

**School Employees Benefits Board**  
**Meeting Minutes**

April 7, 2021  
Health Care Authority  
Sue Crystal Rooms A & B  
Olympia, Washington  
9:00 a.m. – 12:30 p.m.

The Briefing Book with complete presentations can be found at the SEB Board materials and materials webpage: <https://www.hca.wa.gov/about-hca/school-employees-benefits-board-sebb-program/meetings-and-materials#meeting-materials>

**Members Present via Phone**

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

**SEB Board Counsel**

Katy Hatfield

**Call to Order**

**Lou McDermott, Chair**, called the meeting to order at 9:02 a.m. Sufficient members were present to allow a quorum. Board introductions followed. Due to COVID-19 and the Governor's Proclamation 20-28, today's meeting is telephonic only.

**Meeting Overview**

**Dave Iseminger**, Director, Employees and Retirees Benefits (ERB) Division, provided an overview of the agenda. Per our new tradition of highlighting communities we serve, today is San Juan County.

San Juan Island has about 17,000 individuals who live on the various islands in San Juan County. About 4.5% of the population is covered by PEBB benefits and about 3% of the population is covered by SEBB benefits. About 20% of the population is served by the Medicaid program at the Health Care Authority. Between the three large

programs at HCA, SEBB, PEBB, and Medicaid, it's about 28% to 29% of the entire island community population that is covered by programs at the Health Care Authority.

Unemployment, at this point, is about 4%, which is very similar to the statewide average. Per capita personal income is significantly higher than state and national averages, whereas median income is lower. That's indicative of a retiree population and there's a robust retiree community within the San Juan Islands.

Other health care trends in the islands are there is a higher per 1,000 rate of primary care providers (PCPs) than the national average, but lower than the state. There are about 1.6 primary care providers per 100,000 individuals, even though there's not 100,000 individuals on the island. That's higher than the national average but lower than the statewide average of 1.9.

There are lower cancer rates among residents in the San Juan Islands, again, related to a higher retiree population, and lower birth rates and lower teen births, which also leads to a limited availability of pediatricians on the island. Primary care is delivered on the island for minor and urgent needs, but anything that's more elective, planned, or major surgery, tends to come over into the communities of Bellingham or Everett. There is some availability of psychiatric services at some of the new hospitals though there's regularly community requests to work on additional inpatient and outpatient hospital beds for acute behavioral health needs.

San Juan County is a series of islands. The ferry system is a key part of individuals being able to access non-urgent services. Generally, the ferry system runs one ferry per hour, and depending on how many stops it makes within the islands, versus the mainland, a one-way trip can be anywhere from 45 minutes to two hours. That is the primary mechanism for getting on and off the islands in San Juan County. There is a cost prohibitive aspect to that for lower income individuals on the islands. There is also the ability for air transports, or other helicopter, or other plane travel into and out of the islands, but that is even more cost prohibitive than ferries. The access issue requiring extensive planning when it comes to non-urgent services as residents of the island come to mainland Washington State.

Our meeting is being supported physically in Olympia on the traditional territories of the Coast Salish people, specifically, the Nisqually and Squaxin Island peoples. Olympia and the South Puget Sound region are covered by the Treaty of Medicine Creek, which was signed under duress in 1854, and we continue to acknowledge the tribal governments, and their role today in taking care of our lands.

#### **Approval of July 23, 2020 Meeting Minutes**

Alison Poulsen moved, and Pete Cutler seconded a motion to approve the minutes as written. Minutes were approved by unanimous vote.

#### **Approval of January 28, 2021 Retreat Meeting Minutes**

Wayne Leonard moved, and Dawna Hansen-Murray seconded a motion to approve the minutes as written. Minutes were approved by unanimous vote.

## **Long-Term Disability (LTD) Insurance**

**Kimberly Gazard**, Contract Manager, Portfolio Management and Monitoring Section, ERB Division. Slide 3 – March Follow up to questions from last month’s Board Meeting, review policy resolutions, and review stakeholder feedback associated with each policy resolution.

The first question received was around LTD redesign, the transition, and how someone would transition while on an LTD claim. A disabled individual would remain on the same disability claim policy throughout the duration of their disability. When the individual returns to work and is determined to meet SEBB eligibility by the employer, and the reinstatement policy criteria defined in LTD policy, the individual would transition to the redesign with no evidence of insurability (EOI) at that time.

**Dave Iseminger:** Kimberly, I want to make sure everyone understands the answer to the first question. If an individual is on an active claim receiving a monthly benefit and we cross into the new year, and this new proposal has been passed, the rules that apply to that claim are the ones when the claim was initiated. Nothing changes about their current active claim just because we crossed into the new year with a new plan design.

**Kimberly Gazard:** That is correct.

The second question is why HCA recommended a 31-day election period for the LTD redesign. The main reasons were to avoid adverse selection, to align all benefits to help lessen the administrative burden on employers with the various benefits being effective at different times. Extending the election period to 60-days, for example, would increase the likelihood of an employee having more premiums taken from their paycheck, and then having to be refunded that amount by their employer, if the employee chooses to opt-out during their election period.

The third question was what HCA’s decision package included when we requested additional funding during the 2020 session, which was to increase the SEBB’s basic LTD benefit to a maximum monthly benefit of \$1,500 with an estimated cost to the state of approximately \$8 million. HCA did not receive additional funding to increase the basic LTD benefit.

A follow-up request from the SEB Board Meeting last month was to provide a few examples of the benefit waiting period. Slides 4 through 6 are those examples. There is an example when an employee is receiving Paid Family Medical Leave (PFML) benefits for 90 days and they have 30 days in their sick leave bank. There is a Benefit Waiting Period Example when an employee is receiving PFML benefits for 90 days and has 120 days in their sick leave bank. There is an example of a Benefit Waiting Period for 90 days when the employee is not receiving PFML benefits, and they do not have sick leave. The LTD benefit begins paying on day 91.

**Dave Iseminger:** With the first two examples, Kimberly’s illustrating that the benefit waiting periods are not consecutive, they run concurrently. It is the longest of any of the numbers identified.

**Kimberly Gazard:** Slide 7 – Resolution SEBB 2021-10 – Employee-Paid Long-Term Disability (LTD)

HCA received stakeholder feedback about distinguishing between paid time off (PTO) and vacation leave on Resolution SEBB 2021-13. Since Resolution SEBB 2021-10 has the same benefit waiting period language, I'll discuss this topic now. The original benefit waiting period for the proposed language mirrored the PEBB Program's. After we received the stakeholder feedback asking for clarification on the difference between PTO and vacation leave, we engaged The Standard in discussion with the goal of plain talking the benefit waiting period. The changes made for the final resolution we're recommending for action today is separately listing the benefit waiting periods as five separate bullets that may apply depending on the enrollee's circumstances.

There is also clarified language to resolve the confusion caused by references to both PTO and vacation leave. The fourth sub bullet uses the term "non-vacation". For example, many employers, like the state, provide employees with additional emergency Covid paid leave allowing use during the pandemic to ensure that employees have access to paid leave if their other leave balances were too low.

Sub bullet #3 – the term "PTO" has historically been applied when employers do not have a dedicated sick leave bank. Instead, they offer a single bucket used for all purposes, personal, vacation, and sick leave. This entire concept is further complicated because some employers also use terms like vacation, paid time off, paid days, personal leave, annual leave interchangeably. Usually in commercial LTD products, the entire amount of leave in a single PTO bucket is used when calculating the benefit waiting period. We were able to negotiate with The Standard for the SEBB Program LTD benefit waiting period purposes that they would only count 50% of the leave balance when reviewing instances of a single PTO bucket. This resulted in the new term referred to as "fractionated period of paid time off." There will be explicit definitions of paid time off and fractionated period of paid time off in the policy document that will be reviewed and approved by the Office of the Insurance Commissioner (OIC) as shown on Slide 8 – Intended LTD Policy Definitions.

