list to allow for pre-deductible coverage based on clinical evaluation and in accordance with IRS guidance.

Questions?

Christine Davis, UMP Account Manager
Portfolio Management and Monitoring Section
Employees and Retirees Benefits Division

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Appendix

Resolution SEBB 2021-15

7/15/21	UMP High Deductible Preventive Care	Beginning January 1, 2022, the UMP High Deductible plan will allow coverage to treat certain chronic conditions, those presented at the July 15, 2021 SEB Board Meeting, before having to meet the plan deductible.	2021-15
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IRS Allowed Changes to UMP High Deductible

Chronic Condition:	Preventive Care Covered:	Coverage Available Under:	If Approved, 2022 UMP Coverage Would Be:
Asthma	Peak flow meter	Medical	<ul style="list-style-type: none"> • Deductible is waived • Member only pays coinsurance until their out-of-pocket limit is met
Diabetes	Glucometer	<p>Medical* or Pharmacy</p> <p><i>*some specific continuous glucose monitors will be grandfathered</i></p>	
Diabetes	Hemoglobin A1c testing	Medical	
Diabetes	Retinopathy screening	Medical	

IRS Allowed Changes to UMP High Deductible (*cont.*)

Chronic Condition:	Preventive Care Covered:	Coverage Available Under:	If Approved, 2022 UMP Coverage Would Be:
Heart Disease	Low-density Lipoprotein (LDL) testing	Medical	<ul style="list-style-type: none"> • Deductible is waived • Member only pays coinsurance until their out-of-pocket limit is met
Hypertension	Blood pressure monitor	Medical	
Liver Disease and/or Bleeding Disorders	International Normalized Ratio (INR) testing	Medical	