HCA also received feedback on the resolution, which wasn't specific to the changes related to the LTD redesign but around adding an annual inflator to the maximum monthly benefit to maintain the value of the benefit over a period of time. HCA has discussed this topic briefly with The Standard and will assess in greater detail during the next LTD Request for Renewal.

**Dave Iseminger:** I want to highlight the concept in the third sub bullet around a single bucket of PTO. We tried to begin surveying districts to understand how many have two or more buckets and how many have a single bucket. We haven't identified a specific school district that has a single bucket of leave, but we haven't been able to do an exhaustive inventory. I can't say this is a specific scenario that exists in the SEBB Program today, but I also can't say it doesn't. In the PEBB Program, we've identified employers that have a single bucket of leave. It's included in the SEBB resolution due to variability that can still exist from an HR perspective within school districts.

There's also the possibility there could be a legislative change that allows the Health Care Authority to contract certain entities into the SEBB Program. In the PEBB

Program, we have the authority to allow local governments, counties, cities, municipalities, different political subdivisions to contract with HCA and be part of the PEBB Program. There could always be a push to allow tribal schools or other K-12 related public entities access to SEBB Program benefits. This issue would be resolved in an instance where an employer has a single PTO bucket.

**Pete Cutler:** Kimberly, on the fifth bullet, it seems to be different than the prior four, where it talks about the waiting period would be for the period of time the employee is receiving benefits, whereas the prior three involve the period for which the person is eligible to receive benefits. Does that mean somebody who's under the Washington Paid Family Medical Leave law could choose to not continue receiving benefits under that, and as long as it was more than 90 days, that would trigger their eligibility for the long-term disability?

**Kimberly Gazard:** Yes. An individual would have the choice to utilize the benefits they would be receive from Washington Paid Family Medical Leave. That's also considered deductible income under the LTD policy. It's either/or, if the individual chooses to utilize the Washington Paid Family Medical Leave.

**Pete Cutler:** It would be up to them how long? They could do it for 90 days, and then if they wanted to switch over to the long-term disability, they would, even though they were still eligible for a longer period of time? I don't remember the details of the Washington program, so I don't really remember how long it goes.

**Kimberly Gazard:** Usually, in most cases, it goes 90 days. I know there are certain circumstances that the state would approve a longer period of time. It depends on the reason why they're going out on PFML.

**Pete Cutler:** Okay. But the other ones, it's however long you're eligible, even if you say, I don't want to use my sick leave, or my PTO, or whatever. If you're eligible for that leave, then that's going to be a waiting period.

**Kimberly Gazard:** Right. An individual can have 120 days of sick leave, have to wait that period of time, but not necessarily use all 120 sick days, but have to go through that entire duration of 120 days.

**Pete Cutler:** That answered my question. Thanks very much.

**Dave Iseminger:** The concept Pete highlighted, and Kimberly affirmed, has come up quite a bit. You don't have to use all of your leave, but you do have to wait the period equivalent to your leave. That is the embodiment of that phrase, no choice sick leave, the third bullet from the bottom.

**Kimberly Gazard:** Slide 9 – Resolution SEBB 2018-39 – Employee-Paid Supplemental Long-Term Disability (proposed to rescind effective December 31, 2021). There are no changes to this resolution. HCA did receive feedback requesting clarification that evidence of insurability is not required in the first two statements related to the December 31, 2021 change, and then for new employees. HCA was able to accommodate this request. The redline version of the changes is in the appendix on Slide 20.

HCA also received stakeholder feedback asking for clarification if someone would be considered a new employee if they changed school districts. No, as long as the individual maintains eligibility for the plan between each SEBB Organization, the employee-paid LTD coverage would remain as is. If the employee changes SEBB Organizations and they were not insured for employee-paid LTD coverage, they must provide EOI to become insured for the employee-paid LTD coverage. A School Employee Benefits Board Organization is a public school district, educational service district, or charter school established under Chapter 28A.710 RCW that is required to participate in benefit plans provided by the School Employees Benefits Board.

Slide 10 – Resolution SEBB 2021-11 – Employee-Paid Long-Term Disability (LTD) Enrollment Procedures. We clarified in the first bullet that Evidence of Insurability (EOI) would not be required when a school employee reduces coverage from the 60% plan to the 50%. They would be buying down and EOI would not be required.

Slide 11 – Resolution SEBB 2021-11 – Employee-Paid Long-Term Disability (LTD) Enrollment Procedures (*cont.*) No changes to this resolution since the last board meeting. It clarifies the minor changes made to SEBB 2021-12, changing the last two bullets to reflect employer-paid and employee-paid versus basic and supplemental, and adding the additional note for coverage for the 60% coverage level.

Slide 12 – Resolution SEBB 2021-12 – Amending Resolution SEBB 2018-54 Relating to Default Enrollments. This slide spells out the changes for Resolution SEBB 2021-13.

Slide 13 – Resolution SEBB 2021-12 – Amending Resolution SEBB 2018-54 Relating to Default Enrollments. As mentioned earlier, HCA received feedback on this resolution, which also applied to Resolution 2021-10, since these two resolutions have identical benefit waiting period language. The redline version of this slide is in the Appendix on Slide 22. It is identical to Resolution SEBB 2021-10 that we've already discussed.

**Pete Cutler:** I noticed on the last slide in the second bullet, it says the benefit waiting period will be longer the entire period of sick leave but excluding shared leave for which an employee is eligible. If somebody went out on sick leave, but then did receive shared leave from other employees, does this mean they could collect the payment of their shared leave, as well as the long-term disability benefit, for the same period of time?

**Kimberly Gazard:** I will confirm with Standard if that's considered a deductible income, but for the purposes of the benefit waiting period, the shared leave would be excluded.

**Pete Cutler:** Okay, thank you.

**Lou McDermott: Vote – Resolution SEBB 2021-10 – Employee-Paid Long-Term Disability (LTD)**

**Resolved that,** effective January 1, 2022, SEBB 2018-39 is rescinded and the SEBB Program will instead offer the following employee-paid LTD design:

Two separate employee-paid LTD insurance choices including: (a) coverage at 60% or (b) coverage at 50%. Both choices will have the following features:

- The following benefit waiting period (the longer of):
  - 90 days;
  - The entire period of sick leave (excluding shared leave) for which the employee is eligible;
  - The Fractionated Period of Paid Time Off (PTO) for which the employee is eligible, if your employer has a PTO plan, as those terms are defined in the policy;
  - The entire period of other non-vacation salaried continuation leave for which the employee is eligible or
  - The end of the Washington Paid Family and Medical Leave Law for which the employee is receiving benefits
- No Choice Sick Leave
- Choice Pension
- A Maximum Monthly Benefit of \$10,000 for the 60% coverage and \$8,333 for the 50% coverage

Alison Paulsen moved, and Pete Cutler seconded a motion to adopt.

**Jill Clark:** I'm with Lakewood School District. I am the payroll accountant. I also do benefits and retirement for all of our employees at our school district. I'm also the Benefits Administrator for SEBB. I am asking the SEB Board to not approve this resolution today. I feel that taking a supplemental plan and making it an opt-out is fundamentally wrong. I feel that just changing the name to employee-paid does not change the product itself. I also feel that this is an overreach of SEBB to assume that this is what is best for our employees. Our employees had ample opportunity to enroll in the supplemental long-term disability plans. If we feel that the basic benefit is inadequate, let's look at making that better.

Before SEBB we had here at our district an excellent product that was a minimal cost to the district. I would think that because we are pooling all of the school district employees throughout the state, that would offer a really good rate on a supplemental plan, or a better basic benefit, I should say. Also, keeping in mind that starting in January of 2022 there is a new long-term care tax that is going to be administered to all employees in the state of Washington. So now we're looking at a huge hit with that for all of our employees, and then making this mandatory, or an opt-out option, which I do feel that many of our employees will, even though I will do my best to reach out to all employees, many employees will not realize this is something they will need to do during open enrollment and fail to opt-out. They're going to have quite a surprise in their January paycheck.

Between the long-term care tax and having two products, two tiers with the long-term disability, it's going to be a lot for us to manage here at the district. Thank you for your consideration, and thank you for your time.

**Julie Salvi:** Good morning. I'm representing the Washington Education Association. I wanted to speak in favor of this resolution. We appreciate the work that has been done over the last year and all the feedback that has been gathered in developing this option.

We see this as an opportunity for employees to enroll in this benefit on the supplemental benefit side with a better rate structure. They will maintain their choice to opt-out, and the choice of having the option to go to the 50% coverage will be a benefit to some that will allow them to get more long-term disability than what they have today. We, like many districts, will continue to support a more robust basic benefit, but given the structure of benefits that we have today, we are in support of this option. Thank you for your time.

**Marcia Peterson:** I am a former Benefits Strategy Design Manager for the PEBB and SEBB Programs, now retired. I retired in September. And now the only thing I manage is my 2½-year old grandson, if you can call managing a 2½-year old possible. I wanted to speak briefly in favor of the LTD policy resolutions since I worked on it with Kimberly Gazard over the past few years. I want to remind the Board, this goes back a long ways, and the impetus came from staff and also the Board being concerned that both SEBB and PEBB Program members were seriously underinsured with regard to the long-term disability insurance benefit, and our anecdotal information that members were finding themselves in a situation where they were very surprised by how limited the benefit was and in a place of hurt when they came to that situation.

The proposed policy, with all its details, I'm very impressed with how far it's come and what it looks like today. With its opt-out provisions, which are very important, I believe that it addresses these concerns, but still allows for choice. It uses very progressive behavioral economic principles to make it easier for people to do the right thing and harder for people to do the wrong thing. I encourage the Board to pass the resolutions. Thank you.

**Lou McDermott:** Dave, I want to clarify something for myself. If an employee does fail to understand the benefit design, and their first check comes and they feel it is a burden they can't take, they have the ability to opt-out throughout the year, not just during open enrollment, is that correct?

**Dave Iseminger:** Yes, assuming the Board passes Resolution SEBB 2021-11. That is part of the language within the resolution allowing an opt-out at any point and the effective date of that opt-out is the first of the next month.

Voting to Approve: 9  
Voting No: 0

**Lou McDermott:** Resolution SEBB 2021-10 passes.

**Lou McDermott: Vote – Resolution SEBB 2021-11 – Employee-Paid Long-Term Disability (LTD) Enrollment Procedures**

**Resolved that,**

- All school employees who are eligible for the employer contribution towards SEBB benefits as of December 31, 2021 and not already enrolled in supplemental LTD insurance or did not make an election (reducing or declining coverage) during an enrollment period established by the Health Care Authority in 2021, will be auto-



enrolled in employee-paid LTD insurance at the 60% coverage level with an effective date of January 1, 2022 without Evidence of Insurability (EOI).

- A school employee who become eligible for the employer contribution towards SEBB benefits on or after January 1, 2022 must make an election (reducing or declining coverage) during the benefit election period established in Resolution SEBB 2018-13. If the school employee fails to timely elect coverage, the school employee will be defaulted into coverage according to Resolution SEBB 2021-12 without EOI. The effective date of coverage will be according to Resolution SEBB 2020-05.
- After January 1, 2022, a school employee at any time may elect to reduce employee-paid LTD to the 50% coverage plan without EOI or fully decline employee-paid LTD. The effective date of the change in coverage will be the first day of the month following the date the SEBB Organization receives the required election.
- A school employee who seeks to increase coverage from the 50% coverage plan to the 60% coverage plan, or access previously declined employee-paid LTD, will be subject to evidence of insurability. The effective date of the change in coverage will be the day of the month the contracted vendor approves the required form.
- Any school employee who declines employee-paid LTD insurance will remain enrolled in the employer-paid LTD insurance.

Pete Cutler moved and Katy Henry seconded a motion to approve.

**Mitch Thompson:** Thank you, Board. Thank you, Dave. So, the underlying idea of providing long-term disability benefit to employees is a good idea. And it's a great plan to offer. To make it a mandatory opt-out, it's kind of deceiving to the employees, as well as it puts an additional burden on Benefits Administrators at the district level. We're already required to do all the customer service for SEBB, as it exists, and the workload has just become, I don't want to say unmanageable, but that's pretty much how we feel. It's been a whole lot of additional work on our parts. A mandatory opt-out of an optional benefit is a backdoor way to get more participation. I would suggest rather than doing it that way, we actually do more education on the benefit of long-term disability.

Another issue I have with this particular resolution is it takes everyone who is participating in SEBB, and active during open enrollment time this next year, and automatically enrolls them. So generally during open enrollment, we tell employees if you're not making any changes, you don't have to do anything. And now we have to go back and re-educate all of our staff members, and say, "If you don't do something, then you're going to have to pay at least one month's coverage until you actually do something." And that – it just becomes problematic.

In a lot of the Benefits Administrators' eyes, it's deceptive. And it creates more work, more burden on us, as well as not being open and honest with the employees. I don't know of any other optional benefits that people have to mandatory opt-out. I know, at the last board meeting, Retirement was used as an example of a default plan that people were put into. But retirement is mandatory. It's not an option. So, I would hope that the Board would vote no on this resolution. Thank you for your time.

**Lou McDermott:** Dave, on that last point about retirement, the opt-out is referring to the Deferred Compensation Program, isn't that correct?

**Dave Iseminger:** Correct. Obviously, Retirement has multiple different options. There are mandatory components, but then, within state government, there are optional 401k additional contributions that can be made. It's called the Deferred Compensation Program, that truly is optional for state employees, as an example, the Legislature made an affirmative change, I believe it was back in 2016 or 2017, that automatically deducts and makes contributions to this optional deferred compensation 401k plan of 3% of salary and an individual can then opt-out of those additional retirement contributions. So, there are both mandatory and optional parts of the pension system managed by DRS in the state. The truly optional part of it does have an auto-enroll opt-out mechanism. Board Members remember some of the early iterations of our LTD conversation, we were learning about the Department of Retirement's experience with that, which helped shape the proposal that led to today.

**Lou McDermott:** Thanks for that clarification.

**Wayne Leonard:** -- Opting-out is a significantly different benefit design than we've had with long-term disability in the past. There's a benefit design that in the past we have had some control at the local level. We could improve our long-term disability benefit as a group, or if we agreed to pay slightly higher medical premiums. I think, in this situation, I'm gathering from the presentation that we're sitting here waiting for an improved long-term disability benefit. We're waiting for the Legislature to fund it, which is why it hasn't been improved in 40 years. I do appreciate the enhancements to the plan design, and I would also echo what Julie Salvi said, that I would continue to hope for an improved or more robust basic benefit plan. I don't believe that opt-out clause would be in the best situation for our members. I would agree with Mitch in that we should educate employees and have them opt-in.

Voting to Approve: 8

Voting No: 1

Voting to Approve:

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

Voting No:

Wayne Leonard

**Lou McDermott:** Resolution SEBB 2021-11 passes.

**Lou McDermott: Vote – Resolution SEBB 2021-12 – Amending Resolution SEBB 2018-54 Relating to Default Enrollments**

**Resolved that,** SEBB 2018-54's fourth bullet is amended by striking the word "and" from the end of the sentence; the fifth bullet is amended by replacing the word "basic" with the word "employer-paid" and adding the word "; and" to the end of the sentence;

and adding the following new sixth bullet, "Enrollment in employee-paid long-term disability insurance at the 60% coverage level".

So that SEBB 2018-54 now reads:

The default election for an eligible school employee who fails to timely elect coverage will be as follows:

- Enrollment in employee-only medical coverage;
- Enrollment in employee-only dental coverage;
- Enrollment in employee-only vision coverage;
- Enrollment in basic life insurance;
- Enrollment in employer-paid long-term disability insurance; and
- Enrollment in employee-paid long-term disability insurance at the 60% coverage level.

Alison Paulsen moved, and Katy Henry seconded a motion to adopt.

**Dave Iseminger:** I believe Mitch Thompson wants to speak on this resolution as well.

**Mitch Thompson:** It's a moot point now that you voted through 11.

**Wayne Leonard:** My only comment is on the final bullet point. It would seem like if we're opting mandatory enrollment into the long-term disability plan, it should be at the lowest cost level, which I believe would be the 50% coverage level. But so be it. 60% is what was in the prior resolution.

**Dave Iseminger:** Wayne, there was a robust conversation about that. If we were to have the enrollment at the 50% level, all of the provisions about how evidence of insurability would or wouldn't apply creates additional administrative aspects to implementing this change. Additionally, the rate structure itself would have changed because the assumption would be anybody who is buying up to 60% from 50% has a reason to do that. There are more adverse selections that might be occurring that would have to be baked into the rates. From both a rate perspective and the the ability to simply messaging that no evidence of insurability is needed, unless you're coming back or wanting to go up if you opt down later. These simplifications are what led to the recommendation for the 60% on this slide.

**Wayne Leonard:** I understand the discussion. And obviously the insurance company is concerned about adverse selection of people buying up. But that would seem more protection for Standard than for the HCA or for the employee. That's my two cents.

Voting to Approve: 8

Voting No: 0

Voting to Approve:

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

Voting No:  
Wayne Leonard

**Lou McDermott:** Resolution SEBB 2021-12 passes.

**Lou McDermott: Vote – Resolution SEBB 2021-13 – Amending Resolution SEBB 2018-38 Employer-Paid Basic Long-Term Disability**

**Resolved that**, SEBB 2018-38’s title is changed by striking the word “Basic” and adding the word “Insurance” to the end; the first bullet is amended to insert the word “Benefit” before the word “waiting” and striking the word “later” and replacing that word with “the longer” in parentheses; and under the Benefit Waiting Period bullet adding a new second sub-bullet with the words “The entire period of sick leave (excluding shared leave) for which the employee is eligible;”, adding a new third sub-bullet with the words “The Fractionated Period of Paid Time Off (PTO) for which the employee is eligible, if your Employer has a PTO plan, as those terms are defined in the policy;”, adding a new fourth bullet with the words “The entire period of other non-vacation salaried continuation leave for which the employee is eligible; and/or”, and amending the last sub-bullet to read as “The end of Washington Paid Family and Medical Leave Law for which the employee is receiving benefits”.

So that SEBB 2018-38 now reads:

Employer-paid Basic Long-Term Disability Insurance

The SEBB program will offer the following Employer-Paid LTD Plan to subscribers beginning January 1, 2020.

- Benefit Waiting Period (the longer of);
  - 90 days;
  - The entire period of sick leave (excluding shared leave) for which the employee is eligible;
  - The Fractionated Period of Paid Time Off (PTO) for which the employee is eligible, if your employer has a PTO plan, as those terms are defined in the policy;
  - The entire period of other non-vacation salaried continuation leave for which the employee is eligible; or
  - the end of Washington Paid Family Leave Medical Leave Law for which the employee is receiving benefits
  - No Choice Sick Leave
  - Choice Pension
  - Maximum Monthly Benefit \$400 (60% of \$667)

Pete Cutler moved, and Dawna Hansen-Murray seconded a motion to adopt.

Voting to Approve: 9  
Voting No: 0

**Lou McDermott:** Resolution SEBB 2021-13 passes.

## **Policy Resolutions**

**Stella Ng**, Senior Policy Analyst and **Emily Duchaine**, Regulatory Analyst, Policy, Rules, & Compliance Section, ERB Division. There are nine resolutions for action today.

Slide 7 – Board Follow Up. Board Members raised a question at the March meeting regarding Example #8 on Resolution SEBB 2021-01 Amending Resolution SEBB 2018-25. When the employer contribution for SEBB benefits end, how do SEBB benefits work if a classified school employee is paid through the end of August.

Slide 8 – When the Employer Contribution for SEBB Benefits End – Example #8 (New). In this new example, Nancy, a classified school employee bus driver and a 9- to 10-month school employee, hired on May 4, 2021, is anticipated to work 630 hours the next school year and be compensated for at least 17.5 hours a week for at least six weeks in the last eight weeks before summer break on June 21, 2021, and is receiving SEBB benefits. On June 22, 2021, her school district notifies her that she will no longer be working the next school year. There is a typo in this example. June 22, 2021 should be June 30, 2021.

For our school employee in this late hire situation, this person must meet two eligibility criteria to be eligible for SEBB benefits. First, the person needs to be anticipated to work 630 hours the next school year and a 9- to 10-month school employee anticipated to be compensated for at least 17.5 hours a week in six of the last eight weeks counting backwards from the week that contains the last day of school. To maintain eligibility for SEBB benefits, both criteria must continue to be met. If the anticipation to work 630 hours in the next school year changes, SEBB benefits will end the last day of the month in which the change in anticipation occurs.

For Nancy, in this example, the employer contribution for SEBB benefits ends on June 30, 2021, because it's the end of the month the change in anticipation occurs. If Nancy has a contract that pays through August, she will continue to work through June and be paid until August even though her employer contribution for SEBB benefits ends on June 30, 2021.

Slides 9 and 10 are a technical way of amending the resolution, which as written, doesn't address people returning from approved leave without pay, or address the late hire situations. We are recommending additional categories to address these situations.

HCA received one comment from stakeholder feedback for this resolution that did not support the proposed new fourth bullet. Their concern was the new fourth bullet in the proposed resolution, as written, could create inconsistencies between current employees who have returned from an approved leave without pay compared to a mid-year hire. A simple schedule change could negate the intent of the policy from SEBB 2020-02.

Our intent of this resolution is to follow SEBB 2020-02 by adding clarity for those who return from approved leave without pay, who maintain established eligibility under SEBB 2020-02, and who subsequently have a change in their work pattern. We accepted the stakeholder feedback and the changes made are consistent with SEBB 2020-02. Under

the new work pattern, had the work pattern been in effect at the start of the school year, would not have resulted in the school employee being anticipated to work the minimum hours to meet SEBB eligibility for the employer contribution in the school year. The SEBB benefit will be taken away prospectively. The fourth bullet has been revised and the track changes are in the Appendix (Slide 35).

Slide 10 – Resolution SEBB 2021-01 Amending Resolution SEBB 2018-25 – When the Employer Contribution for SEBB Benefits End (*cont.*). The revised fourth bullet now reads:

- The school employee who returns from approved leave without pay, who maintained or established eligibility under SEBB 2020-02 and who subsequently has a change in work pattern that, had the work pattern been in effect at the start of the school year, would not have resulted in the school employee being anticipated to work the minimum hours to meet SEBB eligibility for the employer contribution in the school year. In this case, eligibility for the employer contribution ends as of the last day of the month in which the change is the effective;

Slide 11 – When the Employer Contribution for SEBB Benefits End – Example #6. The description has been revised in Example #6 using the revised proposed policy resolution. The employee is no longer anticipated to work the minimum hours, had the work pattern been in effect at the start of the school year, to meet SEBB eligibility for the employer contribution in this school year. The employer contribution for the SEBB benefits end May 31, 2021. There are no changes to bullets five through seven.

**Dave Iseminger:** If you were wondering why Stella kept referring on the first bullet on Slide 10 as the fourth bullet, once it's codified and if approved, it will end up being the fourth bullet in a series of seven bullets of this policy resolution.

**Lou McDermott:** Due to the length of this resolution, and in recognition of the Board's valuable time, under Robert's Rules, it is acceptable to not read the resolution if it has been distributed to members in advance of the meeting. The final version of this resolution was also published for public review this past Monday evening. Do Board Members have concerns if I do not read the full text of Resolution SEBB 2021-01?

**Alison Poulsen:** I have no concerns.

**Pete Cutler:** I have no concern, but I'd like to, for the record, confirm that it's the resolution shown on slide number 11 and 12.

**Dave Iseminger:** When Chair McDermott reads the motion for adoption, it will specify the Resolution number, title, and slide numbers that are being adopted, which are Slides 9, 10, and 12 through 16.

**Pete Cutler:** Great, thank you.

**Lou McDermott: Vote – Resolution SEBB 2021-01 – Amending Resolution SEBB 2018-25 When the Employer Contribution for SEBB Benefits End**

Is there a motion to adopt Resolution SEBB 2021-01 – Amending Resolution SEBB 2018-25 When the Employer Contribution for SEBB Benefits Ends as written on Slides 9, 10, and 12 through 16?

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

Voting to Approve: 9

Voting No: 0

**Lou McDermott:** Resolution SEBB 2021-01 passes.

**Emily Duchaine:** Slide 18 – Stakeholder Feedback and Questions. HCA stakeholdered feedback for eight resolutions. Before action is taken on the dual enrollment resolutions, I'll discuss stakeholder feedback.

Resolution SEBB 2021-02 had only two questions despite this being a very complex topic. The first question asked how many members are expected to be impacted and the second question was, "If a school employee is auto-disenrolled from SEBB dental, into which PEBB dental plan will the school employee be auto-enrolled?"

Approximately 5,000 members are currently dual enrolled between PEBB and SEBB. It's not possible to know how many of them will be proactive and resolve that on their own during the upcoming fall open enrollment. HCA will engage in extensive communications to encourage members to make their own decisions, so HCA doesn't have to auto-enroll or auto-disenroll them.

School employees without SEBB medical who remain in PEBB medical as a dependent will be enrolled in the PEBB subscriber's dental plan. This is based on Resolution PEBB 2021-03, which mirrors Resolution SEBB 2021-03. If this results in a change in dental carrier mid-treatment, the member could file an appeal citing continuity of care concerns for review, if this rose to the level of disruption in care for active and ongoing treatment.

There was no feedback for the other seven resolutions. These eight resolutions are identical to what was presented at the March 4 Board Meeting, with one exception. Resolution SEBB 2021-09, on Slide 29, changed "waived status" to "waived enrollment," at the request of one stakeholder. This does not change the meaning or intent of the resolution. It more accurately reflects the words and phrasing used in rule. The original proposed resolution introduced on March 4 is in the Appendix.

Slide 19 – Language Used Throughout This Presentation. This slide recaps definitions introduced at the March 4 SEB Board Meeting.

Slide 20 – Guidelines/Principles For Resolving Dual Enrollment recaps guidelines and principles HCA followed for developing the policy resolutions presented at the March 4 Board Meeting.

**Lou McDermott: Vote – Resolutions SEBB 2021-02 through SEBB 2021-09**

**Resolution SEBB 2021-02 – Amending Resolution SEBB 2018-53 School Employees May Waive Enrollment In Medical**

**Resolution SEBB 2021-03 – SEBB Benefit Enrollment Requirements When PEBB Benefits Are Waived**

**Resolution SEBB 2021-04 – Resolving Dual Enrollment When A School Employee’s Only Medical Enrollment Is In PEBB**

**Resolution SEBB 2021-05 – Resolving Dual Enrollment Involving Dual Subscriber Eligibility**

**Resolution SEBB 2021-06 – Resolving Dual Enrollment Involving A SEBB Dependent With Multiple Medical Enrollments**

**Resolution SEBB 2021-07 – Resolving Dual Enrollment Involving A Member With Multiple Medical Enrollment As A Dependent**

**Resolution SEBB 2021-08 – SEBB Benefit Automatic Enrollments When PEBB Benefits Are Auto-Disenrolled**

**Resolution SEBB 2021-09 – Enrollment Requirements When A School Employee Loses Dependent Coverage In PEBB Benefits**

These eight dual enrollment resolutions are lengthy and work together as a set. A significant amount of time has been spent reviewing these proposals and examples from the last meeting, including Emily reading them in full, with the Board expressing appreciation for the thoroughness for the presentation. HCA received no feedback on these resolutions and there are no substantive changes to any of the resolutions. In recognition of the Board's time, and under Robert's Rules, it is acceptable not to read the full text of these resolutions if they have been distributed to members in advance of the meeting. The final resolutions were also published for public review this past Monday evening. Earlier, Board Members had no concerns of not reading the resolutions before action was taken.

Additionally, for the same reasons in this instance, action will be taken on all eight dual enrollment resolutions as a set, at the same time, in one motion, Resolutions SEBB 2021-02 through SEBB 2021-09 on Slides 21 through 29.

Pete Cutler moved, and Wayne Leonard seconded a motion to adopt all eight resolutions.

**Pete Cutler:** I want to congratulate staff for keeping track of all these different, complicated, aspects of these policies, and getting them into the resolutions and rules.



Voting to Approve: 9

Voting No: 0

**Lou McDermott:** Resolutions SEBB 2021-02 through SEBB 2021-09 pass.

### **2021-23 Biennial Budget Update**

**Tanya Deuel**, ERB Finance Manager, Financial Services Division. Today's presentation is an update on what we see in the House and Senate budgets to date. We discussed the Governor's budget at the January Retreat.

Slide 2 – Proposed Funding Rate. Funding rates are set per employee per month. The funding rates so far, in all three proposed budgets, are adequate to maintain our current level of benefits. HCA has no significant concerns with any of the underlying assumptions.

Slide 3 – SEBB Proposed Funding Rates includes all three proposed budgets. Both the House and Senate budgets include the same funding rates for both school years, \$968 for the 2021-22 school year and \$1,032 for the 22-23 school year. These were adjusted to be on a school year basis, so that concern has been resolved in the Senate and the House. HCA has no concerns with the underlying assumptions.

Slide 4 – Proposed Budget Similarities. These decision packages have the same level of funding between the Governor, House, and Senate proposed budgets. The decision packages include approximately \$6 million for our third-party administrator fees. HCA requests increased spending authority each biennium to align with our self-insured enrollment. There was increased enrollment this biennium in our self-insured products, which was just by nature of the new program, requiring the need to increase significantly this biennium to catch up with that self-insured enrollment.

Funding was received for one FTE for UMP member support for member escalation issues with that higher than originally projected enrollment in our self-insured products.

The \$15,000 amount is a small portion of the overall larger decision package for our scheduling tool replacement, mostly attributable to the PEBB Program. The nature of the customer service unit is primarily for our retirees. However, this call center does support our COBRA members within the SEBB Program. Approximately 5% of the total decision package was attributable to SEBB, which was funded in all three budgets.

HCA received funding for two and a half FTEs in our Outreach and Training Unit to support staffing levels for our districts, such as responding to Fuzes. This was a portion of a larger decision package. The majority was attributable to the SEBB Program, with a half FTE funded for the PEBB Program.

Slide 5 – Collective Bargaining. This is similar as well. Everything has remained the same since the Governor's proposed budget. In collective bargaining, the employer medical contribution will remain at 85% of the Uniform Medical Plan Achieve 2. The wellness deductible was increased to \$125 in all three versions of the budget. The benefit allocation factor remained the same in this biennial budget as well for certificated and classified staff.

**Pete Cutler:** I noticed there's a \$40 per month per employee reduction in the funding level proposed by the Senate and the House compared to the Governor's proposed budget. And yet, that's sufficient. Can I infer from that, that new information became available between when the Governor put together his budget and when the House and Senate introduced their budgets in March?

**Tanya Deuel:** Yes. We update utilization, unit costs, our actual experience, enrollment, each quarter. From the timing of when we presented our modeling to the Governor's Office for the Governor's proposed budget, versus when we did for the legislative proposals, we had updated experience with Covid and other factors and experience, which allowed for that lower funding rate.

**Pete Cutler:** Do you have an idea whether it was primarily related like to open enrollment and greater numbers of members in UMP or more dealing with trend assumptions and claims experience?

**Tanya Deuel:** It's primarily the underlying assumptions in our self-insured products with trend and our risk scores within the program.

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

### **2021 Legislative Session**

**Cade Walker**, Special Executive Assistant, ERB Division. Slide 2 – Number of 2021 Bills Analyzed by ERB Division. The ERB Division has completed 143 bill analyses, with 73 hearing reviews. This slide has the breakdown of the various lead and support bills, and the high and low priority. The Division had 14 lead high priority bills which would have either financial implications of more than \$50,000 or policy or rule change implications to our program.

Slide 3 – 2020 Legislative Session – ERB High Lead Bills, is the cascading waterfall of progress of our ERB high and lead support bills. There are six pieces of legislation we continue to watch. This session ends April 25.

Slide 4 – Upcoming Session – Agency Request Legislation. Senate Bill 5322 on clarifying the prohibition of dual enrollment between the SEBB and PEBB Programs has passed the Legislature and is on the Governor's desk for signature.

**Dave Iseminger:** The Governor has an action ceremony at 3:30. It is on the list for action, as this is the maximum number of days for it to be considered by the Governor's Office under the state constitution. We anticipate a favorable response and signing by the end of the day. That will dovetail with the actions just taken by the Board.

**Cade Walker:** Slide 5 – HB 1052 – Group Insurance Contracts. We are closely tracking this piece of legislation, which impacts performance measures. HCA is working in coordination with the Office of the Insurance Commissioner to get this legislation through and continue our practice of having performance guarantees in our contracting with our vendors. It has passed the opposite chamber's fiscal committee and is on the rules for final vote in the Senate. We're hoping to see it finalized before April 25. It has not had a negative vote thus far. We'll continue to track and provide updates.

Slide 6 – Topical Areas of Introduced Legislation provides an update on the status of legislation our Division is following. The two bills pertaining to the Paid Family Medical Leave Program continue to move through the process. HB 1073 and Substitute Senate Bill 5097 continue to move through the appropriate cutoffs. While the bills don't have direct implications on our program, as we do not administer that statewide program, we are tracking changes that may have implications for our members and/or implications for our long-term disability benefit.

We continue to track Senate Bill 5195 pertaining to the opioid overdose medication. It has moved out of House Appropriations.

Slide 7 - Topical Areas of Introduced Legislation (*cont.*). Senate Bill 5018 – Acupuncture and Eastern medicine continues to progress. 2SSB 5313 has had quite a bit of action and a lot of amendments. Additionally, House Bill 1196 on audio only telemedicine continues as well.

HB 1056 - We also are tracking the changes and codifying of the emergency rules regarding public meetings, keeping apprised of those changes and what impacts it may have on the structure for our Board meetings, although we don't see any changes in the current version that would necessitate the Board to change its process.

There have been a number of bills pertaining to data, data security, and privacy on a statewide level and individual agency and program level. HCA's Enterprise Technology Services and Privacy Office are the lead on that legislation. This topic may be included in future updates because of quantity of data we generate through our two programs and the implications that data has with our members.

### **2021 Annual Rule Making**

**Stella Ng**, Policy and Rules Coordinator, ERB Division. This is a high-level overview of this year's rulemaking. Slide 2 – Rule Making Timeline shows action taken in May through July.

Slide 3 – Focus of Rule Making. The focus of this year's rule making is divided into three different areas: administration and benefits management, regulatory alignment, and implement SEB Board policy resolutions.

Slides 4 and 5 – Administration and Benefits Management lists the changes HCA plans to make this season.

Slide 6 – Regulatory Alignment lists changes necessary to implement legislation and to align with federal regulations.

### **Behavioral Health Overview**

**Lauren Johnston**, SEBB Procurement Manager, ERB Division and **Emily Transue**, MD, Medical Director, CQCT Division

**Emily Transue:** Today we're talking about behavioral health coverage in the SEBB Program. It has been at the top of our priority list before the Covid-19 pandemic and has just become more important as the pandemic has gone on. It's become clear that people are under tremendous stress and anxiety right now due to a wide variety of

issues related to both health and other impacts of the pandemic. We are seeing an explosion in behavioral health needs right now. At the same time, there have been a lot of changes in the way care can be delivered.

Slide 2 – Objectives. We'll speak to an overview of the existing behavioral health coverage in our SEBB Program; talk about network adequacy, what that means and how it's measured; what benefits are under review for the future; relevant legislation in this arena; and information and resources available to SEBB Program members and how to access what they have.

**Lauren Johnston:** Slides 3 and 4 – SEBB Plan Behavioral Health Coverage, help illustrate that all of our carriers have comprehensive behavioral health coverage, which means both mental health and substance use disorder treatment. Although our carriers may have different cost shares, all of our plans provide a number of different options in order for our members to access mental health and substance use disorder treatment.

Slide 3 shows the types of in-person care a member can access and Slide 4 shows the types of remote care a member can access, whether it's through a contracted virtual care vendor or speaking with their existing provider remotely. All of our carriers have a nurse line members can call, as well as additional programs they can access.

Slides 5 and 6 – Network Adequacy shows different ways carriers assess their network adequacy. Fully insured carriers, which include Kaiser Northwest, Kaiser Washington, Kaiser Washington Options, and Premera must submit their product filing to the Office the Insurance Commissioner (OIC) every year, which includes network adequacy, such as the number of providers within specific categories that are within a specified radius, or the amount of time it might take to get to a provider. For example, the emergency room. These filings are reviewed by the OIC to ensure they meet the OIC's requirements. All of our carriers are accredited by the National Committee on Quality Assurance, also known as NCQA, which includes accreditation for network adequacy. Our carriers measure access and capacity through things like member calls, outbound surveys, and they identify areas of high-volume services through utilization.

If our carriers address specific areas of need, then they work to expand their network to improve access, decrease wait times, and improve the ease of accessing care for the needs identified. Our carriers are constantly recruiting new providers and trying to retain existing providers. They work to create strategic partnerships and to ensure they have national providers incorporated within their networks. Our carriers have ramped up their virtual care and telehealth offerings recently, especially within the past couple of years. For the last bullet on Slide 6, Kaiser Northwest uses patient partners in mental health to help identify opportunities, programs offered, and processes for accessing care. Each of our carriers measure, in some way, access for routine or urgent care, in order to improve access, and continue to work on improvement.

**Emily Transue:** Slide 7 – Similar Programs Offered Across Multiple Plans. There are some themes across multiple plans and some that are more individual to each plan. All of our plans have, in one form or another, some kind of online or phone applications for mental health. These include myStrength, which is offered by KP Northwest and Kaiser Permanente Washington. This is a cognitive behavioral therapy-based application tailored to the individual needs of each person. People may be familiar with cognitive

behavioral therapy, but it's essentially the idea that people's mental state is strongly affected by their thought patterns, and essentially uses techniques to really be more mindful and conscious of those thought patterns, redirect them in healthier ways, along with directing people toward healthy coping strategies. That's been shown to have a pretty rapid and very significant impact on mental health. Many on this slide are based that approach.

Calm is also offered by both Kaiser programs. This is an app that focuses on meditation, mental resilience, and also on approaches to improving sleep.

Find your words is also offered by Kaiser. It speaks to the fact that people often have a lot of communication difficulty in talking about mental health issues, including depression, others, both in expressing their own symptoms and needs, and then talking to others who have these issues. This has a number of approaches tailored at including talking to clinicians, parents talking to their teenagers, etc.

Ginger, also called Ginger IO, is also offered by the Kaiser programs. This is a virtual therapy option where people can connect with a coach or therapist online. KP Washington has this in place already, KP Northwest plans to start this on June 1.

Slide 8 - Similar Programs Offered Across Multiple Plans Others (*cont.*). Other options offered by multiple plans, or that are similar across multiple plans, are provider concierge services. These acknowledge that people, particularly when they are dealing with mental health challenges, may have a trouble finding the way to access care, particularly because therapists and psychiatrists only take on a limited number of patients. It can be hard to figure out who matches your needs and who's available. These are programs that focus on making that connection happen.

Quartet, which is used by UMP and Premera, matches members to mental health care based on their geography, insurance, clinical needs, and individual preferences that might include gender or areas of focus. This has been described as Match.com for therapy, which I think is an evocative description of what this does. People can use directly or have their primary care provider or other provider access.

Magellan Healthcare, is offered by KP Washington and helps connect people to an in-network provider and to get that first appointment scheduled.

Behavioral health case management is offered by all of our programs. These are licensed specialists whose job it is to help members connect to care, give them assistance and coordination, managing their overall care plan, and understanding and navigating their benefits and care options. Everybody has access to those.

Slide 9 – Plan Specific Programs. KP Northwest offers peer support specialists, others who have had experience of behavioral health issues and have had success in recovery, either from mental health or Substance Use Disorder (SUD). Kaiser Northwest also offers several intensive outpatient programs, one that's aimed at teens, and a new one that will be focused on older teens and young adults who can have very specialized needs. That implementation was delayed a bit because of Covid but is planned for summer of this year.

Slides 10 and 11 – Future Areas of Focus. KP Northwest has the Recovery Pathways Program, which is currently in a pilot stage, focuses on those with co-occurring disorders, people who have both a mental health and an addiction issue. Historically this has been very hard to treat. They often occur together. So far, this pathway has found that focusing on the two together has had a much higher likelihood of success and keeping people engaged in treatment. If it continues to do well, Kaiser intends to expand this program.

KP Northwest is going to be starting a treatment program around Spravato (ketamine). This is a drug that was previously used as a general anesthetic but has been found and recently approved for treatment resistant depression. It was really the first very novel approach to depression that's come up in quite a long time pharmacologically. It's complex to give. The patient has to be monitored in the office for four hours after treatment. So even though it's available on formulary, it can be hard for people to access, and KP Northwest is creating a program to make that access easier.

KP Washington also is doing a mental health and wellness approach that looks at recruitment and retention of providers to addresses gaps in representation of providers in these fields. They have been partnering with the University of Washington Master's in Health Administration Program to do a capstone looking at this work.

Premera has a number of mental health programs currently in proprietary confidential stages of negotiation.

UMP has several programs under consideration. One is Omada Mind which is currently implemented as a pilot. It was available to 1,200 members who signed up in the fall of last year. This is a program that has dedicated support from coaches for anxiety, depression, and stress. UMP is also considering adding myStrength, which we talked about earlier, as an online cognitive behavioral therapy app with a number of tailored programs.

**Lauren Johnston:** Slide 12 – Legislation Passed in 2019. House Bill 1099, also referred to as Brennen's Law, requires our fully insured carriers to provide a directory indicating which providers are closed to new patients, whether a health carrier classifies mental health and substance use disorder treatment as primary care or specialty care, include the average wait times to accessing treatment services, provide information on steps a member can take if they are unable to access covered services, any instances where the Office of the Insurance Commissioner has taken disciplinary action against the carrier. The rules around this law are still being developed with the OIC and our carriers. HCA has included information on Brennen's Law in both the SEBB and PEBB enrollment guides, as well as on our website.

Slide 13 – Legislation Passed in 2020. Engrossed Substitute House Bill 2642 removes barriers to substance use disorder treatment. It requires our SEBB and PEBB fully insured carriers, as well as the Uniform Medical Plan, to provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health agency that provides inpatient or residential substance use disorder treatment prior to conducting utilization review, and to provide coverage for no less than three days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review. It requires our carriers to coordinate care between

facilities, and to ensure seamless transfer, as soon as possible, to an appropriate and available facility or level of care. The health plan shall pay the agency for the cost of care at the current facility until the seamless transfer to the new facility or level of care is complete. This does not require a behavioral health agency to keep a person until the next level of care is available. But if the behavioral health agency does keep the patient, then the carrier is required to pay until the transfer is complete.

**Emily Transue:** Slide 14 – Mental Health Parity. There are also requirements for mental health parity at a national level. In general, federal law prohibits group health plans from imposing less favorable benefit limitations on mental health and substance use than on medical or surgical benefits. This is a law that's been on the books for quite a long time, starting, among other things, with the Mental Health Parity and Addiction Equity Act of 2008. That has gone through multiple modifications, including some that happened in 2016. All SEBB plans are required to meet this requirement, and should continue to actively assess, and make changes as interpretation evolves.

You can envision that the simple pieces of parity, like if you cover inpatient care for medical and surgical issues, you need to cover inpatient and care for behavioral health issues, are fairly straightforward. Things get a lot more complicated as you get into more nuanced and sophisticated approaches to parity. How do you think about applied behavioral analysis for autism, which really doesn't have a clear correlate on the physical health side? This is evolving, I think in very positive ways, in terms of our understanding of what parity should be and should look like over time. That evolution will continue. All SEBB plans are part of that conversation in making sure they are up to date with the most current understanding of what this means.

**Lauren Johnston:** Slide 15 – Information on How to Access Services. Members can find more information on how to access services at the link provided. The information found at this link is also listed by plan in the Appendix. The information provided includes links to different mental health and substance use disorder treatment resources, links to finding a provider, obstacles that a member may encounter when trying to access care and how to mitigate those obstacles, as well as questions that may help guide the conversation when a member calls their plan's customer service. And we always encourage our members to start by calling their health plan.

The slides in the Appendix were originally developed for use by the Educational Service District Navigators. They have access to those slides as well.

**Emily Transue:** Slide 15 – SmartHealth Resources. We also have SmartHealth resources. I think you're getting the theme that this is a problem that many people have with different levels of awareness of what their needs are and of what the resources are. Our aim is to have access be as broad as possible, to as many different kinds of care as possible, and as much information available as possible, about how people find it and access it. SmartHealth is, of course, our HCA wellness program. This is another way of reaching out to people who may not be quite thinking of what they need and how to get it. Each of the carriers has a tile around mental health. There's a tile called Mental Health Tips, which is currently running, and will run through the end of November. May, in case you weren't aware, is mental health month, and a special tile on that will be available throughout the month of May. The way SmartHealth works, of course, is that members can log in or register, and then they can see what's available. By going

through these tiles, and learning about these issues, they can earn points towards their wellness incentive. This is one way we're trying to increase general awareness around these issues and around member's options.

**Pete Cutler:** Do we have any kind of performance standards in our contracts with the carriers, or that we apply to Regence, as the administrator for the UMP, that actually go to evaluating them on their effectiveness? At least assessment of the outcomes of their members' access to behavioral health services, or at least the members' assessment of whether they feel they have access to services?

**Lauren Johnston:** All of our carriers have to do the CAP survey every year, which is a consumer survey that asks a number of different questions about whether or not customer service answered their questions, if they had information on costs, if they were able to see a provider within x number of days, etc. I do not believe the questions are specific to behavioral health. There isn't a question that specifically asks, did you access behavioral health treatment within x number of days. It would be more general in whether they were able to access a provider they were looking for. That's not to say that we couldn't look to see if there are questions under the CAP survey that are available to add.

**Emily Transue:** I think there are a couple of ways in which this is looked at, but none of them may get exactly to your question. The carriers each internally do survey assessments to look at the experience of behavioral health care, but we don't have a specific performance guarantee associated with that. We do have performance guarantees associated with some behavioral health related measures, including antidepressant medication management, which is one of their biggest measures in their contracts. We have some pieces that focus on that. But your direct question in terms of whether we have a direct accountability level to them for experience of mental health care, we don't.

**Lauren Johnston:** I'd also add that depending on how the rules around House Bill 1099 turn out, our carriers are going to likely have to start monitoring the average wait times for somebody to access a behavioral health provider. There might be something in there we could do along those lines, as well, because it's our job to ensure through their contracts that they are in compliance with that legislation. There are certain avenues we could probably take to get that information.

**Pete Cutler:** Over the years I've had a fair amount of experience indirectly in various roles with health care, actual delivery of, or making available behavioral services. People I know have repeatedly run into problems where the carrier's assessment of what they provide is much more generous and robust than what the actual patients, or the persons involved in their coverage, were able to actually access, similar to the issues that led to the adoption of the bill they're writing rules for. At least I know, in one program, paying for the services is done more on a performance basis where there's an analysis of the patients who went in and sought care, after some period of time, were they more effectively engaged in school or at work, with family, those kind of outcomes, which would tend to show the interventions actually were helpful, as opposed to just saying, well, we have X number of people who are providers, and therefore, we assume we are being helpful. It sounds like they're really in the commercial sector, and specifically PEBB and SEBB Programs, that we're really not moving yet to those kind of



performance standards, in terms of evaluating whether the carriers are really making the behavior health services really effectively available.

**Lauren Johnston:** What we can do is go back to our carriers.

**Emily Transue:** This is an interesting question and is evolving in a number of very interesting parallel ways. For example, the old quality measures associated with depression were mostly around adherence to medications. If somebody put you on an antidepressant, were you still seeking it three months later. Those are still the ones used most broadly. There are now quality measures looking at what percentage of the people who are diagnosed with depression then have it resolved, if you look at the PHQ-9 score, which is the standard assessment of depression severity, sort of a quality metric of how many people got better, how many people responded partially, and how many people got completely better. That was recently added last year to the Washington State Common Measure Set, which means it's, now, something we can look at integrating into our contracts.

There are challenges largely with data collection. You have to be fairly sophisticated to be able to get that information out of a patient into an EMR in a way that can then be pulled out and turned into an actual performance metric. That is something, in some of our other HCA roles, we're trying to support around the state. Currently, unfortunately, it's only the most sophisticated systems who are able to do that. I think that will be the way of the future. It's something we're trying to support to really get to those meaningful assessments. Some of the virtual programs have a leg up on that in their ability to have people give more real time feedback about their experience, how they're doing, what's their experience with their symptoms, and their experience of the care they're getting. I think this will evolve in good directions in the coming years, but still some barriers so far.

**Lauren Johnston:** You mentioned the virtual care programs. That's something we can go back and ask our carriers about to see if they are already starting to receive those kinds of metrics and reporting from their vendors. We can look into that as well.

**Pete Cutler:** That's very helpful, and I just fully applaud the HCA's efforts, and specifically SEBB and PEBB Programs, to support and encourage that evolution. I understand it is challenging, but it's great to be a part of the support for those improvements. So, thank you.

### **American Rescue Plan Act of 2021 – Premium Assistance for COBRA Continuation Coverage**

**Emily Duchaine,** Regulatory Analyst, Policy, Rules, & Compliance Section, ERB Division. I'm going to provide a summary of the Premium Assistance for COBRA Continuation Coverage that was made available on March 11 when President Biden signed the American Rescue Plan Act (ARPA) of 2021 into law.

Slide 2 – Overview of the American Rescue Plan Act of 2021. ARPA provides almost \$2 trillion in Covid-19 relief funding and includes multiple provisions as shown on this slide. Today, I'll only be discussing the impacts to COBRA and providing you with a high-level overview of how HCA is preparing for the subsidy.

Slides 3 and 4 – COBRA Subsidy Eligibility. The COBRA subsidy is available to Assistance Eligible Individuals (AEI) as defined in Slides 3 and 4. Federally eligible for COBRA means a qualified beneficiary or their qualified dependents. For example, a legal spouse or child. A domestic partner is not a qualified beneficiary because federal tax laws don't recognize domestic partners. It is important to note that even if the individual did not elect COBRA when it was initially offered to them, or they did elect COBRA but they discontinued it before April 1, 2021, and they're still eligible to elect COBRA, the subsidy allows this. They may either retroactively elect and have COBRA coverage back to when they lost their employer-sponsored group health coverage and pay whatever premiums are due, or they can elect to take advantage of the subsidy during the subsidy period and start their COBRA coverage active April 1.

Slide 5 – Temporary 100% COBRA Subsidy Timeline. The COBRA premiums will be subsidized from April 1, 2021 through to September 30, 2021. The subsidy will end earlier than September 30 for an Assistance Eligible Individual if that individual becomes eligible for Medicare or for other group health coverage.

Slide 6 – SEBB 2020-07 and SEBB 2020-08 Resolutions. These resolutions are still in effect and say the maximum period of continuation coverage is extended until two months after the date the Governor terminates the state of emergency. And the enrollment timelines are extended 30 days past when the Governor terminates the state of emergency.

Slides 7, 8 and 9 – Implementation. HCA must notify Assistance Eligible Individuals who become entitled to elect COBRA during the subsidy period, of the subsidies' availability by May 30, 2021. In addition, HCA must also notify AEIs of their subsidies' expiration between 45 and 15 days before the expiration date of September 30, 2021, unless the subsidy is expiring because the AEI has become eligible for coverage under another group health plan or Medicare. It's possible this subsidy timeline will be extended past September 30, 2021. HCA will plan for that if it happens. HCA plans to seek reimbursement for the subsidy directly from the federal government.

HCA will also identify AEIs with help from SEBB Organizations. We plan to create an SMA reason code, specific to the eligibility for the subsidy, for future use by SEBB Organizations, and we will provide guidance as well.

HCA will prepare communications once the federal model notices are done. The federal government is required to release the model notice within 30 days of the enactment of the Act, which was March 11. Information is going to be made available on the SEBB Continuation Coverage (COBRA) website. We will also be training staff responsible for determining eligibility of AEIs.

**Dave Iseminger:** I want to emphasize that this was intended to be very high-level. The legislation passed and signed barely three and a half weeks ago. There are key pieces of information that still aren't known because we are anticipating additional federal guidance and model notices within the next week. That's why may be counterintuitive that the subsidy began six days ago, yet there isn't a notification requirement until the end of May. This was brought to the Board as general awareness. We will bring a subsequent presentation to the next Board Meeting regarding operational aspects when we have more details.

**Wayne Leonard:** Emily, when can I tell my staff to expect your requests for this information that you need to gather?

**Emily Duchaine:** That's a good question. I would say it will be based largely on when the federal guidance and model notices come out, but because the notifications are required by the end of May, I would say we're probably going to start before the end of the month. I don't want to speak out of turn because I'm coming more at this from the policy side of things and not as heavy into the communication side.

**Dave Iseminger:** Emily, you're right that there's this crunch time. We have to do the notices before May 31. We're making reasonable assumptions as to what we think is the understanding of the eligibility and pre-pooling data so that as soon as we can validate that with the federal guidance, we'll be able to get that out as quickly as we can. We will give districts as much time as we can. We're at the mercy of waiting for information that comes out of the trifecta of federal agencies that influence this, which is Treasury, Health and Human Services, and IRS.

**Wayne Leonard:** Since Governor Inslee's order last year, we've been carrying medical premiums for a number of people who have quit or been terminated because of his emergency order. Would this subsidy allow us to get reimbursed for that expense?

**Dave Iseminger:** The subsidy begins April 1 of 2021. There is no retroactive aspect.

**Wayne Leonard:** Okay, so the people we're carrying on medical insurance are not on COBRA. They're on our existing group plan.

**Emily Duchaine:** This subsidy is only for COBRA premiums, not for group health premiums.

**Wayne Leonard:** Okay.

### **Public Comment**

None

### **Next Meeting**

May 5, 2021

9:00 a.m. – 1:00 p.m.

### **Preview of May 5, 2021 SEB Board Meeting**

**Dave Iseminger**, Director, Employees and Retirees Benefits Division, provided an overview of potential agenda topics for the May 5, 2021 Board Meeting.

**Lou McDermott:** I wanted to thank the Board for the LTD vote. One step that always blew me away was 1 in 4 working Americans will be disabled at some point during their careers, even if only temporarily. This benefit will greatly help those who find themselves in that position, unfortunately, as I've heard so many stories about folks who

find themselves only with the basic benefit, and not able to cover their expenses, and going into debt, and all the things that happen when you don't have enough money to pay your bills. I do appreciate that vote.

Meeting adjourned at 11:50 a.m.